

North Dakota Sexual Assault Evidence Collection Protocol 4th Edition

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A Collaboration of:

North Dakota Office of the Attorney General,
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And
The Otto Bremer Foundation

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Information contained in this document is to be utilized in the forensic evidence collection process in sexual assault cases. This process has been approved by the Attorney General of North Dakota, the Attorney General's Office State Crime Laboratory, and the Council on Abused Women's Services/Coalition Against Sexual Assault in North Dakota.

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PREFACE

As the U.S. Department of Justice has stated, “Sexual assault is a **crime of violence** against a person’s body and will.” It is a crime that “continues to plague our Nation and destroy lives.”¹ In North Dakota alone, more than **700 new cases** of sexual assault have been reported each year since 1995. In 2004, **825 primary victims** and more than **350 secondary victims** of sexual assault were served by sexual assault crisis centers throughout North Dakota.²

This document has been created for the sake of these victims. Its primary purpose is to promote a **uniform evidence collection protocol** that will assist to:

- **Minimize** the physical and psychological **trauma** to the victim of sexual assault.
- Offer communities a means to develop a **victim-centered response**.
- Maximize the probability of collecting and preserving physical evidence for potential use in the **legal system**.
- Provide guidance to **local communities**.

The North Dakota Sexual Assault Evidence Collection Protocol contains the following sections:

- Sexual Assault: Important **Information**
- Role of Community **Agencies**
- **Law Enforcement** Response Protocol
- **Medical** Response Protocol
- Sexual Assault of **Children**: Important **Information**
- Sexual Assault of **Children**: **Law Enforcement** and **Child Protective Services** Protocol
- Sexual Assault of **Children**: **Medical** Response Protocol
- Overview of the **Forensic-Medical Exam**
- The Sexual Assault Evidence Collection **Kit**
- Evidence Collection from a **Suspected Perpetrator**
- **Post-Evidence Collection** Procedure: Medical Personnel and Law Enforcement

Although each case of sexual assault is unique, this overview provides the basis from which to **develop policy and conduct evidence collection**. In addition, basic medical, psychological, and support issues have been addressed throughout. **For more detailed information** on the medical, psychological, investigative, and legal aspects surrounding sexual assault treatment, please consult topic-specific literature.

¹ U.S. Department of Justice/Office of Violence Against Women *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents*, 2004, p. iii-1.

² North Dakota statistics on sexual assault are compiled by the North Dakota Council on Abused Women’s Services (NDCAWS) and the Coalition Against Sexual Assault in North Dakota (CASAND), in conjunction with the North Dakota Department of Health, Division of Injury Prevention and Control.

The term “**sexual assault**,” for the purpose of this Protocol, will refer to all sex crimes, defined broadly as:

Any act of sexual contact or intimacy performed upon one person by another without mutual consent, or with an inability of the victim to give consent due to age or mental or physical incapacity.

BACKGROUND

In 1987, a task force formed in North Dakota for the primary purpose of addressing the unmet needs of sexual assault victims. The **multidisciplinary task force** was comprised of representatives from law enforcement, healthcare, rape crisis organizations, the North Dakota Hospital Association, the ND Office of the Attorney General, the ND Department of Human Services, and the ND Department of Health and Consolidated Laboratories.

The task force sought to meet the following **goals**:

- To **develop materials** that would encourage **uniform procedures** and thereby **reduce trauma** to individuals who report a sexual assault.
- To enhance the **quality and quantity of evidence collection** so as to facilitate **prosecution** of the crime.

The task force engaged in **public hearings** throughout the state, which reinforced the commitment to create both the **North Dakota Sexual Assault Evidence Collection Protocol** and the **Sexual Assault Evidence Collection Kit**. Adopting the U.S. Department of Justice Protocol as a framework, the task force made modifications specific to facilities and services within North Dakota.

In 1994, under the direction of then Attorney General Heidi Heitkamp, the Protocol was newly **revised** and edited with the goal of **facilitating the successful prosecution of the offender**. To this end, the Protocol sought to coordinate the needs of individuals who report a sexual assault with available medical and law enforcement responses.

In 2001, a multidisciplinary ad hoc committee or “**team**” was formed and funded by the North Dakota Council on Abused Women’s Services. Members of the 2001 team brought particular experience in working with sexual assault victims; they represented professionals from the fields of medicine, law, law enforcement, victim advocacy, and forensic science. The team offered recommendations that were based on the physical and emotional needs of the sexual assault victim, and were reasonably balanced with the basic requirements of the legal system.

The **2004 Sexual Assault Evidence Collection Protocol Committee** was expanded to include federal and state victim-witness coordinators and Tribal Judicial representatives. This expanded team modified the Protocol to be more user-friendly; to be compliant with the national protocol provided by the U.S. Department of Justice; and to accompany the Sexual Assault Evidence Collection Kits, which the Attorney General’s State Crime Laboratory distributes to local hospitals.

While North Dakota shares wide diversity in training, education, facilities, and cultures, the members of the 2004 Protocol Committee hope this Protocol and Sexual Assault Evidence Kit serve you well. **We truly hope these resources support your local team** to take effective action when a sexual assault victim comes forth.

INFORMATION UPDATED FROM THE 3RD EDITION OF THE PROCOTOL

The North Dakota Evidence Collection Kit has been revised along with the 2004 Protocol. Please note the following **procedural changes** from previous editions, which reflect a desire to be more sensitive to the victim during the initial examination and to **avoid subjecting the victim to unnecessary collection procedures**. Please note, as well, that this Protocol has additional information related to **suspect evidence collection**.

The Protocol instructions should supplement the instruction form enclosed in the Kit.

- Evidence shall be collected **up to 96 hours** following a sexual assault – extended from 72 hours, due to advances in technology in the detection of evidence and DNA. Other circumstances such as whether or not a victim has showered prior to reporting will need to be evaluated by attending medical personnel, law enforcement, and the advocate to determine if collection of evidence is appropriate beyond 96 hours.
- In order to implement the Health Information Portability and Protection Act (HIPPA), **two separate consent forms must now be used**, one to give the medical facility “consent to perform the examination and treatment” and another to allow the “release of protected health information.” These forms can be found in the Appendix. Additional forms may be required by your individual agency.
- The **collection of fingernail clippings is no longer mandated** unless it is clear at the time of collection that such samples would be of evidentiary value. If the nails of the victim were not broken during the assault, there is no reason to collect fingernail clippings. Scrapings of the nails are sufficient.
- **No wet mount analysis** is to be performed. The observation of sperm (motile or non-motile) has proven to be of no evidentiary value. In addition, inclusive or contradictory results between medical reports and forensic reports can hamper the criminal investigation.
- The **collection of pulled pubic and pulled head hair samples is no longer recommended**. The buccal swab and blood collection will produce the DNA standard needed.
- Based on the National Recommended Standards of Care from the Centers for Disease Control, **treatment for prevention of pregnancy or emergency contraception** should be provided in all assaults in which there is a risk of pregnancy.
- National Standards of Care and the Centers for Disease Control recommend providing **prophylactic treatment of sexually transmitted infections** rather than performing cultures, unless there is a medical need for cultures.

- The medical facility should **never directly bill a victim** for the forensic-medical examination. The medical facility should work with third party payers and Crime Victims' Compensation to set up a payment option for all examination expenses. (Please refer to Appendix K.)
- The **Suspect Section** is a new section added to ensure proper evidence collection in cases in which a suspect is apprehended and evidence of a sexual assault may exist.

SEXUAL ASSAULT: IMPORTANT INFORMATION

Medical Care, Criminal Investigation, and Victim Rights

Ideally, every sexual assault victim should have a **medical check-up as quickly as possible** to determine whether he or she has sustained internal injuries that could lead to complications, to determine the risk of pregnancy, and to collect evidence of the sexual assault.

A victim of sexual assault, however, **does have the right to refuse medical examination**. A sexual assault victim can choose (1) no medical exam, (2) a medical exam for personal medical care only, or (3) a medical exam for personal medical care and to collect evidence of the sexual assault.

Similarly, the **victim can choose the extent to which she or he cooperates with the investigation** by law enforcement. Law enforcement should encourage cooperation, of course, but ultimately the decision is the victim's. In addition, law enforcement is charged with the responsibility of clearly informing the victim of the following: Although it is more difficult for the State to prosecute a sexual assault case without the victim's report or cooperation, the **decision to prosecute is the State's and not the victim's**.

In other words, **though the victim can decide her or his own level of cooperation with the investigation, the victim does not need to “press charges” in order for the State to prosecute**.

To best serve the needs of victims, professionals should be willing to deal with all concerns brought up by the victim and to provide the victim with enough information to be able to make **informed decisions**.

Note also that **reporting by certain professionals** is mandated by law.

Sensitivity to Victim Needs

Unfortunately, both the medical examination and the investigative interview bear a **resemblance to the traumatizing experience** that the victim has already suffered: They each involve either physical or emotional re-visiting of the sexual assault.

For this reason, medical personnel and law enforcement officers play a crucial role – not just in the collection of evidence, but in the victim's eventual recovery. These professionals are in a unique position to **offer immediate support and help in the victim's re-empowerment process**. The more truly supportive these professionals can be, the less likely they are to **further traumatize the victim** and thus **hinder the evidence-gathering process**.

One significant way to minimize additional trauma is to ensure a victim-centered response in all aspects of the sexual assault investigation. A **victim-centered matrix** provides an opportunity to establish the roles and responsibilities for team members who respond to sexual assault. (Please see Appendix A for a sample “Victim-Centered Responsibilities Matrix.”)

A **broad understanding** of sexual assault and its dynamics is helpful in providing support. With this understanding, professionals are able to address their own **perceptions** of sexual assault, its victims, and its results. Professionals are also able to consider the ways in which they **make their perceptions known** to the victim – intentionally or otherwise.

First and foremost, please know that **sexual assault is NEVER the fault of the victim**, regardless of the circumstances.

Surprisingly perhaps, **70% of rape victims report no major physical injury**.³ They may arrive at the emergency department or police department, not for assistance with a physical injury, but for protection and general assistance.

In any situation, victims experience **varying degrees and types of trauma**. The effects of **psychological trauma** are often more difficult to recognize than physical trauma. A severely traumatized victim may appear to be calm, indifferent, submissive, jocular, angry, or even hostile toward those who are trying to help. **Any and all of these responses are appropriate responses** to sexual assault – which is, after all, a crime against a person’s “body and will.”⁴

In general, **victims of sexual assault may experience**

- shock,
- numbness,
- disorientation,
- difficulty concentrating,
- withdrawal,
- denial,
- nightmares,
- flashbacks,
- rage,
- anger,
- depression,
- difficulty eating or sleeping,
- extreme and unexplainable fears,
- guilt, and
- self-blame.

³ U.S. Department of Justice/Bureau of Justice Statistics *Rape and Sexual Assault: Reporting to Police and Medical Attention, 1992-2000*, August 2002.

⁴ U.S. Department of Justice/Office of Violence Against Women *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents*, 2004, pp. iii-1.

While there is neither a “typical” sexual assault, nor a “typical” pattern of response to sexual assault, counselors report that a victim *may* experience a number of different responses:⁵

Fear

Fear that the **perpetrator** will retaliate: Perpetrators often threaten to harm or kill victims if they report the crime, saying, “I will find you somewhere or somehow.”

Fear of the **reactions of others**, including medical personnel, law enforcement, family, friends, and community: Those who have been sexually assaulted are aware that other victims have been blamed for their own sexual assault.

Fear of **others who resemble the perpetrator** in some way: As a natural protective response, a victim may develop a generalized fear of men, adults, people wearing a certain type of clothing, etc.

Fear of **not being believed**: This fear can be especially marked if the victim knew the perpetrator in advance or if the perpetrator is well known in the community.

Guilt

Guilt because he or she has **internalized the societal belief that victims are somehow to blame for sexual assault**: “I should have been wearing something else.” “I should have locked the door.” “It must have been something I did.” A victim may need to be reminded that the assault is a crime committed against her or him and that the perpetrator is responsible.

Guilt because he or she **didn’t attempt to fight the perpetrator** – or didn’t fight hard enough: Again, a victim may need to be reminded that staying alive was of the utmost importance and that fighting the attacker could have caused more harm or even death to the victim.

Guilt because he or she knew the perpetrator ahead of time, but **didn’t “see it coming”**: In this case, a victim may benefit from the reminder that there is no way to know who will be – or won’t be – a perpetrator. The victim may have been in the assailant’s company previously without being assaulted, so the victim would have been likely to develop a sense of trust.

⁵ Rape & Abuse Crisis Center of Fargo, North Dakota *Red Flag, Green Flag*, 2001.

Guilt because he or she **used to believe in the power to resist**: In the past, a victim may have seen her- or himself as someone who could spot, ward off, or effectively fight a perpetrator. After the sexual assault, a victim may feel tremendous self-doubt and guilt about not being able to stay safe.

Embarrassment

Embarrassment about **discussion of the assault**: Many victims are embarrassed to talk about the physical details of the assault. Like many people in the United States, they believe that their bodies and sexual traumas are private and not to be revealed.

Embarrassment about **possible reactions by friends and family**: Many victims isolate themselves from family and friends because they are embarrassed to be seen as a victim.

Embarrassment about the **medical examination**: In the exam, a victim's body is again exposed to others, possibly reminding the victim of the sexual assault itself.

Anxiety

Anxiety in **psychological form**, such as flashbacks and nightmares.

Anxiety in **physical form**, such as shaking, shortness of breath, and panic: With any type of anxious reaction, a victim may benefit from reminders that the current environment is a safe one, and that the physical reactions are occurring as a result of feelings about the assault.

Anger

Anger about the **sexual assault** itself.

Anger about **events following the sexual assault**, such as having to change lifestyle, testify in court, seek continued medical care, pursue ongoing counseling, and adjust to an overwhelming sense of powerlessness.

(Please note that anger can be a very **therapeutic** reaction for victims of assault; anger with the perpetrator can mark the beginning of recovery. Counseling, reporting, and prosecuting may be ways to vent and transform a helpless sense of anger.)

Victim Populations

Just as each victim has a unique reaction to sexual assault, each victim may face an additional set of **circumstances that affect how he or she recovers**.

Age of the Victim

The age of the victim is **one of the most crucial factors** to consider when responding to any victim of sexual assault – in determining the proper method of administering an interview, conducting a medical examination, and/or providing psychological support.

In North Dakota, approximately **75% of sexual assault victims are between the ages of 13 and 29**.⁶ Many forensic evidence collection issues apply equally to adult, youth, and child victims of sexual assault. Even so, the needs of a young victim can be markedly different from those of an adult.

The **Child Protocol** sections of this document discuss various issues of concern in examining or interviewing a child victim. While these sections are included to assist child victims and those who respond, the collection of evidence is only one aspect of investigating child sexual assault.

Indeed, the dynamics involved in caring for child victims are too many to sum up in a few paragraphs. Therefore, it is recommended that child victims be examined and interviewed at **treatment centers that specialize** in the collection of evidence with children and in child forensic interviews.

As with other sexual assault victims, **elderly victims** can experience extreme humiliation, shock, disbelief, and denial. An elderly victim may not feel the full emotional impact of the assault until after his or her initial contact with advocates, attending medical personnel, and the police. At this time, an older victim might begin to realize the full extent of the violation – the effect of possible illness caused by the assault, as well as the increased physical vulnerability and threat of mortality. Fear, anger, or depression can be especially severe in older victims who can often be **isolated**, lack a support system, and live with limited resources.

In general, the elderly are physically more vulnerable than the young, and injuries from an assault are **more likely to be life-threatening**. In addition to possible pelvic injury and sexually transmitted infections, the older victim may face increased risk of other tissue or skeletal damage, as well as **exacerbation of existing illnesses and vulnerabilities**. For many of these reasons, the emotional recovery process can tend to be lengthier for elderly victims of sexual assault.

Hearing impairment and other physical conditions attendant to advancing age can render the elderly victim **unable to make her or his needs known**. As a result, the victim may prolong the period before reporting the assault and then may receive **inappropriate treatment**.

⁶ North Dakota Council on Abused Women's Services/Coalition Against Sexual Assault in North Dakota *Facts of Sexual Assault in North Dakota*, 2003, January 2004.

Unfortunately, hospital and law enforcement personnel may incorrectly conclude that **senility** – rather than sexual assault – is responsible for the victim’s confusion and distress.

All follow-up services must be made **easily accessible** to older victims, so that these victims become more able to seek or receive help. With encouragement and assistance in **locating services**, older victims may become less reluctant to proceed with examination and investigation. With **intensive follow-up**, elderly victims can become less vulnerable and isolated; consequently, they may recover more rapidly and be less likely to experience **re-victimization**.

Sex, Gender, and Sexual Orientation

Females are the victims of sexual assault in 96% of cases reported to the North Dakota Council on Abused Women’s Services.⁷

In the United States, where men hold the majority of positions of power and authority, a female victim of sexual assault can face an intensified experience of loss – **loss of power and authority over her own body**.

In many cultures, the female’s **loss of virginity** is an issue of paramount importance as it may render the victim stigmatized, considered unclean, or unacceptable for an honorable marriage. In other cultures, the loss of virginity may not be as great a concern as is the assault itself.

Religious doctrines may prohibit a female from being disrobed in the presence of a male who is not her husband, or forbid a genital examination by a male sexual assault forensic examiner; such practices are considered a further violation. In any circumstance, a **female sexual assault forensic examiner** should be made available for patients who request one.

Perhaps only a small percentage of **male victims** of sexual assault ever report the crime, seek medical care, or pursue counseling. Present social and cultural values can increase the trauma of the reporting experience by the male victim. As a result, many adult males seek medical care only if they have also been seriously injured. At the same time, there does appear to be **an increase in the number of male child victims** who receive treatment at hospitals.

A male victim may have serious **psychological trauma** because of concerns over his inability to resist the assault or confusion about the nature of his role as victim; perhaps he experienced an involuntary physiological response to the assault, such as stimulation or ejaculation. Like female victims, male victims can benefit from **reassurance** about the nature of the assault, as well as the likelihood of recovery; they may need to be reminded that the assault was indeed a crime, that they are not to blame for the crime, and that sexually assaulted males do recover and emerge as survivors.

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

⁷ North Dakota Council on Abused Women’s Services/Coalition Against Sexual Assault in North Dakota *Facts of Sexual Assault in North Dakota*, 2003, January 2004.

As with all persons who have been sexually assaulted, the victim's recovery depends upon her or his support network and the response of individuals to the report of sexual assault. **Gay, lesbian, bisexual, and transgendered (GLBT)** victims of sexual assault confront issues similar to all other victims of sexual assault. They may blame themselves for the assault, question their sexuality or gender identity, and fear pregnancy or sexually transmitted infections. They may fear being "outed" (exposed as GLBT) by the perpetrator as punishment for seeking services. They may be extremely reluctant to seek services at all, **fearing discrimination or disrespect** by medical personnel, law enforcement officers, and other helping professionals.

It is important for individuals responding to sexual assault to have sorted through their feelings about GLBT people, so that they can **treat all victims with dignity, respect, and compassion.**

Physical, Developmental, and Communicative Disabilities

The general **difficulty** of providing an adequate response to the sexual assault victim is compounded when the victim is disabled. Victims with disabilities may have limited mobility, cognitive differences which impair perceptual abilities, impaired or reduced mental capacity to comprehend questions, or limited language or communicative skills to describe the sexual assault.

Criminal and sexual acts committed against persons who are disabled (physically, developmentally, or communicatively) generally go **unreported and seldom realize successful prosecution.** Offenders are often family members, caretakers, or friends who **repeat their abuse** when their victims are unable to report the crimes against them.

Victims who are disabled, as well as their families, should be given **high priority and attention** in the emergency room. Additional time should be allotted for evaluation, medical examination, and the collection of evidence.

The victim who is **physically disabled** may be more vulnerable to a brutalizing assault. She or he may need **special assistance to assume the positions necessary** for a complete examination and collection of evidence. Improvisation of guidelines may be indicated in some instances.

The victim who is **developmentally disabled** may be particularly confused or frightened, possibly unsure of what has occurred and unable to understand that he or she has been exploited and is the victim of a crime.

In sexual assault cases involving a victim with **communicative disabilities**, the use of anatomically correct dolls has proved to be a successful method of communication. Also, under § 504 of the Federal Rehabilitation Act of 1973, any agency (including hospitals and police departments) that directly receives federal assistance or indirectly benefits from such assistance, must be prepared to offer a **full variety of communication options** in order to ensure that hearing-impaired persons are provided effective health care services. These options include the provision of a sign language interpreter.

Referrals to specialized support services and reports to law enforcement agencies are particularly necessary for those who may need protection, physical assistance, or transportation for follow-up treatment and counseling. Follow-up with support staff is critical for a comprehensive care plan and victim-centered response.

Refugees and Immigrants

Refugees and immigrants in the United States may be **particularly vulnerable to victimization**. Perpetrators may rely on victims' limited ability to communicate in English, their legal residency status, or their fear of reporting. Many refugees and immigrants may have faced torture and/or sexual assault as part of political conflict. As a result, the trauma inflicted by a sexual assault may compound the effects of previous assaults.

Extra care must be given to refugees and immigrants, whether or not they reveal previous experiences of trauma. In their past experiences, medical personnel and law enforcement officers may have been present or involved in the administration of torture and assault. Consequently, the medical examination and investigative interview may induce overwhelming anxiety and fear in the victim.

Consequently, **medical procedures and legal rights should be fully explained**, so that the victim clearly understands the procedures and also realizes her or his right to refuse them. To reduce the occurrence of flashbacks, the victim should be encouraged to keep his or her eyes open during the examination process. **Interpreters and specially trained support persons** should be available for support, at no cost to the victim.

Cultural Differences

A person's heritage, culture, and customs can play a major role both in the **experience of sexual assault and in its aftermath**, affecting the victim perceives the sexual assault, the healing process, the criminal justice system, and professionals wanting to help. As such, it is crucial to continue to develop **culturally-sensitive responses to all victims of sexual assault**. As much as possible, the ethnicity and culture of team members should **reflect the community** in which services are provided.

In North Dakota, **services for Native American women can be limited** due to a range of issues including economics, language, religion, and family values and relations. When working on sexual assault issues, these **barriers to services** must be considered. Sacred Circle, the National Center to End Violence Against Native Women, encourages **accessibility and accountability of service providers**, recommending that services be non-racist, non-offensive, respectful, collaborative, and flexible. Additional information is available in "Cultural Competency and

Native Women: A Guide for Non-Natives Who Advocate for Battered Women and Rape Victims” and from “**Sacred Circle**” (1-877-RED-ROAD).⁸

Loss of Life

Death investigations sometimes indicate an associated sexual assault. When such a case arises, it is appropriate to collect specimens and standards from the victim’s body during the postmortem examination or autopsy. The Sexual Assault Evidence Collection Kit described in this Protocol can be used for deceased persons. In these cases, the basic collection instructions are modified to **require the collection of all necessary and obtainable evidence specimens**, such as the known blood sample, saliva sample, combed head hair, and pubic hair. It is important that evidence specimens are adequate and representative, as the autopsy is the last opportunity to obtain these specimens from a deceased victim.

⁸ Maicki, C. *Cultural Competency and Native Women: A Guide for Non-Native Women Who Advocate for Battered Women and Rape Victims*, date unavailable. Rapid City, SD: Sacred Circle.

ROLE OF COMMUNITY AGENCIES

With only **16% of sexual assault victims reporting the crime**, communities must look for ways to encourage reporting by

- inspiring victim confidence that the system will offer **sensitive and respectful** treatment; and
- establishing a response that allows victims **many entry points into the system**.⁹

Collaborative efforts – of law enforcement, medical personnel, victim advocacy services, forensic experts, victim-witness personnel, and criminal justice personnel such as prosecutors and judges – are essential to creating a community that is **responsive to the needs of victims, holds perpetrators of sexual crimes accountable, and increases public safety**.

Law Enforcement

The victim's first contact after the assault is often with law enforcement. For this reason, the responsibilities of the responding officer are numerous. At the **initial response** stage, the **primary considerations** of the responding officer should be

- the **physical and mental health** of the sexual assault victim,
- **forensic collection of evidence**, and
- learning the **history** of the assault.

After the medical-forensic examination is complete and the victim has had the opportunity to wash and dress, the investigating officer may arrange for an **in-depth interview**. Depending on the wishes and condition of the victim, however, the interview may take place at this time or may need to be delayed for several hours or more.

Sexual Assault Victim's Advocate

It is highly important that an advocate or support person be available to each sexual assault victim. Whenever possible, **one support person** should be assigned to stay with the victim during any interviews, as well as the entire visit to the emergency department.

Well-trained support persons can

- provide the **crisis intervention** necessary when victims first arrive for treatment;
- **counsel family members or friends** who may be at the treatment facility;

⁹ Kilpatrick, D., Edmunds, B., Seymour, A. *Rape in America: A Report to the Nation*, April 1992, National Victim Center, Crime Victims Research & Treatment Center.

- answer **questions** that victims might have;
- offer counseling **referrals** and other information, such as the availability of victim compensation programs or other types of assistance; and
- emphasize the importance of **follow-up care** for possible sexually transmitted infections or other medical concerns.

Some treatment facilities have **in-house staff** specially trained to treat victim trauma and to provide crisis intervention for victims and their families; this staff may also be qualified to provide **follow-up counseling** to victims on a short or long-term basis.

Local **sexual assault crisis centers** provide trained crisis intervention advocates for the victim and the family during the medical exam, the investigation, and the criminal justice process. In addition, sexual assault advocates can also **assist in coordination** with medical personnel, law enforcement, prosecutors, and other community services to provide a victim-centered response.

The Sexual Assault Forensic Examiner

The **role of the “sexual assault forensic examiner”** is to perform a forensic-medical examination on an alleged perpetrator or victim of a sexual assault – for the purpose of evidence collection, documentation, and preservation of evidence.

Typically, a **nurse** will collect all evidence, except evidence resulting from pelvic exam; then a **physician** will perform the pelvic exam and collect related swabs. In this case, the physician would be considered the “sexual assault forensic examiner.”

“Sexual assault forensic examiner,” however, is a broad term used not just to describe the physician, but **any medical professional who is authorized to perform the forensic-medical exam** for the sexual assault. In total, healthcare professionals who can perform the pelvic exam include Nurse Practitioners, Sexual Assault Nurse Examiners (SANEs), Physicians, or Physicians Assistants:

Advanced Practice Registered Nurse

A licensed advanced practice registered nurse who has completed either a graduate degree with a nursing focus, or the education requirements in effect when the person was initially licensed (N.D.C.C. § 43-12.1). The advanced practice registered nurse has the authority to **assess, diagnose, and prescribe** as defined in his or her scope of practice.

Sexual Assault Nurse Examiner (SANE)

A **registered nurse, R.N.**, who has **advanced education in forensic examination of sexual assault victims.**

Physician

A medical school graduate with a completed residency program in a chosen specialty of practice. Must be **certified or eligible for certification** in the chosen specialty and **licensed to practice** in the state of North Dakota.

Physician Assistant

A **graduate** of an accredited physician assistant program, who has completed the **national certification exam.**

A Note about Training of Sexual Assault Nurse Examiners

SANE training typically includes **40 hours of classroom instruction** specific to completing sexual assault exams – such as chain-of-custody, forensic evidence collection, documentation, courtroom testimony, sexually transmitted infections and preventative care, pregnancy risk and prevention, working with special populations, and obtaining clinical experience performing speculum exams.

SANE programs have developed in the U.S. over nearly 30 years, as medical professionals and advocates recognized that the **needs of sexual assault victims were not being met.** The SANE Development and Operation Guide suggests that victims often face

- long waits in the emergency department lobby during which they were not allowed to drink or urinate due to fear of losing evidence,
- emergency department staff with little or no orientation to perform medical forensic exams, and
- physicians who were unwilling to perform the exams.

Nurses, who tended to perform much of the evidence collection, developed SANE programs in order improve services for victims.

Treatment Facilities

It is in the best interest of sexual assault victims to seek medical treatment and evidence collection from a **health care facility that has “Sexual Assault Evidence Collection Kits,”** as supplied by the Crime Laboratory Division of the North Dakota Attorney General’s Office. Not only do these health care facilities tend to be open on a 24-hour basis, they tend to be more familiar with the specific medical and evidence collection procedures relevant to sexual assault victims.

Facilities providing sexual assault treatment should offer

- a **24-hour emergency department**,
- **staff trained** in sexual assault examinations,
- the **on-call availability** of a Sexual Assault Nurse Examiner (SANE) or a specially trained physician for consultation,
- the services of a **local sexual assault victim advocate** and/or hospital support persons, or
- **contingency plans** for the transfer of cases to a facility which has these services.

State's Attorney/Prosecutor

At the conclusion of evidence gathering, the police submit their investigation to the state's attorney, who acts as director of the case. The state's attorney determines whether there is **sufficient evidence** to charge the suspect and, if so, with which crimes the suspect is to be charged. Subsequently, the state's attorney may ask the court to authorize an **arrest warrant for the suspect**.

Using victim interviews, hospital records, witness statements, expert testimony, and results of the forensic-medical examination information and analysis – the state's attorney's office **re-constructs the events** leading up to the assault, as well as the aftermath.

To best prosecute the case, the state's attorney should **work with a victim advocate** both to contact the victim and to facilitate meetings, interviews, and court appearances. **Collaborative efforts** of medical personnel, law enforcement, victim advocacy, and the state's attorney's office help not only to support the victim, but to **hold the perpetrator accountable**.

LAW ENFORCEMENT RESPONSE PROTOCOL

Primary Responsibilities

As always, the primary responsibility of the law enforcement officer is to **ensure the immediate safety and security of the victim** of sexual assault.

After establishing safety, the officer should **explain** the following to the victim:

- The importance of seeking an **immediate medical examination**, as injuries or sexually transmitted infections can lead to more serious health problems that often go unnoticed or appear at a later time. **Healthcare professionals** can answer questions and provide information about sexually transmitted infections and pregnancy.
- The importance of **collecting and preserving potentially valuable physical evidence**. The officer should explain to the victim that such evidence can be inadvertently destroyed by activities such as washing, showering, brushing teeth, using mouthwash, douching, eating, drinking, urinating, or defecating.
- The importance of preserving potentially valuable evidence that may be present on **clothing** worn during the assault, as well as on **bedding** or other materials at the **crime scene**.

It is **best practice** to

- **inform the treating facility** that law enforcement will soon be arriving with or sending a sexual assault victim.
- **notify an advocate from the local sexual assault crisis center** to respond to the facility. (Please see Appendix J.)
- arrange, if possible, for a **change of clothing** to be brought to the treatment facility, in the event that the victim's clothing could be collected for evidentiary purposes.

Conducting the Initial Interview

At this initial stage, it is most effective to engage in a **joint-interview process** with medical personnel and advocacy support services. The responding officer should lead the interview, with the medical personnel documenting information needed for the forensic-medical exam. During the initial stage of reporting a sexual assault, a victim is likely to experience intense trauma and distress, **limiting any therapeutic benefit from repeating the events multiple times**.

At this time, the officer and team should **convey to the victim**:

- The **right to refuse** to answer any or all questions;
- The information the victim provides may be vital to the **apprehension of the assailant**.
- The officer will relay pertinent information to **investigators**.

During the **initial interview**, the officer is charged with the responsibility of eliciting the following information:

- A **brief description of injuries**, if any, to the **victim**.
- A brief description of **what happened**.
- How the incident **began**.
- **Where** the assault took place (e.g., residence, open area, vehicle, etc.).
- The **identity** (name) and/or **description** of the **assailant(s)**, if known, or of other persons who may be able to identify the assailant.
- A **brief description of injuries**, if any, to the **assailant** (e.g., whether the assailant may have been scratched or hit by the victim).
- Where the assailant(s) **lives** and/or **works**, **vehicles** used, or **areas frequented**, if known.
- The **direction** in which the assailant(s) left and a description of the **means** by which the assailant(s) left (e.g., if the assailant left by vehicle, a description of the vehicle should be obtained).
- Whether or not a **weapon** was involved.
- **Items taken from or left at the scene** by the victim or the assailant(s).
- Items used by the assailant to **conceal identity** or **biological evidence** (e.g., condom, mask, gloves, items used to wash).

Securing the Crime Scene

Once the initial interview with the victim is complete, the collection of evidence becomes the primary concern. Attending medical personnel are responsible for collecting evidence from the body. The officer has a responsibility to **secure the crime scene**, **collect evidence from the scene**, and **collect statements** from any potential witnesses.

Conducting the In-Depth Interview

After the medical-forensic exam is complete, the victim should be given time to **wash and dress before meeting with law enforcement** again.

After the completion of the medical forensic exam, and **depending on the assessment of trauma to the victim**, the investigating officer may arrange for an in-depth interview with the victim. Please remember, however, that intimate details of the attack may be traumatic and embarrassing for the victim to recall.

In some cases, it may be necessary to **delay this interview for several hours or longer**. Often, delays at hospitals are caused by the length of time necessary for the medical examination, as well as by the determination of the team as to the victim's "readiness" for such an interview.

In coping with these sometimes frustrating delays, the **law enforcement officer is asked to understand** the role of hospital staff and the priorities of the emergency department.

General guidelines for the **follow-up investigative interview** include the following:

- It is usually beneficial to a victim that a **support person** be present during this interview. An advocate can fulfill this role.
- When an investigative interviewer can demonstrate that he or she is **sympathetic and understanding of the victim's trauma**, two important goals are met – supporting the victim's sense of **security**, and increasing the likelihood that the victim will provide **complete information** about the assault.
- The investigative interviewer should establish him- or herself as an **ally of the victim**, cushioning the victim from **pressures** by family, friends, or others, as well as from **possible threats** made by the perpetrator.
- The victim should be allowed to provide a narrative account **without interruption** by the investigative interviewer or others. When the victim has an opportunity to vent pent-up feelings in describing the assault, she or he is likely to **reveal important details** that may otherwise have been missed. (The victim also gains a sense of **trust** in the interviewer and begins the **recovery** process.)
- A special note should be made to record anything the **perpetrator might have said** in order to help establish the modus operandi or crime pattern.
- The investigative interviewer should **go back over the account** and, using the notes taken, ask specific questions covering any areas of the narrative that may have been incomplete or unclear.

Transportation of Evidence

Only law enforcement officials or duly authorized agents are allowed to transfer physical evidence from hospitals to the State Crime Lab for analysis. The transfer of evidence must be performed within a **reasonable time period** – and must be recorded with the **date and time of transfer**, the name of the **current custodian**, and the **name of the acquiring custodian of the evidence**.

Rationale

With each of the above components in place, the entire system is best able to respond to victims of sexual assault. There is less trauma to victims, **increased reporting and participation** of victims in the process, and a better opportunity to hold perpetrators accountable and keep communities safe.

MEDICAL RESPONSE PROTOCOL

Because the emotional, psychological, and physical response by adults and children to a sexual assault may vary, this **Protocol is primarily intended for use with adults.**¹⁰ Please note, however, that many evidence collection issues apply equally to adults and children.

Advocate or Support Person

If law enforcement has not already done so, **medical personnel should be certain to provide any victim of sexual assault with an advocate or support person.**

Age of Consent

Under North Dakota law, **any person age fourteen years or older may consent** to receive examination, care, or treatment for sexually transmitted infections/diseases (STIs) **without permission, authority, or consent of a parent or guardian.** Due to the nature of sexual assault, however, it is recommended that when appropriate, a parent or guardian be notified to assist with issues that may arise during the exam and to support the minor after the assault. Please note that **minors age 14 and older have the right to refuse treatment and evidence collection whether or not the parents request evidence collection.**

Mandatory Reporting of Suspected Sexual Assault

According to North Dakota law, **medical personnel are mandated to report** violent crimes, including sexual assault. Medical personnel are required to notify local law enforcement authorities **as soon as is practicable.**

Pursuant to N.D.C.C. § 43-17.41, any physician, physician assistant, or any individual licensed under N.D.C.C. Chapter 43.12.1 (Nurse Practice Act) **who performs any diagnosis or treatment of any individual suffering from any wound, injury, or the physical trauma** that is inflicted with a knife, gun, or pistol **is required to report the act** to a law enforcement agency in the county in which care is rendered.

In addition, the same medical personnel who perform any diagnosis or treatment of any individual in which there is **reasonable cause to suspect the wound or injury was inflicted in violation of any criminal law of the State** are required to report the injury to a law enforcement agency. Therefore, the same medical personnel **must report any suspected sexual assault.**

This law **does not apply to mental health professionals, clergy, or others providing services** that are not related to physical injury of a crime victim.

¹⁰ The term “adult” refers to a person eighteen years of age or older; the term “child” or “minor” refers to a person under eighteen years of age.

Mandatory Reporting of Suspected Child Abuse and Neglect

North Dakota law **mandates the reporting of suspected child abuse and neglect**. Pursuant to N.D.C.C. § 50-25.1-03 and N.D.C.C. § 50-25.2-03, the following persons are required to make a report when they have **knowledge or reasonable cause to suspect** abuse or neglect:

physicians, nurses, dentists, optometrists, medical examiners, coroners, any other medical or mental health professionals, religious practitioners of healing arts, school teachers or administrators, school counselors, social workers, providers of daycare or any other care, law enforcement officers, and members of the clergy (unless information is derived in the capacity of spiritual adviser).

Reporting of Suspected Abuse and Neglect of Vulnerable Adults

North Dakota law also recommends the reporting of suspected abuse and neglect of **vulnerable adults** under N.D.C.C. § 50-25.2-03.

Medical Treatment Facilities Process

The treatment of victims of sexual assault is a medical emergency. Although many victims may not have visible signs of physical injury, they will, at the very least, be suffering from some degree of emotional trauma.

A **private location** within the hospital should be utilized for the preliminary consultation with the victim. This could be a room adjacent to the emergency department, the examination room, or private office located nearby.

Over the past several years, many hospitals have developed "**code**" plans, such as "Code R" or "SA" to use when referring to sexual assault cases. This **eliminates the needless embarrassment** to victims or their families of being identified in the public emergency or examining room setting as the "rape" or "sexual assault" victim. Other methods can be devised to avoid inappropriate references to sexual assault cases. Treatment facilities are encouraged to **develop their own sensitive code plans to ensure privacy.**

Victim Consent to Evidence Collection and Consent to Release Information

With the implementation of HIPPA, medical facilities are required to obtain two forms of consent. One is the consent to **collect evidence**; the other is to allow the medical facility to **release this information to law enforcement.**

It is the standard practice of medical treatment facilities to obtain a sexual assault victim's **fully-informed, written consent prior to conducting a medical examination or administering treatment.** Medical treatment facilities should follow their usual procedures for obtaining consent in extraordinary cases (e.g., for severely injured or incoherent victims).

Informed consent and consent to release information should be a **continuing process** that involves more than obtaining signatures on forms. When under stress, many victims may not understand or remember the reason for or significance of unfamiliar, embarrassing, and sometimes intimidating procedures. Therefore, all procedures should be **explained as thoroughly as possible**, so that the victim can understand both the procedures and the reasons for the procedures. Although much of the examination and evidence collection process can be explained by an advocate, support person, or law enforcement, the **ultimate responsibility lies with attending medical personnel**.

Right to Refuse

Having a **sense of control** is an important part of the healing process for victims, especially at the early stages of examination and interviewing. When written consent is obtained, it should not be interpreted as a "blank check" for performing tests or questioning the victim. If the victim expresses resistance or non-cooperation, the attending medical personnel **should immediately discontinue that portion of the process** and consider going back to it at a later time in the examination – if the victim then agrees.

The victim does have the **right to refuse any and all tests**, as well as **any and all questions**.

Drug-Facilitated Sexual Assault

If it is believed that an individual has been drugged to facilitate sexual assault, a urine collection sample should be obtained immediately – with informed consent. It is recommended that the procedure be performed using a State Toxicology Collection Kit from the Crime Laboratory Division of the North Dakota Attorney General's Office. In a drug-facilitated sexual assault case, the likelihood of detecting the drug used to commit the crime diminishes each time the victim urinates. Therefore, it is imperative that **immediate action** be taken to **preserve the evidence**.

There are several **indications** that should cause the attending medical personnel to **suspect a drug-facilitated sexual assault**. For instance, the victim may

- give a history of having only one or two drinks and suddenly feeling **"very drunk"**;
- report becoming highly intoxicated within a matter of **five to fifteen minutes**, especially after receiving a drink from someone or **leaving a drink unattended**;
- describe **"cameo appearances"** – awakening, seeing the perpetrator, being unable to move, and then losing consciousness again.
- exhibit signs of memory loss, dizziness, confusion, drowsiness, impaired motor skills, impaired judgment, reduced inhibition, or a variety of other **symptoms**; or
- appear intoxicated or **"hung over."**

Depending on the timeframe and circumstances, some of the **abovementioned symptoms may still be present** when the victim speaks with attending medical personnel.

Unfortunately, perpetrators often use drugs to facilitate a sexual assault by **incapacitating** the victim. **Examples** of commonly-used drugs include

- Alcohol,
- Rohypnol and other benzodiazepines,
- Gamma Hydroxybutyrate (GHB),
- Ketamine,
- Sedatives, and
- Codeine.

The drug most commonly used to facilitate sexual assault is **alcohol**. This drug is easily obtainable, socially accepted as a drug, and used frequently because the victim may voluntarily ingest it. Because alcohol consumption slows motor function and decreases inhibition, a perpetrator has a **greater likelihood of subduing a victim** who has ingested alcohol. Increased alcohol use leads to “**blackout**” stages in which an individual has no recollection of previous interactions with others. This “blackout” stage is often followed by a period of unconsciousness in which the victim loses control of her or his motor skills and experiences **amnesia**.

Benzodiazepines are another class of drugs used in drug-facilitated sexual assault. Rohypnol, generically Flunitrazepam, is a benzodiazepine prescribed as a sleeping pill. This drug is similar to Valium but is approximately ten times stronger. In the United States, its illegal use appears most frequently in conjunction with alcohol. Benzodiazepines cause muscle relaxation, slow psychomotor responses, and lower inhibitions. When taken in high doses or in combination with alcohol, they can cause **blackouts**, combined with amnesia, that last eight to twelve hours. During these blackout episodes, it is not uncommon for a victim to have a “**cameo appearance**” in which he or she sees the surroundings and the perpetrator but is unable to move or speak.

Perpetrators have been successful in administering Rohypnol to **avoid drug charges**. Routine benzodiazepine screens do not detect Rohypnol’s presence, and traces in the blood and urine may only be detected for up to 8 to 12 hours after ingestion.

Street names for benzodiazepines include rophies, roofies, ruffies, R2, roofenol, Roche, roachies, la rocha, rope, and rib. Other benzodiazepines that may be used include Alprazolam (Xanax), Clonazepam (Klonopin), Diazepam (Valium), Flurazepam (Dalmane), or Lorazepam (Ativan).

Another drug commonly used in sexual assault, **Gamma Hydroxybutyrate (GHB)**, is a fast-acting central nervous system depressant. It is produced in powder form, capsule, or as a colorless and odorless liquid with a salty taste. It has been used in Europe to induce short-term comas, for surgical anesthesia, as a treatment for narcolepsy, and in the withdrawal of alcohol and opiate addictions. GHB may produce a feeling more extreme than alcohol intoxication, resulting in decreased inhibition. Its effects are exacerbated, of course, when it is combined with

alcohol. The effects can occur within 15 minutes to an hour of ingestion, possibly causing nausea, drowsiness, respiratory distress, dizziness, seizures, and amnesia with cameo experiences.

GHB has been marketed as a health food product for its hypnotic effects and to promote muscle development and weight loss. It has also been sold over the counter as a dietary supplement.

Street names of GHB include liquid ecstasy, grievous bodily harm, Georgia home boy, liquid X, liquid E, soap, scoop, easy lay, salty water, cherry meth, zonked, and somotomax.

Clearly, when any drugs, including alcohol, are used in combination, the effects can be **fatal** for the victim. **Immediate response** is always required when medical personnel suspect that a victim of sexual assault may have ingested drugs of any kind.

Before the In-Depth Interview with Law Enforcement

A victim **must be allowed to wash and dress** prior to undergoing the in-depth investigative interview with law enforcement. This gives the victim an opportunity, once again, to regain a sense of control and composure.

Rationale

With each of the above components in place, the entire system is best able to respond to victims of sexual assault. There is less trauma to victims, **increased reporting and participation** of victims in the process, and a better opportunity to hold perpetrators accountable and keep communities safe.

SEXUAL ASSAULT OF CHILDREN: IMPORTANT INFORMATION

A Note about Terminology

Often a sexual assault with a child victim is referred to as “**sexual abuse.**” For the purposes of this Protocol, however, the term “**sexual assault**” will be used, as defined by the North Dakota Century Code.

Mandatory Reporting of Child Abuse and Neglect

Persons required to report suspected child abuse or neglect include any physician, nurse, dentist, optometrist, medical examiner or coroner, any other medical or mental health professional, religious practitioner of the healing arts, schoolteacher, school administrator, school counselor, addiction counselor, social worker, provider of day care or any other child care, police or law enforcement, and member of the clergy (except if information is derived in the capacity of spiritual adviser).

Mandatory reporting of suspected sex offenses falls under the definition of “child abuse.” If a **child appears to be a victim of any sex offense**, reporting is mandated.

Age	Mandatory Report	Sexual Act
Minor under 15	any sexual activity	any
Minor under 18	any sexual activity with an adult	any
Minor ages 15 to 17	any sexual activity with another individual ages 15 to 17 if:	use of threat, force, incapacitation, mental defect/disease, or in official custody

When making a report, mandated reporters are required to **file a written Suspected Child Abuse or Neglect Form** (960 Report Form) with the local child protection services division of the local county social services department.

Sexual Assault of Children

The sexual assault of children tends to fall into **three major categories**:

- Sexual assault of a child by a **stranger**. These assaults usually occur on a random basis, are more likely to result in severe physical injuries to the child, may involve kidnapping or use of a weapon, and account for a growing number of sexual-assault-related deaths of children.
- Sexual assault of a child through the use of **pornographic materials and exploitation**. In this category of sexual assault, many children involved are considered "run away" or

"throw away" children who are dependent upon the exploiters for physical survival and, in some cases, affection.

- Sexual assault of a child by a **family member or other person known to the child** and whom the child trusts to some degree.

The child may have varying **connections to the offender**, based upon whether the assault is intra-familial or extra-familial.

Intra-Familial

Generally the following **relationships** are involved:

- The offender is **legally related** and a member of the child victim's **immediate family** (e.g. biological or adoptive parent or sibling).
- The offender is a member of the child victim's **extended family** (e.g., grandparent, aunt/uncle, or cousin).
- The offender is **not legally related**, but is seen by the child as part of the immediate family because the **offender lives or has daily contact with the family** (e.g. step parent, guardian/foster parent, or male or female friend of parent).

Extra-Familial

The offender in an extra-familial assault usually has an opportunity for **frequent contact** with the child or may represent an **authority figure** whom the child may believe to be trustworthy. These relationships can include, but are not limited to, a neighbor, day care/school employee, clergy, scout leader, friend of family, or babysitter.

Dynamics of Child Victimization

Many child victims experience victimization over a **period of years**. Long-term sexual activity is common in both intra- and extra-familial situations, beginning when the child is three years of age or even younger. This victimization may continue well into adolescence or until the child leaves home.

Outside the home, there is **little opportunity for young children to learn** what constitutes appropriate and inappropriate physical contact with an adult or older child. The child may sense the inappropriateness of sexual assault, but may be **reluctant to seek help** because of shame, embarrassment, uncertainty, or **direct threats of personal harm** by the offender to the child or to the child's family.

Unless children **are educated about proper and improper touching** and the importance of **telling someone** when inappropriate behavior occurs, many children do not understand that they should report the incident(s).

Intra- and extra-familial sexual assault can begin as fondling or gentle touching and escalate to manual penetration or full intercourse after an extended period of time. The offender is usually viewed as an **authority who "must know what is best,"** which often allows the offender to convince the child that the sexual contact is normal. The situation is made even more complicated when the offender is **someone whom the child loves or trusts**, such as a parent or other close family member.

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

Some children reach **adolescence** before realizing, in educational settings or through general discussions with other teenagers, that the sexual contact they have experienced is wrong and does not occur in most other households. By this time, however, the child may have assumed a great deal of **guilt** about the sexual activities and may be even **more reluctant to reveal the situation** to a family member or any adult.

Indicators

Because of the inability of most children to secure medical treatment on their own, **the majority of sexually assaulted children do not receive immediate medical attention**. When medical attention is received, it is usually at the request of someone other than the child.

This request is frequently made by a **parent** who notices unusual genital soreness, discharge, or urinary problems; a **teacher** who sees a sudden change in the child's behavior; a **relative** who suspects physical abuse; or **medical personnel** who discover a sexually transmitted infection from a vaginal, urethral, or throat culture.

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

- The child **staying inside** the house more frequently.
- The child **not wanting to go to school**.
- The child **crying** without provocation.
- The child **bathing** excessively.
- A sudden onset of **bed wetting**.

SEXUAL ASSAULT OF CHILDREN: LAW ENFORCEMENT AND CHILD PROTECTIVE SERVICES RESPONSE PROTOCOL

Advocacy

Under no circumstances should the child be left alone during his or her time at the hospital or during an interview. Arrangements must be made to **provide a support person** who can establish good rapport with the child and remain with the child.

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

Collaboration between Law Enforcement and Child Protective Services

Circumstances surrounding the child sexual assault may indicate that the interview by law enforcement and/or Child Protective Services (CPS) should take place at a location away from the hospital, such as the child's home, school, or an agency. It is the **responsibility of the investigating officer** to ascertain the most supportive **environment** for the child during the follow-up interview. However, space adjacent to the emergency room or pediatrics unit of the examining hospital should always be provided for those situations where the interview must be held immediately after the medical examination.

Privacy is, of course, crucial to the success of this interview. It is preferable that the officer be dressed in **civilian clothing** and not have handcuffs or weapons visible to the child. If wearing civilian clothes is not feasible, great care should be taken to **minimize the amount of equipment carried** during the interview so that it does not further intimidate or traumatize the child.

The **goal** of the CPS or investigator's interview with the child victim is to:

- **Avoid further trauma** to the child and **offer protection** to the child.
- Determine whether the assault was committed by a **stranger, family member, or other trusted adult**.
- **Obtain accurate information** needed for case investigation and medical treatment.

To minimize trauma caused by multiple interviews, the law enforcement interview should be conducted as a **joint interview with Child Protective Services**. Specifically, it is recommended that a **trained child sexual assault forensic interviewer** work with law enforcement when undertaking the full investigative interview. To avoid confusion, however, only one person should be the **primary interviewer**.

It is important for all responding professionals to be aware of their role in the interview. In all cases, each professional must be there for a specific purpose and must be **psychologically supportive to the child**. As always, an **advocate** should be present to offer comfort and support to the child.

Presence of Parent/Guardian

Under no circumstances should any interview be held in the presence of a parent/guardian who is a suspected offender.

In all cases of a known or a suspected child sexual assault, the team must decide whether or not the **presence of a parent or guardian** during the interview or medical examination is desirable.

Some parents may be so emotionally distraught or disbelieving upon hearing the child's narrative that their presence has a **negative impact** upon the child and the interview/examination process. When these situations occur, the parent/guardian should be taken to a **private area** and provided with support and comfort.

Often, it is not preferable to have a family member present during the medical history interview or physical examination of the child. **Dismissal of the family member** may minimize confusion and additional trauma to the child, and may also support the child to disclose crucial information that might otherwise be censored.

Please note, however – If the **child expresses a need for support from a parent/guardian**, if that parent/guardian is **not** the suspected offender, and if the parent/guardian is able to be supportive to the child, the presence of the parent/guardian may be very appropriate. Some children, particularly very young children, are **more relaxed and informative** with a parent/guardian present; these children may not be willing to cooperate in an interview without such support. Also, parents or relatives may be the only adults to whom the child will talk. In such a situation, **questions can be directed to the child through these family members** – but only after initial efforts of the interviewer to talk directly with the child are unsuccessful.

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

Conducting Child Interviews

The **attending medical personnel** should obtain the information necessary to complete the medical examination and for the collection of evidence.

The **law enforcement representative**, in conjunction with the Child Protective Services representative, has the responsibility of **investigating the allegations of child sexual assault**.

The following **general guidelines** apply to the interview itself:

- When children are interviewed about their sexual experiences with adults or other children, their **inability or reluctance to answer** can be due to fear, embarrassment, shyness, loyalty to family, or lack of an understanding of the question itself.
- Child interviewers must be aware of the **long-term ramification of their questions**. While the immediate goal is to elicit the clearest possible information from the child, the interviewer should be aware of his or her own feelings about child sexual assault, so as not to communicate any attitudes which might **create or increase the child's trauma**.
- It is important to **assess the child's verbal skill level** and to use terms that are understandable to the child. This assessment can be accomplished by asking topical questions about family, school, television, and everyday events. After a degree of **rappport** has been established, the child can then be asked to describe what happened.
- An **assessment of the child's emotional state** is a vital part of the interview process. This is an age-dependent interpretation based on factors such as how the child relates, his or her body posture, and the language used.
- The interviewer should be **supportive and sensitive** through tone of voice, body expression, and the maintenance of eye contact. The interviewer should also **sit at eye level with the child** so that the child is not intimidated, and so that the interviewer is perceived as genuinely interested.
- Younger children tend to have a **short span of attention**. Therefore, the interviewer should **avoid long and open-ended questions** and **provide short rest periods** at appropriate intervals during the interview. For example, "Tell me about the assault?" would be an open-ended question. Instead, it would be better to use a series of short questions calling for direct response such as, "Did someone touch you in a way that made you uncomfortable?"
- The use of **interview aids** is extremely helpful. Drawings, pictures, and anatomically correct dolls are particularly effective. When using these aids, **ask the child to name the different body parts** (i.e., nose, fingers, knees, etc). Then, ask the child what she or he calls the intimate areas without correcting them. **Make note of the terms used** and what areas or body parts these terms represent.
- The child must be allowed to tell about the incident(s) with **as few interruptions as possible** and to use **her or his own words** in describing what happened.
- It is absolutely **vital that the child be believed** at all times, especially in cases where the child's account is disputed by adults. The child's account should be taken at face value. Avoid making value judgments and demonstrating any shock or surprise.

- It must be made very clear to the child, as often as needed throughout the interview, that the **child was not at fault** for what happened and that professionals are there to give **help and protection**.
- **Statements made by the child should be recorded accurately.** The child should not be led in such a manner that he or she answers questions to "please" the interviewer.
- Younger children do not often experience times and dates as adults do. In order to **establish a time frame in which the abuse occurred**, it can help to discuss favorite events or activities. These could include asking about television shows, a vacation, a trip to see a relative, or a birthday.
- It may be necessary for the interviewer to **follow the child's description with clarifying questions** in order to learn exactly what happened. For instance, in situations where penetration did not occur but where there was other sexual contact, the child may not at first differentiate between oral and manual stimulation.
- It is important to determine **what reactions the child has been exposed to following the disclosure** of sexual activity. For instance, the interviewer should try to ascertain if the child's family has been supportive, ambivalent, disbelieving, angry, or blaming.

Limitations on Prosecution

Awareness of the **applicable statute of limitations** will provide a better understanding of the time parameters in which assaults may be prosecuted. All suspected cases of child abuse or neglect must be reported to law enforcement. The prosecutor will determine the limits of prosecution.

The law provides that the prosecution of a sexual assault with a child victim must be commenced within a certain number of years from the time of the offense. As a general rule, a **prosecution must be commenced within seven years from the child's 15th birthday**, or from the time of the offense if the child is over 15 years of age. If the child does not report the offense to the authorities during that seven-year period, an additional three-year window is available to file charges, beginning the date that the victim does report the assault.

Any time the **perpetrator is outside the state of North Dakota** does not count toward any of the above periods.

SEXUAL ASSAULT OF CHILDREN: MEDICAL RESPONSE PROTOCOL

Medical Treatment Facility Process

Each hospital that treats adult victims of sexual assault should have a **multi-disciplinary team, available on an on-call basis**, for the evaluation and examination of child sexual assault cases.

This team should consist of

- a **physician** specially trained in performing Colposcopic exams,
- an **advocate**,
- a **nurse** or Sexual Assault Nurse Examiner (**SANE**), and
- a **Child Protective Services representative** to provide coordination with law enforcement.

Each team member should be trained in the management and psychodynamics of child sexual assault victimization. An **obstetrician/gynecologist** should also be available on an on-call basis to provide consultation and follow-up when necessary.

In the absence of these resources, the minimum requirements should be **transportation** to a qualified treatment facility.

Intake

Children are often brought to the hospital by a police officer or parents who are seeking examination and treatment for child sexual assault. This is considered a **medical emergency** if the assault has occurred within 96 hours.

When an officer accompanies the child, the **officer should be directed immediately to the emergency/pediatric department** so that a brief history of the assault can be provided to attending medical personnel.

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

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

Attending medical personnel should **explain physical examination procedures to the child's parents/guardians**. Parents/guardians should be told **which lab tests** will be done, the **purpose** of each test, and **when the results will be available**.

Consent

Consent to conduct a medical examination and collect physical evidence should be obtained from **parents/guardians of all children under the age of 18**. A **child victim of any age** may personally consent to emergency care, however. Any child victim **age fourteen or older** may personally consent to receive examination, care, or treatment for **sexually transmitted infections** and/or **pregnancy**.

If consent cannot be obtained from the parent or guardian of the child, law enforcement may take the child into **protective custody through Juvenile Court or a child protective service agency**. A representative of the custodial agency can then sign an appropriate consent form as temporary guardian of the child.

This **temporary custodial transfer** by the court allows

- **medical staff** to provide diagnosis and treatment;
- **child protective and law enforcement agencies** to investigate the assault; and
- at least on a short-term basis, **protection of the child** from further abuse.

Authorization to Release Medical Information

Although there have been instances where a parent or guardian has refused to authorize the release of evidence to law enforcement in child sexual assault cases, the actual incidence of this has been very low and could be considered a crime when it interferes with the best interest of a child. **If a parent or guardian does refuse**, the attending medical personnel and law enforcement may be able to **assert authority** and sign for the release. If the local child protective service or law enforcement agency is not already involved in the case, they should be contacted for assistance by hospital personnel. **Each individual hospital should ascertain the policy of their local child protection team**.

Presence of Parent/Guardian

Under no circumstances should any evaluation be held in the presence of a parent/guardian who is a suspected offender.

In all cases of a known or a suspected child sexual assault, the team must decide whether or not the **presence of a parent or guardian** during the interview or medical examination is desirable.

For important **additional information**, please review “Presence of a Parent/Guardian” on **page 38** of this document.

Medical History Interview

Prior to starting the medical-forensic exam, an experienced medical staff member should interview the parents/guardians about the child's medical history. The purpose of this interview is to obtain the information necessary to conduct a proper medical examination and possible collection of physical evidence. **During the exam**, additional questions may be asked to clarify any medical questions needed for treatment.

The interview should be held in a **private room** adjacent to the emergency or pediatrics department and must be **free from interruptions**.

Medical-Forensic Examination

The steps and procedures of a child's medical-forensic exam are **similar** to those of an adult victim. The evidence is gathered in much the same way, except for instances in which a **child's body size** precludes standard procedure.

Regardless when the assault might have occurred, valuable evidence can still be obtained through a medical examination and interview of the child. Therefore it is vital that such an examination be performed (if consent is gained) and that all paperwork be completed, **whether or not evidence specimen are collected**.

If it was determined during the interview that the last sexual contact took place **more than 96 hours prior** to the hospital visit, a careful evaluation must be made to decide which, if any, evidence collection procedures should be implemented.

If it was established that the last sexual contact took place **within the prior 96 hours** or if the **time frame cannot be determined**, then **evidence procedures should be implemented according to the adult instructions with the following modifications:**

Medical Examination

An immediate assessment of the child's status must be made to determine the presence of any significant **vaginal, rectal, penile, or other major trauma/sites of bleeding**. If present, their control/stabilization must be the priority.

The presence of **genital and/or other types of physical injuries or abnormalities** can serve as corroborative evidence and should be carefully recorded in the medical record. The **location** of these injuries should be **recorded** on drawings of the female and male body. (Please see Appendix G.)

Any **specific explanations given by the child** for the injury should also be included in the medical record, using the child's exact words if possible.

The more **common medical indicators** of a sexual assault are:

- Presence of a **sexually transmitted infection**.
- Unexplained **vaginal bleeding, discharge, or trauma**.
- Inappropriate **sexual behavior** for age.
- Suspicious **stains or blood** in the underwear.
- **Lesions, bruising, or swelling** of the genital area not consistent with history.
- **Pain** in the anal or genital area.
- Unexplained pain or soreness in the **abdominal area**.

Attending medical personnel should note the presence of any bruises, abrasions, lacerations, burns, or other dermatologic lesions and record them on the documents in the **Sexual Assault Evidence Collection Kit**. Any fractures, loose or absent teeth, grab marks, or suction or bite marks should also be recorded, as they may provide further confirmation of victimization. These injuries should also be **photographed** for documentation.

Examination of the Anal Area

The attending physician must decide on a **case-by-case basis the extent to which anal examinations should be performed** with female and male children during the initial examination.

Recent anal trauma may manifest as perianal erythema, edema or contusions, skin tags, or spasm of the anal sphincter. An examination of the **sphincter tone** for spasm or laxity is important, and **any findings should be noted**.

If an **anal tear or bleeding** is present, an **anoscopy** should be performed. If the collection of a specimen is needed, **only one swab** should be used at a time to collect the specimen. Although "gaping" of the anus can be the result of certain chronic medical conditions, such as constipation, it can also be an indicator of **chronic sexual activity** involving the rectum.

Genital Examination

At the beginning of the genital examination, it is often helpful to estimate the level of sexual maturation of male and female children, using **Tanner Staging**.

Female Genital Examination

The attending physician must decide on a **case-by-case basis** the extent to which vaginal examinations should be performed. For the young female child, a complete gynecological exam

is **not recommended unless there is evidence or reasonable suspicion of genital trauma**. In any case, a careful visual inspection should still be made.

Sexually active female children should have pelvic examinations. In all cases where a pelvic examination is conducted, a **small speculum** should always be used.

With the young child present on the caretaker's lap (if appropriate), or supine on the examining table, the **vaginal and perineal areas** can be inspected. Record should be made of the presence of erythema, hematomas, excoriations, abrasions, old scars, bleeding, discharge, and odors, as well as the overall appearance of the introitus and the interlabial spread. The **urethral meatus** should be examined for any signs of trauma or abnormal dilation.

An attempt to visualize the **hymen** is usually successful in prepubescent girls.

- The hymen is a thin circular or semicircular **membrane** encircling the inner edges of the vaginal entrance.
- There are **anatomical variations** in both the size and types of openings, ranging from imperforate to completely absent. Only in extremely rare cases is the hymen enclosed over the vaginal opening. This is considered a **medical emergency**.
- **Inspection** should also be directed at any discharge (seminal or purulent), as well as odors, evidence of a foreign body, tears, skin tags, and tenderness.

Male Genital Examination

Please note that both the **glands and the scrotal area** can be targets of trauma in acute sexual assault.

Evidence of erythema, bruises, suction marks, excoriations, burns, or lacerations of the **glands and frenulum** should be recorded. Important signs of possible trauma or infection include the presence of **testicular or prostatic tenderness** or discharge from the urethra; these should also be noted.

Sexual Assault Discharge Planning Form

A “Sexual Assault Discharge Planning Form” should be completed. The victim's parent or guardian should **sign** the form at the bottom and then **receive a copy**. (Please see Appendix I.)

Follow-Up Services

The provision of **psychological or counseling services for children and their parents/guardians** is crucial. If this service is not available through the hospital, a referral should be made to an appropriate agency or individual who has approved credentials and training in the field of child sexual assault.

It is extremely important that children return for a **follow-up visit within one week**, so that any genital or other injuries can be **reevaluated** and, if necessary, **cultures** can be performed.

This follow-up visit will also provide the examining team an opportunity to **assess how well the child and/or family are coping** with the trauma and whether or not counseling has been received or is necessary.

OVERVIEW OF THE FORENSIC-MEDICAL EXAMINATION

Medical Exam, Forensic Exam, or Both?

A **medical examination should be performed in all cases of sexual assault** (when consent is obtained), regardless of the length of time that may have elapsed between the time of the assault and the examination.

A **forensic exam**, using the Sexual Assault Evidence Collection Kit, should also be performed if the assault **occurred within the past 96 hours**. Beyond 96 hours, the determination should be made on a **case-by-case basis** through the consultation of medical personnel, law enforcement, and a crisis center advocate or support personnel.

If the sexual assault took place more than 96 hours prior to the examination, it is unlikely that **trace** evidence will be present on the victim. **Evidence should still be gathered**, however, by documenting any findings obtained during the **medical examination**; evidence can include documentation of bruises or lacerations, photographs, and statements the victim may make about the assault.

Please note that some **victims may ignore symptoms** that would ordinarily indicate serious physical trauma, such as internal injuries sustained by blunt trauma or foreign objects inserted into body orifices. Please also be alert to areas of **tenderness**, which may later develop into bruises.

The majority of sexual assault victims seek medical treatment **not for the forensic collection of evidence**. Instead, they tend to be primarily concerned with the possibility of becoming pregnant or contracting a sexually transmitted infection (STI). Therefore, whether or not the victim agrees to the forensic collection of evidence, **pregnancy and STIs must be addressed at the initial exam**.

To ensure a complete evidentiary examination, **the instructions in the Protocol** must be followed. All **potential forensic evidence** should be collected.

Supplies for additional evidence collection may be obtained from the medical treatment facility's stock or from a second Evidence Collection Kit.

Attending Personnel

The **attending medical personnel** and a **trained support person or advocate** are the only persons who need to be with the victim in the examining room. Although every effort should be made to limit the number of individuals in attendance during the examination, there may also be instances when a victim requests the presence of a **close friend or family member**. If at all possible, these requests should be honored.

There is no medical or legal reason for a law enforcement representative, male or female, to observe the medical examination or evidence collection process. Medical and law

enforcement personnel **communication** should be **reciprocal**, as the release of medical information form indicates. Maintaining the chain of custody **during the examination** is the sole function of the attending medical personnel and requires no outside assistance.

Medical Report and Examination

The least traumatic and time-consuming method of collecting physical evidence from sexual assault victims is to **integrate the collection procedures into the medical examination**.

Throughout the evaluation and medical examination, the attending medical personnel should **explain to the victim**

- why **questions** are being asked,
- why certain **medical and evidentiary tests** may need to be performed; and
- what **treatment**, if any, may be necessary.

When conducting the **general medical examination**, the following types of information should be evaluated and **recorded in the medical record**:

- **Vital signs** and other initial information, such as the **date and time** of both the examination and the assault.
- A brief description of the **medical** details of the assault, including **areas of soreness**, pain, lacerations, abrasions, bleeding, bruises, bite marks, blood, or other secretions, with particular attention to the **genital and rectal areas** of both male and female victims. Common sites of **soreness, tenderness, injury, or redness** include
 - the breasts,
 - the upper portion of the inner thighs, arms, wrists, or legs; and
 - scalp area, back, or buttocks.
- The **victim's account** of what happened. This account permits the **mapping of locations on the body** where potential injury and evidence might be found.
- Information regarding the **physical location of the assault** (e.g. car, rug, grass, pavement). This information assists in determining where to look for evidence and what evidence to collect (e.g. hair, fibers, other trace material).
- **Significant medical history** of the victim, including any allergies, current medication, acute or chronic illness, surgery and any post-assault symptoms such as bleeding, pain, loss of consciousness, nausea, vomiting, or diarrhea.
- Information on the **gynecological history** of female victims. This information includes **menstrual history** (last menstrual period, date and duration, menstrual cycle),

pregnancy history (including evaluation of possible current pregnancy), and **history of contraceptive use**.

As part of the medical examination, a victim's risk of pregnancy should be assessed. A **urine pregnancy test** should be conducted to establish a baseline for possible preexisting pregnancy – **before providing emergency contraception**.

If victims report any **possible bruising**, arrangements should be made for follow-up documentation **48 hours after the forensic-medical exam**.

Integrity of the Medical Record and Interview

The indiscriminate use of the term “rape” or “sexual assault” on a medical document is a conclusion that may **prejudice future legal proceedings**. Instead, the diagnosis on the chart should be stated as “**sexual assault examination**,” plus any pertinent medical findings.

In addition, an important **distinction** must be made between information gathered for the purpose of providing **medical treatment** and information gathered for the **follow-up investigation** and potential prosecution.

Hospital personnel should not be expected to expand their role to that of “investigator.” As such, they should **not ask for details beyond those necessary** to perform the medical and evidentiary collection tasks. It is the responsibility of the law enforcement officer to ask the more detailed questions for the purpose of in-depth investigation.

Presence or Non-Presence of Semen

The forensic examiner is particularly interested in the presence of **seminal plasma** in cases where a sexual assault is alleged to have occurred with a **male perpetrator**. It is primarily the seminal plasma, not spermatozoa (semen), which gives **evidence of the genetic markers** of the donor of the specimen. Seminal plasma is produced in the ejaculates of all males, whether vasectomized or otherwise.

Even when spermatozoa is **not in evidence**, a sexual assault **may have occurred**. The spermatozoa may have been **destroyed** after being deposited, or it may **never have been deposited** at all. Spermatozoa may not be present for a number of reasons:

- The increase in the number of **vasectomies** in the U.S.
- **Sexual dysfunction** of offenders who may not ejaculate during the assault.
- Use of a **condom**.
- **Low sperm count**, which is frequent with heavy drug or alcohol use.
- Offender ejaculation **somewhere other** than in an orifice or on the victim's clothes or body.
- Non-ejaculation in cases where the assault may have been **interrupted**.

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

As a result, the medical facility should **not administer an analysis of smears to determine the presence of sperm** obtained during the evidence collection process.

Please note: When collecting the vaginal specimen, **water may be used to lubricate the speculum**.

Permanent Smears

Permanent smears (**dry mount slides**) should be made from the samples obtained. Permanent smears must be **labeled, retained as evidence, and placed in the Kit** before sealing.

It is recommended that testing for the presence of motile sperm NOT be conducted at the medical facility. It is not uncommon for the tests run at the State Crime Lab to contradict those run at the medical facility. Because of the enhanced detection ability of the State Crime Lab, for instance, **traces of semen may be found despite negative test results from the hospital**. Forensic personnel must then testify in court to explain the contradiction.

To minimize the chance of contradictions occurring, all medical and forensic specimens collected during the sexual assault examination must be kept separate – both in terms of collection and processing.

Those specimens that are **required only for medical purposes** should be kept and processed at the examining hospital; those specimens that are **required strictly for forensic analysis** should be transferred with the Sexual Assault Evidence Collection Kit to the State Crime Lab for interpretation.

Collection of Secretions on the Body

The most appropriate technique in terms of collecting secretions is to **swab areas on the body that pertain to the history of the assault**. Please note that a **Wood's Lamp is a limited tool** in the detection of secretions. While the use of a Wood's Lamp is shown to be effective in identifying protein-based secretions, **saliva and other body fluids may not illuminate** under a Wood's Lamp light source. Therefore, swabs of areas on the body should be collected, as indicated by the victim's history of the assault.

If secretions are found on the hair, the **matted hair can be cut and placed in a paper bundle**. Medical personnel must be careful, however, to obtain **consent** from the victim before cutting hair. Consent is most freely given when the need for the procedure is **fully explained**.

Thinner stains can be collected with the use of swabs that are **moistened in distilled water**, and then **air dried** and **packaged in an envelope or tube**. Secretions that are still **moist** can be collected with dry swabs to avoid dilution, air dried, and packaged in the same way.

Use of Colposcope/Medscope

Genital trauma can be an indication of recent **forced** sexual contact. Therefore, the use of a **colposcope** is recommended to obtain photographic evidence of injuries. Recent research indicates that injury to the **posterior forichette**, the point of greatest stress in forced penetration, is characterized by an **acute mounting injury**. This injury is indicative of non-consensual sexual activity. Other trauma sites may include **labia minora**, **hymen**, or **fossa navicularis**.

Video or camera equipment can easily be attached to a **colposcope**, and these test results can be used as forensic documentation. The **non-invasive** nature of this procedure makes it valuable for use with all victims, especially children and the elderly.

Toluidine Blue Injury Detection

Toluidine Blue is used to aid in the detection and visualization of injury to the **external genitalia**:

- Using a **cotton-tipped applicator**, toluidine blue can be gently swabbed onto the external genitalia.
- The dye should be allowed to **dry for approximately one minute**.
- It should then be **decolorized by wiping** with a cotton-tipped applicator that has been moistened with **lubricating jelly**.
- This wiping should be repeated until **no further recovery of dye** occurs.
- At this point, **photographs and written documentation** should be made of any injuries that are indicated by the retention of the toluidine blue in the exposed nucleus of ruptured cells.

Pregnancy and Sexually Transmitted Infections

A **major fear** for most female sexual assault victims is becoming pregnant. The attending medical personnel should discuss this possibility with the victim and explain her **options for pregnancy prevention**.

Medical treatment facilities should offer emergency contraception as a minimum standard of care. This standard applies to **all women who are at risk of pregnancy**. This option should be offered to victims along with information regarding the **risk of pregnancy, effectiveness, and side effects of treatment**.

In addition to the risks of pregnancy, sexual assault may cause the victim to contract a **sexually transmitted infection** (STI).

Best practices have confirmed that **prophylactic treatment of STIs** – rather than performing cultures – results in more desirable outcomes for the following reasons:

- Performing cultures at the initial exam has **not proven helpful to the prosecution** of the perpetrator.
- Positive cultures at the initial exam have been **used against the victim in court** to indicate sexual promiscuity.
- STI cultures are **expensive and time consuming**.
- Victims often **do not return for follow-up** testing and treatment.

Prior to Hospital Discharge

Many victims would like to **wash** after the examination and evidence collection process – **before the in-depth interview with law enforcement**.

Arrangements should be made to **provide the basics required**, such as mouth rinse, soap, and a towel. These arrangements can be **coordinated** by an advocate, law enforcement personnel, and/or attending medical personnel.

In those instances where law enforcement officers transport victims from their homes to the hospital, officers should be instructed to advise victims to **bring an additional set of clothing** with them in the event any garments are collected.

If garments are collected for evidentiary purposes, however, and no additional clothing was brought to the hospital, **arrangements should be made to ensure that the victim does not have to leave the hospital in an examining gown**. Moreover, arrangements should be made in a **timely** fashion, so that the victim is also prevented from needing to wear an examining gown during the **in-depth interview with law enforcement**.

Hospitals and law enforcement can address the availability of alternate clothing by developing a **community plan** with local victim assistance organizations.

Discharge Plan

Before the victim leaves the hospital, a "**Sexual Assault Discharge Planning Form**" should be completed. (Please refer to Appendix I.) A crucial aspect of discharge and treatment is to discuss **follow-up services** for both medical and counseling purposes. There are a number of **considerations** in discharging the sexual assault victim:

- The **type and dosage of any medication** prescribed or administered should be recorded on the **first portion** of this form.
- The **second portion** of the "Discharge Planning Form" should be used to record all follow-up and referral information.
- Victims should be encouraged to obtain **follow-up tests** for possible **pregnancy, STIs,** and urinary tract or other **infections** – **at two weeks, three months, and six months** after the initial hospital visit.
- Unfortunately, many sexual assault victims **may not return for these follow-up tests.** Possible reasons include **denial of the assault; denial of the need for follow-up testing,** particularly if no unusual symptoms are experienced; and **inadequate information provided by the facility** concerning the necessity for follow-up treatment.
- Both **written and verbal information** must be provided at the time of discharge. This information should include the **location of a public health clinic** or a **referral to a private physician** for medical follow-up if the victim does not wish to return to the treating hospital.
- **Attending medical personnel and victim advocates** can be helpful in explaining the need for a return visit and what kinds of tests should be performed.
- A **follow-up appointment** should be made with a trained hospital counselor, social worker, or psychologist in the community who is known to provide quality service. While **encouragement** should be given to seek follow-up counseling, the victim's decision to do so must be **voluntary.**
 - During follow-up contact by **advocate services,** the victim can be given **choices** as to which follow-up services he or she prefers – if any.
- For many reasons, some victims may be **reluctant to talk with a counselor.** They may be **more likely to participate in follow-up counseling,** however, if **counseling has been coordinated with the examination process.**
- The **original copy** of the "Sexual Assault Discharge Planning Form" should be given to the **victim.** A **second copy** should be **retained** for the hospital's records.

Follow-Up Contact

Any further contact with sexual assault victims must be carried out in a very **discreet** manner. Mail or telephone calls at home or work might **breach confidentiality** or cause embarrassment.

Victims should be asked, **prior to leaving the hospital**, whether or not they can be contacted about follow-up services, and if so, at **what address or phone number**.

Informational Brochures

Many **victim advocacy agencies** and **individual hospitals** have developed informational brochures about sexual assault and its aftermath. These brochures can be helpful in explaining to victims some of the **common problems** they may encounter, such as disturbances in sleeping or eating patterns, flashbacks of the attack, and Post-Traumatic Stress Syndrome. Brochures can also provide **reassurance** to the victim that sexual assault victims are not responsible for the assault.

All victims of sexual assault should receive “A Criminal Handbook for Adult Sexual Assault Victims.” This handbook can be obtained through the North Dakota Council on Abused Women’s Services/Coalition Against Sexual Assault in North Dakota. (Contact information is provided on **page two** of this document.)

Please note that N.D.C.C. § 43-17.41(3) **requires that referral information be provided to sexual assault victims and their families when they leave the hospital.**

Final Kit Instructions

When all evidence specimens have been collected, they should be placed in the **Sexual Assault Evidence Collection Kit**.

- All items must be **properly labeled and sealed**.
- Any **unused** Kit components or medical specimen collected for non-evidentiary purposes should **not be left in the Kit box**.
- The completed Kit and clothing bags should be **kept together** and stored in a **secure area**.
- The **larger paper bags** should be placed adjacent to, but not inside, the completed Kit box.
- All required information should then be completed on the **top of the Kit box**.
- The Kit should be **sealed with red or orange evidence tape** at the indicated area.

Payment for Sexual Assault Medical-Forensic Exams

Under the Federal Violence Against Women’s Act, sexual assault **victims must not be charged any out-of-pocket cost** related to the forensic-medical exam.

Reimbursement through a third party and Crime Victims’ Compensation is available to cover costs. Information about direct reimbursement from Crime Victims’ Compensation can be obtained by calling (701) 328-6195.

Victims of crime are eligible for **victim compensation**, which is awarded by the state for expenses related to a crime. Pursuant to N.D.C.C. § 54-23.4-16, victims of injury in relation to a crime must report to a law enforcement officer **within 72 hours** after the occurrence of the crime. The claimant is also expected to **cooperate** fully with appropriate law enforcement agencies.

Due to the particular dynamics of sexual assault, however, Crime Victims’ Compensation allows for a “**cause exemption**” in cases of sexual assault. This exemption permits victims to seek compensation when cause is established for **inability to meet eligibility requirements**.

Information about the **Crime Victim Reparation Program** is available by calling (701) 328-6195 or 1-800-445-2322.

(Please see Appendix K.)

THE SEXUAL ASSAULT EVIDENCE COLLECTION KIT

Instructions

The following sections of the Protocol detail the **necessary steps for evidence collection** as part of the Sexual Assault Forensic Examination. These instructions **supplement the instructions on the Instruction Form** included in the Kit itself.

Contents of the Evidence Collection Kit

The **contents of the Kit** include a number of documentation forms, as well as items to aid the collection and preservation of evidence.

The following **forms** can be found on the **top of the Kit**:

- “**Receipt** of Information”
- “Sexual Assault Forensic **Examination Procedures** Chart Summary”
- “**HIPPA Authorization** for Release” (Steps 1 and 3)

The following items can be found **inside the Kit**:

- Instructions
- “Informed Consent for Examination and Treatment” (Step 2)
- “Clothing Documentation” (Step 4)
- “Sexual Assault Report Form for Crime Laboratory” (3 pages) (Step 5)
- “Physical Condition Form” (Step 11 – General Physical; and 15 – Genital Area)
- 5 paper bags with labels affixed:
 - outerwear, pants, shirt, underwear, and bra (Step 6)
- 2 sterile, cotton-tipped swabs for body secretions (Step 7)
- 2 folded paper sheets, 2 fingernail scrapers, 2 white envelopes (one for each hand) (Step 8)
- 2 plastic combs, 2 folded paper sheets, 2 envelopes (Step 9 – Head; and 12 – Pubic)
- 4 sterile, cotton-tipped swabs (Step 10 – Oral)
- dental floss and standard envelope (Step 10)
- 4 sterile, cotton-tipped swabs (Step 13)
- 2 slides, 2 slide mailers (Step 13)
- 4 sterile, cotton-tipped swabs (Step 14)
- 4 swab boxes (Steps 10, 13, and 14)
- filter paper disc (Step 16 – Known Saliva Sample)
- standard envelope
- lancet and paper disc (Step 17)

STEP 1:

HIPPA AUTHORIZATION FOR RELEASE

A copy of this form can be found in the **Kit** itself and in **Appendix C** of this document.

The “**HIPPA Authorization for Release**” pertains to release of information. When a victim signs this form – or a copy of it – she or he permits attending medical personnel to communicate with advocates, law enforcement, and the state’s attorney’s office about **information gathered during administration of the forensic-medical examination**.

Items obtained as evidence may be released from a hospital **only** if this written authorization is in place. Therefore, it is important to obtain consent **prior to collecting evidence**.

An informed **adult victim**, age 18 or older, may sign the authorization. If the victim is a **child**, however, or appears **unable** to understand or execute the release, an **authorized third party** may act on the victim’s behalf. (Please refer to page 42 for more information.)

In general, the following signatures must be obtained regarding the **release of items collected as evidence**:

- Signature of the **victim or authorized third party** on the “Authorization” form.
- Signature of the **hospital staff person** turning over the evidence.
- Signature of the **law enforcement representative** taking custody of the evidence.

STEP 2

INFORMED CONSENT FOR EXAMINATION AND TREATMENT

A copy of this form can be found in the **Kit** itself and in **Appendix D** of this document.

It is standard practice in any medical facility to **receive informed consent prior to administering** any procedure, treatment, or care. The same standard of practice pertains to a patient who presents with a history of sexual assault.

Prior to any evidence collection or treatment, the informed consent form should be signed by the adult victim or by an authorized third party.

One copy of this form should remain with the **victim’s medical records**, and **one copy** should be sealed in the **Kit**.

STEP 3

URINE SAMPLE COLLECTION KIT

A copy of the pertinent form can be found in the **Kit** itself and in **Appendix C** of this document.

There are **two absolutely crucial practices** regarding evidence collection, drug screening, and sexual assault:

- **It should never be routine** to collect drug screens on sexual assault victims.
- Before a specimen can be collected, the victim must give **informed consent** to the drug screen.

The victim can give informed consent on the form mentioned in Step 1 – “HIPPA Authorization for Release.” She or he gives consent by **initialing** this sentence on the form:

“The **results of tests for the presence of drugs**, legal or illicit, from the urine sample collected.”

If attending medical personnel **suspect a drug-facilitated sexual assault**, they should abide by the following procedures:

- **Explain** to the victim the **need to collect a urine sample** for a drug screen – and **why** (i.e. a drug-facilitated sexual assault is suspected).
- Clearly inform the victim that a urine sample can indicate **any illegal or prescription drugs that he or she may have taken during the previous several days or months**.
- Explain that he or she **may refuse the drug screen**.
- **Determine whether ingestion of the drug in question occurred within the previous 96 hours**. If so, **immediately collect a urine specimen** as specified below.
 - **Use a sterile urine container** – one from either the **hospital supply** or the **Urine Toxicology Kit** from the State Crime Laboratory.
 - Collect **100 ml** of urine. If it is not possible to collect 100 ml, **at least 30 ml** should be collected.
 - **Label** the container with the victim’s name and the date and time of collection.
 - **Seal** the container and place it in a Ziploc or **plastic bag** to avoid leakage.
 - Indicate on the **documentation** provided in the Kit that a **drug-facilitated sexual assault is suspected**.

- **Freeze** the specimen, maintaining appropriate procedures for **chain-of-evidence**.
- **Document**
 - the estimated date and time the suspected **drug ingestion** occurred;
 - how many times the patient **urinated** since the estimated time of ingestion; and
 - whether the patient has taken any **prescription or over-the-counter medications** during the previous four or five days;
 - if so, the **names of these medications**, as well as the dates and times they were taken.

STEP 4

CLOTHING DOCUMENTATION

A copy of this form can be found in the **Kit** itself and in **Appendix E** of this document.

In order to maintain the chain of evidence, documentation should be made of **all articles of clothing that are collected**.

Clothing may contain stains, rips, cuts, stretches, blood, hair, saliva, or other trace evidence that can **corroborate a victim's statement**. All such trace evidence should be **documented** for personnel at the State Crime Laboratory.

In addition, each item should be carefully **inspected**, so that clothing can be **packaged** in a way that protects stains, marks, and alterations from **cross-contamination**.

STEP 5

SEXUAL ASSAULT REPORT FORM FOR CRIME LABORATORY

A copy of this form can be found in the **Kit** itself and in **Appendix F** of this document.

Certainly, it can be helpful to the State Crime Laboratory to receive certain written information with the Kit. By their nature, however, medical records may contain **confidential information that is not required for the forensic examination**.

Therefore, in the interest of protecting and **maintaining victim confidentiality**, a **separate form** is recommended for the purpose of providing information that is required **solely for the forensic analysis of evidence**.

Examples of **confidential medical information not relevant to the forensic evaluation of evidence** include the following:

- Information concerning **gynecological history**, such as abortions, past or current pregnancy, hysterectomy, or and tubal ligation.
- Information on the victim's **emotional status**, drug **allergies**, or past **medical concerns**, such as cancer.

The following **information should be included** with the evidence sent to the State Crime Lab:

- **Date and time of collection**, as well as date and time of **assault**.
 - This includes information regarding **period of time that has elapsed** between the assault and the collection of evidence.
- **Number and gender of offenders**.
 - Personnel at the State Crime Lab seek evidence of **cross-transfer of trace materials** including foreign **hair** and the deposit of **secretions** from the assailant(s) on the victim. Knowing the **number of offenders** in advance enables the State Crime Lab to **obtain evidence more quickly and thoroughly** from the victim's specimen's, the scene of the crime, and the assailant(s).
 - Information regarding the **gender(s) of the perpetrator(s)** helps the State Crime Lab to determine, among other things, the **type of foreign secretions** (i.e. semen or vaginal secretions) that might be found on the victim's body and clothing.
- **Actions of the victim** since the assault.
 - The **quality of evidence can be critically affected** both by the victim's actions and by the passage of time. For example, **self-cleansing** by the victim – as well as length of time that elapsed between the assault and collection of evidence – can affect the rate of drainage of semen from the vagina or rectum. **Trace evidence can also be lost**, evidence such as foreign hair, fibers, plant material, or other microscopic debris deposited on the victim by the assailant or transferred to the victim at the crime scene.
 - The State Crime Lab should be informed about which activities the victim performed prior to examination – activities including **bathing, urination, brushing of teeth, and changing of clothes**, all of which could explain any **absence of secretions or other foreign materials**. For example, douching would have an obvious chemical effect on the quantity and quality of semen remaining in the vagina.

- If apparent contradictions are **not adequately explained**, failure to explain the circumstances under which evidence could have been destroyed might **jeopardize criminal prosecution**. Conversely, **adequate documentation** can be crucial in providing **support** to the victim and to the criminal justice system.
- Information regarding **contraceptive** use and **menstruation**.
 - Various contraceptive preparations can **interfere with accurate interpretation** of the preliminary chemical test that is frequently used by the State Crime Laboratory in the analysis of potential seminal stains. In addition, **contraceptive foams or creams** can destroy spermatozoa.
 - Knowing whether a **condom** was used can be helpful in explaining the absence of semen.
 - **Lubricants** of any kind, including oil or grease, are **trace evidence** and may be compared with potential sources left at the crime scene or recovered from the body of the assailant.
 - **Tampons** and **sanitary napkins** can absorb the assailant's semen, as well as any menstrual blood. In addition, the presence of **blood** on the vaginal swab can be the result of trauma, menstruation, or both.
- **History** of the sexual assault.
 - An **accurate description of the sexual assault** is crucial to the proper collection, detection, and analysis of physical evidence. This description should include information as to whether there was **oral, rectal, or vaginal penetration** of the victim; **oral contact** by the offender; **ejaculation** (if known by the victim); and **penetration** digitally or with a foreign object(s).
- Details of physical **examination**.
 - In the search for cross-transfer of trace evidence, it is essential that State Crime Lab personnel know the **location and extent of injuries** sustained by the victim. This information enables the Lab to ascertain whether the victim's blood, for instance, might be found on the **body or clothing of the assailant**, as well as at the **crime scene**.
 - If the victim was **bitten**, the assailant's **saliva** may have been deposited on the victim's body or clothing. As such, **swabs** should be taken of those specific areas of the victim's body. In addition, the State Crime Laboratory must know **precisely where any bites occurred**, so that they may perform an effective search for possible saliva stains on the victim's **clothing**.

- Marks, bruises, cuts, scrapes, and other injuries may be visible on the victim's body and should be **photographed**. This photographic documentation is critical in **corroborating the victim's non-consent** in sexual activity. Because bruises do not tend to appear until days after the assault, however, arrangements should be made with the victim so that **maturing bruises** can be photographed in 12 to 24 hours if possible.

STEP 6

OUTER CLOTHING AND UNDERWEAR COLLECTION

Clothing Evidence

Clothing often contains **important evidence**:

- Clothing can provide **laboratory standards** for comparing trace evidence from the victim's clothing with trace evidence collected from the suspect or the crime scene. Clothing offers a surface on which **traces of foreign matter** may be found, such as the assailant's semen, saliva, blood, hair, and fibers, as well as debris from the crime scene. Though foreign matter can be washed or worn off the body of the victim, the same substances can often be found intact on clothing for a **considerable length of time following the assault**.
- Damaged or torn clothing may serve as significant **evidence itself**. Clothing may offer physical evidence of **force** or **struggle**.

Clothing Collection Procedures

Trace evidence may be present on **items that come into contact with the victim's clothing**.

- If the victim was wrapped or resting in a sheet during **emergency transport** to the treatment facility, the **sheet** should be collected.
- To minimize loss of evidence, the **victim should disrobe over a white cloth or sheet of paper**. This white cloth or sheet of paper should also be collected.

Before any clothing is collected as evidence, the victim's **consent must be reaffirmed** and the **reasons for clothing-collection** must be fully explained.

All pertinent clothing should be **collected** in accordance with the following **procedures**:

- If the victim cannot undress without assistance, such that items of clothing must be cut away, **no cuts should be made through existing rips, tears, or stains.**
- In **all cases** where the victim gives consent for the collection of clothing, the **underwear** that he or she is wearing should be collected.
- Depending on the history of the assault, **hosiery, blouses, shirts, and slacks** are likely to be sources of evidence. There also are instances when **coats** and even **shoes** may contain evidence and should be collected.
- Prior to the full examination, great care must be taken by the attending medical personnel to **determine if the victim is wearing the same clothing he or she wore during or immediately following the assault.** If so, any clothing should be collected that appears to be **torn or damaged** or to contain **debris, hair, or stains** related to the assault.
- If it is determined that the victim is **not wearing the same clothing involved in the assault,** the attending medical personnel should inquire as to the **location of the original clothing** (e.g. at the victim's home or at the laundry for cleaning).
 - This information should then be given to the **investigating officer** so that he or she can make arrangements to retrieve the clothing before any potential evidence is destroyed.
- Any **statement the victim makes** that pertains to her or his clothing should be documented in **quotation marks** in the “History” section of the “Sexual Assault Form for Crime Laboratory” (e.g. “He grabbed my left arm.”).

(Please refer to Appendix F.)

Clothing Packaging Procedures

It is imperative that garments be **packaged separately** and **sealed**, both to prevent cross-contamination and to enable the State Crime Lab to **reconstruct the crime.**

For example, if semen in the female victim's underpants is accidentally transferred to her bra or scarf during packaging, the finding of semen on those garments might appear **contradictory** to the victim's own testimony in court.

Thus, the following **procedures** should be followed in the **packaging** of clothing:

- **Wet stains** such as blood or semen should be **air dried.**
- After being air dried, all items should be placed in **separate paper bags.**

- **Small items** (e.g. underpants, hosiery, slip, bra) should be placed in separate small paper bags.
- **Larger items** (e.g. pants, dress, blouse) should be placed in separate larger paper bags.
- Each piece of clothing should be **folded inward**. **A piece of paper should be placed against any stain, so that the stain is not in contact with the bag or with other parts of the clothing.**
- Each item of clothing should be **individually bagged**. The Kit contains paper bags for outerwear, pants, shirt, underwear, and bra. **If the Kit does not contain enough paper bags, any clean paper bag is acceptable.**
- Any **foreign materials** should be collected, placed in a small **paper envelope**, properly **labeled**, and **sealed with evidence tape**.

STEP 7

DEBRIS COLLECTION

Dried Fluid or Dried Secretions

Semen and **blood** are the most common secretions deposited on the victim by the assailant. Other secretions, such as **saliva**, can also be analyzed by State Crime Laboratory personnel to aid in the **identification of the perpetrator**.

Dried Fluid Collection Procedure

A number of procedures should be followed in **collecting dried fluids**:

- During the examination itself, medical personnel should **examine the victim's body for evidence of foreign matter**.
- Dried secretions (such as blood or semen) should be collected by slightly moistening a swab with **saline**, and then **swabbing** the indicated area.
 - A **different swab** should be used for **each secretion collected from each location** on the body.
 - Extra supplies are not provided in the Kit, however, so **available hospital supplies** should be used.

- The swab should be allowed to **dry** and then returned to a **mailer**.
 - **If no cardboard tube is available**, the cotton swab should be allowed to **dry** and then placed in an **envelope** or **paper bag**.
- The mailer (or envelope or paper bag) should be **labeled** and **sealed with tape**.
 - The label must indicate the **location of the secretion** on the victim's body.

STEP 8

FINGERNAIL SCRAPINGS

During a physical crime, a victim comes into contact with both the **environment** and the **assailant**. Trace materials – such as skin, blood, hair, soil, and fibers from upholstery, carpeting, blankets, etc. – can **collect under the fingernails of the victim**. As such, fingernail scrapings are collected as potentially useful **evidence of cross-transfer** or **identification**.

The following **procedures** should be maintained in obtaining fingernail scrapings:

- Determination should be made as to **whether a victim may have scratched the assailant's face, body, or clothing**.
- Scrapings for each hand should be made **over a separate piece of paper** (i.e. one paper for the **left hand**, one for the **right**).
- The victim's fingernails should be scraped, **one hand at a time**, using the **stick** provided in the Kit.
- If fingernail damage is present, the nail should be **clipped proximal to the damage**. A **victim may want to perform this function** and should be encouraged to do so.
 - **Please note: Nails should not be clipped unless they are damaged or broken.**
- **Scrapings** for each hand should be placed in **separate envelopes**.
- Each piece of **paper** should be **folded** and placed in a **standard, individual envelope** (i.e. one envelope for the left-hand piece of paper, and one envelope for the right-hand piece of paper).
- Each envelope should be **labeled**, making a clear differentiation between "**left hand**" and "**right hand**." The envelopes should then be **sealed with tape**.

STEP 9

HEAD HAIR COMBINGS

In order to collect all loose hair and fibers, the **victim's head hair – top, back, front, and sides – should be combed over a piece of paper.**

The **combings, comb, and paper** should be placed in an envelope marked “**head hair combings.**” After labeling information is complete, the envelope should be **sealed with tape.**

STEP 10

ORAL SWAB AND FLOSSING COLLECTION

The **purpose** of this test is to **recover possible seminal fluid** from recesses in the oral cavity where traces of semen could survive. If the assault is reported **within 12 hours**, seminal fluids may be present at the time of examination.

Because the oral samples can be as important as the vaginal or anal specimens, the following **procedures** should be closely maintained:

- **Four cotton swabs** should be used to swab the mouth.
 - **Attention** should be given to the areas where seminal material might remain for the longest period of time, such as **between the upper and lower lips and gum.**
- If the victim reports that oral copulation occurred, **unflavored floss or floss sticks** may be used to floss the victim's teeth.
 - If standard floss is used, **only the used portion** should be sent to the State Crime Lab.
 - Floss should be placed in a **paper envelope**, sealed with **tape**, and **labeled.**
- When the oral swabs have **air dried**, they should be inserted into a **cardboard tube.**
- The end flaps of the tube should be **sealed**, taking care **not to cover the air hole** with tape. A white **label** should then be completed and **affixed** to the cardboard tube.
- A **colposcope** or camera may be used to document oral injury.

STEP 11

PHYSICAL CONDITION FORM

A copy of this form can be found in the **Kit** itself and in **Appendix G** of this document.

Diagrams

The Sexual Assault Evidence Collection Kit includes **diagrams of adult male and female figures**. In addition to a written description of the trauma, these diagrams should be used to indicate the **location and size of any injuries**. In order to document any injuries to **child victims** of sexual assault, these adult figures should be **adapted**.

Photographs

Photographs of extremely brutal injuries or bite marks can prove beneficial in court. Because some injuries become apparent only after several days, however, there is **no guarantee** that photographs will show the extent or the severity of the injury. Consequently, **photographs should only be taken in those instances where clear pictorial evidence of injury**, such as bruises or lacerations, **can be obtained**.

Colposcope

Colposcope pictures of **genital injury** are highly indicative of **forced sexual conduct**. Pictures taken by trained personnel during a colposcope exam may show **extremely small injuries** that can only be seen with the aid of this equipment. If these photographs are not available, drawings and accurate written descriptions are essential in **court proceedings**.

Bite Mark Evidence Collection

Bite marks found on the victim **should not be overlooked** as important evidence.

In cases where a bite mark is present, minimum procedures include **collecting saliva**, providing **documentation**, and **photographing** the affected area:

- Saliva from the bite mark should be collected **before cleansing or dressing any wound**.
- Saliva should be collected from the bite mark area by **moistening** a swab with **distilled water** and gently **swabbing the affected area**. The same procedure for **collection of other dried fluids** should be followed. (Please refer to pages 64 through 65.)
- If the skin is broken, the **actual punctures should not be swabbed**.
- Bite marks should be noted on the **body diagrams**.

- To demonstrate the size of the bite mark, an **ABFO Measurement Tool** (ruler) should be placed adjacent to – but not covering – the bite mark. The bite mark should then be **photographed**. (Please note that these supplies are **not provided in the Kit**.)
- In order to show different signs of bite marks and bruising and to prevent the camera’s flash from “washing out” the bruise, it is recommended that **at least three photographs** be taken of **each target area**: (1) **straight on**; (2) at a **slight angle**; and (3) at an **increased angle**. For close-up photographs, a **macro lens** is recommended. If a Polaroid camera is being used, photographs should be taken at least an **arm’s length (or 3 feet) away from the target area**. The **responding officer** or investigator can offer additional suggestions regarding effective camera use.

STEP 12

PUBIC HAIR COMBING

The following **procedures** should be used in gathering evidence from pubic hair:

- In order to collect falling hair and other evidence, a piece of **paper or paper towel** should be placed **beneath** the area of combing.
- A **comb** should be used to collect **any loose hair or fibers** from the pubic area.
 - A **victim may prefer to do the combing** so as to reduce embarrassment and salvage a sense of control over her or his body.
- The combing should be performed in a **vigorous and thorough manner** so that all valuable evidence can be collected.
- If **semen or other material** is present, this evidence may be **collected in the same manner as other dried fluids**. (Please refer to pages 64 through 65.) The **swab** should then be placed in a small paper **envelope** and **labeled** “possible secretion sample from pubic hair.”
 - Although this evidence can be collected by **cutting** off the matter or material, the victim must give **permission** before any significant amount of hair is removed.
- The **pubic hair combings** and the **comb** should be placed in an **envelope** marked “**pubic hair combings**.” After all the labeling information is complete, the envelope should be sealed with **tape**.

STEP 13

VAGINAL OR PENILE SWABS AND SMEARS

Important Information

The **purpose** of making smears is to allow the State Crime Laboratory to test microscopically for the **presence of spermatozoa**. If spermatozoa are not detected, the analyst uses the swab(s) to identify the components of **seminal plasma** and thus confirm the presence of **semen**.

The number of tests that forensic laboratories can perform is **limited by the quantity** of semen or other fluids collected. Therefore, **four swabs** should be used when collecting specimens from body orifices.

For a number of reasons, it is recommended that the victim be encouraged to **allow three orifices – mouth, vagina, and rectum – to be examined** and **specimens** to be collected from them. Depending upon the type of sexual assault, **penetration** may have occurred in any of these orifices. In addition, **semen may leak** from the vagina or penis into the anus, even without rectal penetration. Moreover, due to embarrassment, trauma, or a lack of understanding of the assault itself, the **victim may be vague or mistaken about the areas of sexual contact**.

In cases where a victim insists that contact involved only one or two orifices – or no orifices at all – the victim must be **permitted to refuse these additional tests**. This "right of refusal" reinforces a primary therapeutic principle, that of **returning control** to the victim.

If a victim must use **bathroom facilities** prior to evidence collection, he or she should be **cautioned** that semen or other evidence may be present in pubic, genital, or rectal areas; as such, special care should be taken **not to wash or wipe away** those secretions until after the evidence has been collected.

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

Vaginal Swabs and Smears Collection

Vaginal smears should be **prepared** using the following **procedures**:

- As vaginal specimens are collected, the vaginal orifice must **not be aspirated** and secretions must **not be diluted** in any way. If necessary, **water-based lubricant** may be used to enable insertion of a speculum or anal probe.
- **Documentation** must be provided on the **exam form**, indicating which, if any, **lubricant** was used. This information enables the State Crime Laboratory to separate chemicals used in evidence collection from any that pertain to **physical evidence**.

- The vaginal vault should be swabbed using **two cotton swabs** together.
- The sample should be **rolled across the frosted side**.
- The swabbing (with another two swabs) should be repeated, as should the slide preparation. **A total of four swabs and two slides should be collected.**
- The **frosted-end slides** must be properly labeled and include the word “**vaginal**” to indicate the origin of the specimen. To **prevent smudging** of labeling information, a **pencil** should be used.
- **No slide should be fixed or stained.**
- Each glass slide should be permitted to **dry** and then returned to the **mailer**. A label specifying “**vaginal smear**” should be affixed to the mailer. After air-drying is complete, the mailer should be **sealed with tape**.
- After being allowed to **air-dry**, vaginal cotton swabs should be placed in a cardboard tube. The end flaps of the tube should be **sealed**, taking care **not to cover the air hole** with tape. A white **label** should then be completed and **affixed** to the cardboard tube.

Penile Swabs

If the Sexual Assault Evidence Collection Kit is available, the **envelope labeled “Vaginal Smear/Swab”** should be used for penile swabs.

For the male adult and child victim, the presence of saliva on the penis could indicate that **oral-genital contact** was made. The presence of vaginal secretions could help corroborate that the penis was introduced into a **vaginal orifice**. Feces, seminal plasma, or lubricants might be found if **rectal penetrations** occurred.

Specific **procedures** for the collection of penile swabs include the following:

- **Two cotton swabs** should be slightly moistened with **distilled water**.
- The **external surface of the penile shaft and glands** should be thoroughly swabbed, using the two cotton swabs together. In addition, any **outer areas of the penis or scrotum** should be swabbed where sexual contact is suspected.
- The above process should be repeated with another set of swabs. **A total of four swabs should be collected.**
- After being allowed to **air-dry**, penile cotton swabs should be placed in a **cardboard tube**. The end flaps of the tube should be **sealed**, taking care **not to cover the air hole** with tape. A white **label** should then be completed and **affixed** to the tube.

STEP 14

RECTAL SWABS

The following are **procedures** for collecting rectal swabs:

- **Two cotton swabs** should be slightly moistened with **distilled water**.
- The **rectal area** should be thoroughly swabbed, using the two cotton swabs together.
- The above process should be repeated with another set of swabs. **A total of four swabs should be collected.**
- After being allowed to **air dry**, rectal cotton swabs should be placed in a **cardboard tube**. The end flaps of the tube should be **sealed**, taking care **not to cover the air hole** with tape. A white **label** should then be completed and **affixed** to the tube.
- As always, the examiner should **take special care not to contaminate** collections from rectal areas with secretions or matter from other areas. Such contamination could **jeopardize evidence used in prosecution of the offender.**

STEP 15

PHYSICAL CONDITION FORM

A copy of this form can be found in the **Kit** itself and in **Appendix G** of this document.

Using the “Physical Condition Form,” findings from the physical examination should be **documented** as completely as possible. **Testimony** of attending medical personnel can be necessary in legal proceedings. As such, a **thorough and legible record**, as well as an accompanying **body diagram**, will assist medical staff in recalling the incident.

Please note: **When gathering information during the medical and evidentiary examination, attending medical personnel must be absolutely certain not to include any subjective opinions or conclusions regarding whether a crime occurred.**

STEP 16

KNOWN SALIVA SAMPLE

DNA Typing and Profiling

The purpose of collecting known saliva and blood samples is for **DNA (deoxyribonucleic acid) typing and profiling**. As the fundamental building block of an individual’s genetic makeup,

DNA is a **component of virtually every cell in the human body** – including semen or other bodily fluids.

DNA found in the victim’s saliva and blood samples can be **compared** with DNA found in samples obtained from the victim’s clothing, swabs, and body. This comparison can enable the State Crime Laboratory to identify the **DNA of the possible offender(s)**.

Currently, every state in the U.S. is in the process of implementing the “**Combined DNA Index System**” (CODIS). North Dakota began its participation in December of 2000. An electronic database of DNA profiles, CODIS can help to **identify suspects** in crimes such as sexual assault, murder, and child abuse.

Upon **conviction** and sample analysis, a perpetrator’s DNA profile is entered into the CODIS database. Subsequently, DNA evidence found at **future crime scenes** can be put through the system, potentially enabling law enforcement to link suspects to other crimes.

Saliva Specimen Collection

The following **procedures** should be maintained in collecting the saliva sample:

- The victim should **not eat, drink, or smoke for a minimum of 15 minutes** prior to collection of this saliva sample.
- **Filter paper discs** – not gauze pads – should be used in collecting the saliva sample. The loose weave of gauze pads can disperse the saliva, making the specimen more difficult to analyze; in addition, filter paper discs dry more quickly. The filter disc and envelope are **provided in the Kit**.
- The **victim** should be instructed
 - to place the disc, **manually**, in her or his mouth, **satulating** it with saliva.
 - **not to chew** the disc, but to **moisten** it for a few seconds.
 - to **remove** the disc with his or her own fingers.
- If the victim is unable to administer the above procedure without assistance, a **hemostat** may be used. Because the slightest contamination from another person's secretions may be detected, however, the **disc must never be touched by anyone other than the victim**.
- When **dry**, the disc should be completely inserted into its original **envelope**. **Labeling** information should then be completed, and the envelope should be **sealed** with tape.

STEP 17

KNOWN BLOOD SAMPLE

For information on **DNA typing and profiling**, please refer to STEP 16 above.

Blood Sample Collection

The following **procedures** should be maintained when collecting a blood sample:

- Using the **lancet** included in the Sexual Assault Evidence Collection Kit, the skin should be **pierced** at the end of one of the fingers.
- **Three to five droplets** of blood should be placed on a **paper disc**.
- The disc should be allowed to **air dry**, placed in an **envelope, sealed, and labeled**.

COMPLETION

When the Sexual Assault Evidence Collection process is complete, the medical personnel who collected evidence must **carefully check each item** to be certain it is accurately **sealed and labeled**.

Law enforcement should then be notified that evidence is ready for pick-up at the medical facility. To ensure the proper “**chain of evidence**,” all articles must be kept either in the **possession of the medical personnel** or in a **locked location**, until retrieved by law enforcement. Upon release of evidence to a law enforcement officer, the officer must **sign, date, and time** the evidence.

Special Storage and Transportation

- **All Sexual Assault Evidence Collection Kits must remain refrigerated** until delivered to the State Crime Laboratory.
- **All Urine Toxicology Samples must remain frozen** until delivered to the State Crime Lab.

EVIDENCE COLLECTION FROM A SUSPECTED PERPETRATOR

Time Limits and Warrants

There is **no time limit** to gather evidence from a suspect who **volunteers** for Forensic Evidence Collection.

When a **warrant** is issued for collection of forensic evidence from a suspect, the issuing **judge sets applicable time limits**.

In certain cases, law enforcement may request that forensic evidence be collected from a suspected assailant. The **officer must first obtain a search warrant** and then share it with medical personnel.

Procedures

It is the task of a jury or judge to determine whether a suspect is guilty of sexual assault. Neither medical personnel nor law enforcement should **assume** that a suspect is indeed a perpetrator. Unfortunately, there are **no** physical – or even emotional – traits that can positively **identify** a sex offender.

Procedures for a **Suspect Forensic Exam** are similar to procedures for the **forensic exam of the victim**. The Sexual Assault Evidence Collection **Kit** is to be used in either case, and the principles of evidence collection and handling are the same.

There is one major **exception**, however.

- **Law enforcement should remain with the suspect during the exam to ensure the safety of attending medical personnel.**

The “**Suspect Forensic Exam Form**” can be found in **Appendix H** of this document. The following **procedures** apply specifically to collecting evidence from a suspected offender:

- If an officer presents a suspect with a **search warrant**, the search warrant will state exactly which samples are to be collected. The items explicitly stated on the search warrant are the **only samples that can be obtained**.
- If the suspect **consents** to the collection of evidence, **Steps 1 through 17** of the Kit should be followed.
- In cases where the suspect **consents** to the collection of evidence, attending medical personnel should **consult with law enforcement** to determine which evidence is needed (e.g. head hair, pubic hair, blood, penile swabs, etc.).

- **Please note:** If at all possible, medical personnel who performed the victim’s exam **should not be the same personnel** who collect evidence from the suspect. In other words, **different personnel should perform the exam of the victim and the exam of the suspected perpetrator** related to that case. When this practice is followed, allegations of **cross-transfer of evidence** or **evidence contamination** by the examiner are less likely.

Documentation

General Physical Appearance:

Using the “**Physical Condition Form**” (included in the Sexual Assault Evidence Collection Kit and in Appendix G of this document), the following should be **documented**:

- any torn **clothing**; disheveled **appearance**; or **stains** or trauma from carpet, sand, grass, dirt, rocks, etc.
- **any cuts, fingernail scratches, marks, bruises, or red marks** that may indicate physical struggle or use of force.

In addition, any **signs of injury or struggle** should be **photographed**.

Intoxication or Drug Use:

Suspicion of intoxication should always be **documented**.

If law enforcement or attending medical personnel have cause to believe the suspected assailant is intoxicated, a **State Toxicology Test** should be **collected** and **included** in the Sexual Assault Forensic Evidence Kit.

Please note, though, that samples for toxicology testing should only be collected upon **consent** of the suspect, or upon order through a **search warrant**.

In cases of drug- and alcohol-facilitated sexual assault, the suspect may state that the victim was **equally intoxicated**. Toxicology tests and witness interviews, however, can reveal **differences between the suspect's and the victim's levels of consumption**, possibly forming the basis for prosecution as a **Drug-Facilitated Sexual Assault**.

Suspect's Clothing:

The condition of the suspect’s clothing may **corroborate victim statements**. As such, any possible evidence of **struggle** should be noted – tears; missing buttons; grass, dirt, or other stains – with particular attention to the **elbows** and **knees**.

During the examination, attending medical personnel may find **drugs, drug paraphernalia, or drug packaging** that is consistent with drugs believed to have been used to facilitate sexual assault. Attending medical personnel should immediately **alert law enforcement** so that the officer may collect the evidence.

Law enforcement should also **collect** any of the following items that may be found in the suspect's clothing:

- **condoms** or lubricants.
- any evidence **that may belong to the victim**.
- **weapons** or any item that resembles a weapon.

Genital Exam:

Victim statements may be **corroborated** by the following:

- **collection of trace evidence** (e.g. hairs, fibers, twigs, or grass).
- **collection of biological evidence** (e.g. semen, blood, or saliva).
- **documentation of genital abnormalities** (e.g. venereal warts, tattoos, or shaved pelvic area).
- **documentation of any injuries** (e.g. scratches, bruises, or bite marks).

Smaller cotton swabs (Chlamydia type) should be used to swab the penis.

Fingernail Scrapings and Clippings:

Fingernail scrapings and clippings can contain the **victim's epithelial cells** following digital penetration, even after the suspect has bathed or washed his or her hands. As such, **fingernail scrapings and clippings should always be collected from the suspect**.

Hand swabs should be performed whenever **digital penetration** is suspected. Additional swabs should be taken around **rings and jewelry**.

Court-Ordered Testing for Sexually Transmitted Infections:

In order to determine whether a defendant or alleged juvenile offender has a sexually transmitted infection, a **court may order testing** of any **defendant** charged with a sex offense (or any **juvenile** offender who is alleged to have committed certain crimes). The court may order this testing, however, only if the **court receives a petition** either from the victim or from the prosecuting attorney with a **written request from the victim**.

**POST-EVIDENCE-COLLECTION PROCEDURES:
ATTENDING MEDICAL PERSONNEL AND LAW ENFORCEMENT**

Special Storage Conditions

Paper Containers:

Clothing and other evidence specimens must be **air dried** and then **packaged separately**, so as not to cross-contaminate other evidentiary items.

In addition, clothing must be **sealed in paper containers** in order to prevent the degradation of biological fluid stains and the loss of hair, fibers, or other trace evidence. **Absolutely no specimens or evidence should be sealed in plastic.** When plastic containers are used, moisture remains sealed in the evidentiary items, permitting the growth of **bacteria** that can quickly **destroy biological evidence**. Unlike plastic, paper “breathes” and allows moisture to escape. Paper containers are **included in each Kit**.

Each paper container should be **sealed with tape – not with staples**. Staples present a **biohazard** to lab personnel and do not provide a permanent seal.

Refrigeration:

The Sexual Assault Evidence Collection Kit must be **refrigerated (not frozen) at all times** after the evidence has been collected. Either the **hospital or law enforcement** must maintain this refrigeration until delivery to the State Crime Lab.

Standard transportation regulations must be followed to **prevent freezing** during winter months or **heating** during summer months.

Freezing:

Urine specimens collected in drug-facilitated sexual assault must be frozen at all times, including transportation. The high acidic level of urine can cause the **decomposition** of drugs and chemical analogs if the sample is not frozen.

Chain of Evidence

Law enforcement and medical personnel must work cooperatively to ensure the appropriate **transfer of medical forensic evidence**. The Sexual Assault Evidence Collection **Kit** and any **additional items**, such as clothing or urine samples, must be maintained in the **chain of evidence**.

From the moment of collection until the moment the Kit is introduced into court as evidence, the **custody of the Kit and the specimens it contains must always be accounted for**. This practice is absolutely crucial in order to **maintain the legally necessary “chain of evidence,”** sometimes called “chain of custody,” or “chain of possession.”

Unless the “chain of evidence” can be established, **evidence cannot be introduced in court.**

All evidence must be properly **handled**, and information must be **recorded** appropriately. In order to maintain the integrity of the “chain of evidence,” the following practices should be implemented:

- Evidence specimens should be **packaged, sealed, and labeled**, specifying the **date**, the **time**, the identity of the **victim**, the name of the attending **medical personnel**, and the **area of the body** from which the specimen was taken.
- The **number of persons** handling the evidentiary specimens should be minimized.
- Each person who does handle the specimens should **initialize, date, and time** them.
- Note should be made about how and when samples are **transferred** from attending medical personnel to law enforcement. Law enforcement should initial, date, and time the **external labels**.
- Both the **individual releasing evidence** and the **individual accepting evidence** should be certain that all individual evidentiary items are properly **sealed, signed, dated, and marked with the applicable time**.
- The **names** of any persons involved in the examination, collection of evidence, or handling must be **legible** on the evidence specimen. In addition, enough **contact information** must be recorded so that these persons can be **located** in the event that their testimony is needed in court.

Because medical facilities cannot be expected to have adequate facilities for storage of evidence, it is **crucial that law enforcement take custody of evidence as soon as possible.**

Transportation of Evidence to the State Crime Laboratory

All Sexual Assault Evidence Collection Kits must be sent to the **State Crime Laboratory for analysis.**

Only law enforcement officials or duly authorized agents, however, are allowed to transfer physical evidence from hospitals to the State Crime Lab. The transfer of evidence must be performed within a **reasonable time period** – and must be recorded with the **date and time of transfer**, the name of the **current custodian**, and the **name of the acquiring custodian of the evidence.**

Report of Findings

The State Crime Laboratory **reports** its findings both to the **submitting law enforcement agency** and to the **state's attorney in the applicable county**. This report is crucial to continued investigation of various aspects of the assault.

Maintaining Evidence

Evidence must be maintained until the statute of limitations expires, which is **seven years** in the case of sexual assault.

The **statute of limitations is suspended**, however, if a "**John Doe Warrant**" is issued. This warrant is based upon a DNA profile developed using evidence taken from the scene of a sexual assault.

Sources of Corroborating Evidence

Numerous forms of **evidence** can be crucial to corroborating a report of a sexual assault. Sometimes **overlooked**, these forms of evidence can include

- Used tampons, **menstrual products**, or **condoms**, which may be found in the **garbage**.
- **Washcloths or towels** used by either the victim or the offender after the assault.
- **Vomit residue** around a toilet rim, residue which may be analyzed if a **Drug-Facilitated Sexual Assault** is suspected.
- Foreign objects or **lubricants**.
- Disheveled sheets, turned-over lamp, clump of hair, or broken fingernails, all of which could indicate **non-consensual** contact.
- **Communications** such as emails, phone messages, or letters between the victim and the perpetrator.

Appendices

To North Dakota Sexual Assault Evidence Collection Protocol

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Appendix A

Victim-Centered Responsibilities Matrix

CRITICAL ELEMENTS FOR SEXUAL ASSAULT CRIME RESPONSE							
INSTRUCTIONS	A D V O C A T E	M D I C A L	L E W E N F O R C E M E N T	P R O S E C U T O R S	V I C T I M W O R T H I N E S S	C O U N S E L I N G	P R O B L E M A R E A
1. Place a “P” in the column where the <u>primary</u> responsibility exists.							
2. Place a check mark (√) under any other column that may share or possess follow-up responsibility.							
3. If you have a critical element that is not being adequately addressed or inherently causes problems, or you would like to more fully discuss this element, place an asterisk (*) in the “problem area” column.							
Receive Victim Report of Sexual Assault							
9-1-1/Police department							
Rape Crisis							
Third party reporting: friends, schools, etc							
Hospital emergency department							
Prosecutor’s office							
First Responder							
Ensure safety							
Educate on options: reporting, care, legal							
Determine need/willingness for emergency medical care							
Arrange transportation to/from hospital							
Advise victim of evidence preservation steps							
Determine if assailant is still nearby							
Determine if victim wants crisis counseling							
Determine if victim wants victim assistance							
Work with secondary victims							
Medical Intake							
Record victim’s statement/condition accurately							
Determine extent of injuries requiring medical attention							
Inform victim about evidence collection procedures and receive authorization							
Determine if victim wants advocate support during examination							
Forensic Examination							
Collect and preserve evidence in accord with established protocol: rape kit							

Victim-Centered Responsibilities Matrix

CRITICAL ELEMENTS FOR SEXUAL ASSAULT CRIME RESPONSE								
<u>INSTRUCTIONS</u>	A D V O C A T E	M E D I C A L	L A W E N F O R C E M E N T	P R O S E C U T O R S	V I C T I M W I T N E S S	C O U R T S	C O R R E C T I O N S	P R O B L E M A R E A
1. Place a “P” in the column where the <u>primary</u> responsibility exists.								
2. Place a check mark (✓) under any other column that may share or possess follow-up responsibility.								
3. If you have a critical element that is not being adequately addressed or inherently causes problems, or you would like to more fully discuss this element, place an asterisk (*) in the “problem area” column.								
Provide clothing at hospital								
Minimize patient discomfort								
Medical Concerns Related to Sexual Assault								
Pregnancy								
Sexually transmitted diseases (STDs)								
HIV/AIDS								
Administer pregnancy prevention treatment with consent								
Administer prophylactic treatment for STD with consent								
Obtain blood sample for HIV baseline status with consent								
Referral for further medical care								
Referral for psychological counseling								
Review financial issues (victim’s compensation, etc.)								
Initial Interview								
Determine interview information needed								
Develop strategy to avoid multiple interviews								
Ask victim preference of interviewer gender								
Determine if victim requires interpreter								
Provide comfortable, private setting for interview								
Determine if victim wants to file a complaint and move toward prosecution								
Investigation								
Provide private setting for interview								
Determine location of crime								
Crime scene/victim evidence: fingerprints, trace evidence, photographs, clothing, sheets, etc.								

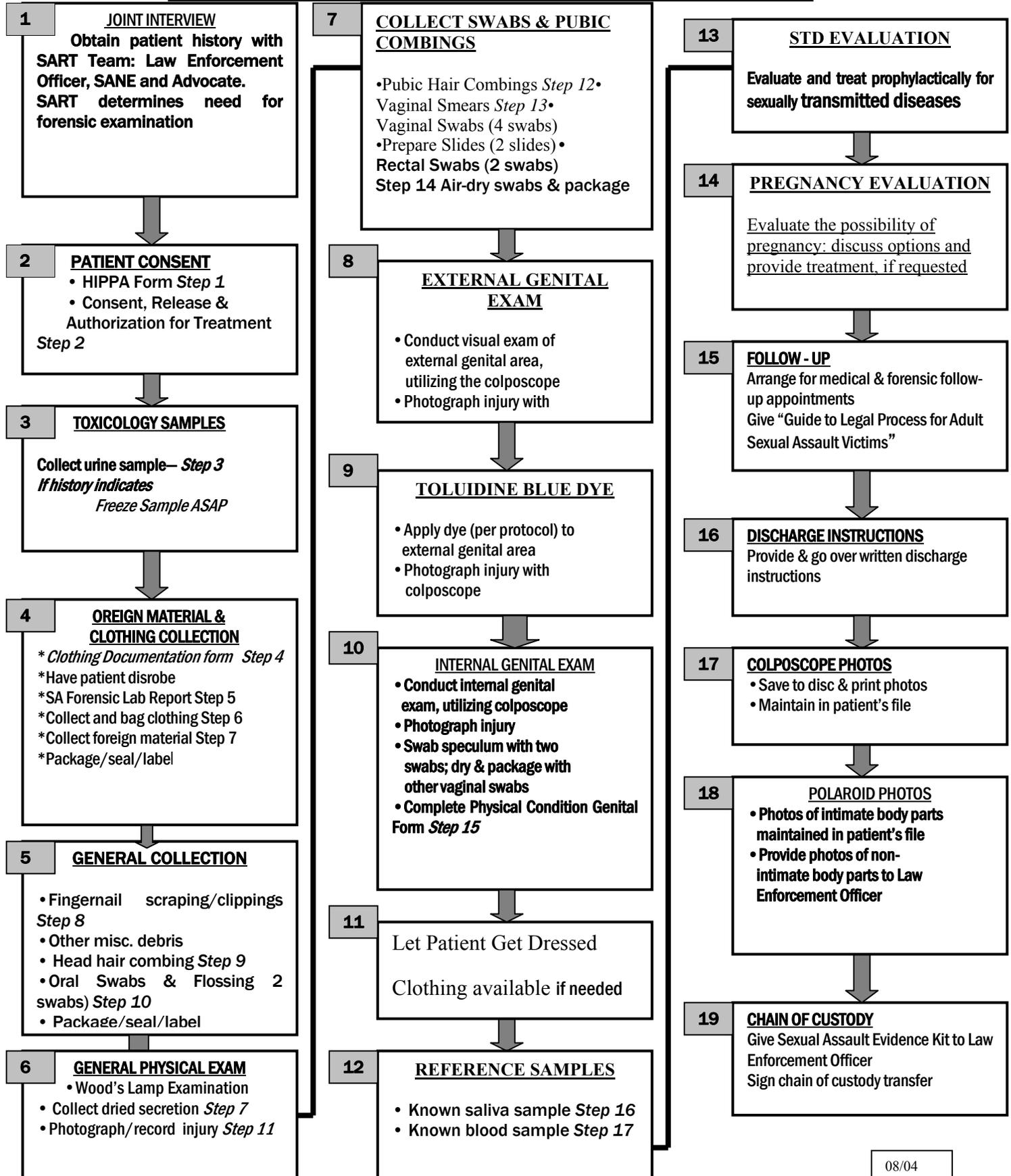
Victim-Centered Responsibilities Matrix

CRITICAL ELEMENTS FOR SEXUAL ASSAULT CRIME RESPONSE								
<u>INSTRUCTIONS</u>	A D V O C A T E	M E C C L	L A W E N F O R C E M E N T	P R O S E C U T O R S	V I C T I M W I T N E S S	C O U R T S	C O R R E C T I O N S	P R O B L E M A R E A
1. Place a “P” in the column where the <u>primary</u> responsibility exists.								
2. Place a check mark (✓) under any other column that may share or possess follow-up responsibility.								
3. If you have a critical element that is not being adequately addressed or inherently causes problems, or you would like to more fully discuss this element, place an asterisk (*) in the “problem area” column.								
Search warrants								
Suspect kit								
Keep victim informed of case status								
Address victim’s concerns of safety								
Arrest/initial appearance								
Notify victim of time and place of hearing								
Discuss desired conditions of release with victim before bail hearing								
Request any release on bail include protection orders for victim								
Pretrial								
Inform victim of pretrial hearings/motions								
Include victim’s participation in all hearings in which defendant has a right to be present								
Consider needs of victim in scheduling proceedings								
Plea Negotiations								
Inform victim of reasons to consider a negotiated plea								
Describe optional courses of action								
Determine what action the victim wants to take								
Consider the needs of the victim in accepting a plea								
Sentencing								
Ensure opportunity for victim impact statement as part of sentence considerations								
Include victim needs as part of sentence (i.e. restitution, protection, emotional security)								
Incarceration								
Notify victim about changes in offender status								

Victim-Centered Responsibilities Matrix

CRITICAL ELEMENTS FOR SEXUAL ASSAULT CRIME RESPONSE									
<p style="text-align: center; margin: 0;"><u>INSTRUCTIONS</u></p> <p>1. Place a “P” in the column where the <u>primary</u> responsibility exists.</p> <p>2. Place a check mark (✓) under any other column that may share or possess follow-up responsibility.</p> <p>3. If you have a critical element that is not being adequately addressed or inherently causes problems, or you would like to more fully discuss this element, place an asterisk (*) in the “problem area” column.</p>	A	M	L	P	V	C	C	P	
	D	E	A	R	I	C	O	C	R
	V	I	W	O	S	T	U	R	O
	O	C	E	S	E	I	M	S	R
	C	A	N	C	M	S	S	T	E
	A	L	F	U	W	I	T	I	O
	T	O	R	O	R	T	N	S	N
	E	M	E	S	S	S	S	S	S

**SEXUAL ASSAULT FORENSIC EXAMINATION
PROCEDURES CHART SUMMARY**



Appendix C (STEP 1)

Authorization for Use or Disclosure of Protected Health Information

Hospital/Clinic: _____

Victim's Name: _____
PRINT

Date of Birth: _____

I _____ authorize the Hospital [Clinic] named

[PRINT Victim's Name]

and any member of its professional or administrative staff to use and/or disclose the following protected health information to:

County State's Attorney, Law Enforcement Officials, the Attorney General's Office, the Bureau of Criminal Investigation, the State Crime Laboratory, the Federal Bureau of Investigation, or Tribal Law Enforcement Officials that are investigating this Sexual Assault and the Domestic Violence/Sexual Assault Advocate.

Description of the information to be used or disclosed:

Initial sections:

_____ **The results of tests for the presence of sperm and venereal disease, clinical observation and physical evidence, including specimens and blood samples used for examination and laboratory analysis, including history, findings, x-rays, photographs and diagnosis, and any health information related to my examination and treatment, including copies of any of these items or records, as well as clothing or other miscellaneous items collected by the hospital, emergency medical services personnel, or any other health care provider.**

_____ **The results of tests for the presence of drugs, legal or illicit, from the urine sample collected.**

This protected health information is being used or disclosed for the following purposes:

The criminal investigation of a sexual assault, including any juvenile proceeding, or a proceeding for the civil commitment of a sexual predator.

This authorization shall be in force and effect for seven years (statute of limitation) or until the completion of all investigations and legal actions related to this matter, including the completion of any appeal or review, or the expiration of the time for filing any such appeal or review.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to

_____ [Hospital] at _____,
_____, ND 58 _____.

I understand that a revocation is not effective to the extent that the Hospital [Clinic] staff has relied upon the authorization for the use or disclosure of the protected health information.

I understand that information disclosed under this authorization may be further disclosed by the recipient and may no longer be protected by federal or state law.

We will not condition your examination or treatment on whether You provide this authorization for the requested use or disclosure.

_____, Relation _____
Signature of Patient (assault victim) or Personal Representative

Date

You are not required to sign this authorization form. If you do sign this form, you have a right to receive a copy of the completed authorization.

Form Revised: May 9, 2003

Appendix D (STEP 2)

Informed Consent for Examination and Treatment

Hospital/Clinic: _____

Victim's Name: _____
PRINT

Date of Birth: _____

I, _____, freely consent to allow
(Print Name)

_____ attending medical personnel, her or his medical
(Print Name)

and nursing assistants and associates to conduct an examination to collect evidence concerning a reported sexual assault. This procedure has been fully explained to me and I understand that this examination will include tests for the presence of sperm and venereal disease, as well as clinical observation for physical evidence of penetration of or injury to my person, or both, and the collection of other specimens and blood samples for laboratory analysis.

I fully understand the nature of the examination and the fact that medical information gathered by this means may be used as evidence, if I sign a separate authorization for disclosure of specified protected health information.

Date

Signature

Relationship to the victim, if an individual other than the patient signs the release:

Victim's Parent / Guardian / Other (specify): _____

Appendix E (STEPS 4 & 6)

Clothing Documentation

Patient's Description of Clothing Worn During Assault: (check all that apply)

_____ Presented at Hospital Wearing Clothing Worn During the Assault.
Initial

_____ Presented at Hospital Wearing Clothing Put On Immediately After the Assault.
Initial

_____ Brought clothing worn during assault. Collected by attending medical personnel.
Initial

_____ Clothing worn at the time of the assault collected by law enforcement prior to
Initial the arrival of the forensic examiner.

_____ Patient provides location of clothing worn at the time of the assault and/or
Initial additional evidence and law enforcement is notified at _____ hours.

_____ Clothing collected by law enforcement.
Initial

Describe clothing (with minimal handling) carefully noting condition (clean, dirty, rips, tears, stretched out elastic, missing buttons) and visible signs of foreign material (grass, fiber, hair, twigs, soil, splinters, glass, blood, dry or moist secretions).

Procedure for wet clothing: Items must be dry to preserve evidence. If clothing is wet, lay on a sheet of clean, unused, white paper, and cover with another sheet of white paper. Gently fold each article of clothing and place in a paper bag; then label and seal the bag. Give to the Law Enforcement Officer. **Advise the Officer the clothing is wet. (Note: Laboratory cannot accept wet evidence).**

Bra: _____

Shirt: _____

Undershirt: _____

Sweater: _____

Jacket: _____

Pants: _____

Underwear: _____

Socks (state one or two socks present): _____

Shoes (state one or two shoes present): _____

Original (White) -- Evidence Box Yellow -- Law Enforcement Pink -- SANE File

Appendix F (STEPS 5 & 11)

Sexual Assault Form for Crime Laboratory

Patient Name _____

M / F DOB: _____ Age: _____ Race: _____

SANE _____

Date & Time of Reported Sexual Assault: Date: _____ 20 _____ Time: _____ am/pm

Date of Collection _____ Time of Collection _____

Place of Reported Sexual Assault: City _____ County _____ State _____

of Assailants : _____ Assailant (s) Name: (if known): _____

M / F _____ Race (if known): _____

___ Stranger ___ Brief Encounter (known less than 24 hours)

___ Non-Stranger ___ Relative

Prior to evidence collection, victim has:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Urinated			Lubricant Used			<u>Condom</u>		
Defecated						Removed		
Genital Wash/Wipe			Contraceptive-Foam Used					
Bath/Shower						• Menstruating		
Douche			Diaphragm			<u>Tampon</u>		
Changed Clothes			Removed			Removed		
Drank/Ate			Inserted			Inserted		
Rinsed Mouth								
Brushed Teeth			Sponge			<u>Sanitary Pad</u>		
Vomited			Removed			Removed		
•			Inserted			Applied		

Check if Patient Indicates Any of the Following Occurred:

- | | | |
|-------------------------------------|-------------------------|---------------------|
| ___ Physical Blows by Hands or Feet | ___ Physical Restraints | ___ Bites |
| ___ Grabbing | ___ Fondling | ___ Strangled |
| ___ Hit with Weapon | ___ Licking | ___ Use of Ligature |
| ___ Holding | ___ Kissing | ___ Burns |
- Original (White) -- Evidence Box Yellow -- Law Enforcement Pink -- SANE File

Sexual Assault Form for Crime Laboratory (continued)

Patient _____

Contact Described by Patient

SANE _____

<u>Type of Contact</u>	YES	NO	Attempted	Unsure
<u>Penetration of Vagina</u>				
Penis				
Finger				
Foreign Object (Describe)				
<u>Penetration of Rectum</u>				
Penis				
Finger				
Foreign Object (Describe)				
<u>Oral Copulation</u>				
Assailant to Patient				
Patient to Assailant				
<u>Masturbation</u>				
Assailant to Patient				
Patient to Assailant				
Assailant to Self				
<u>Ejaculation</u>				
Location				
Condom Used by Assailant				
Lubricant Used by Assailant				

History:

Original (White) -- Evidence Box Yellow -- Law Enforcement Pink -- SANE File

Appendix G (STEPS 11 & 15)

Physical Condition Form

Appendix H

Suspect Forensic Exam Form

Today's Date: _____

Name of Facility: _____

Address of Facility: _____

Facility's Phone Number: _____

Technician's Name: _____

Suspect's Name

Suspect's Address

 Male

Female

Suspect's Phone Number

REQUEST FOR FORENSIC EVIDENCE COLLECTION

The search warrant indicates collection of the following or

Suspect volunteered the following:

Finger Nail Scrapings Buccal Swabs Penile Swabs Urine

Blood Clothing Other

(specify): _____

Communicable Diseases of Risk:

Hepatitis TB Herpes Syphilis HIV

Gonorrhea Chlamydia Other (specify):

I, _____ consent to a physical examination and Forensic

Print Your Name

Evidence Collection conducted by the above named individual on _____.

Today's Date

X _____

Suspect's Signature

Date

X _____

Witness's Signature

Date

Appendix I

Sexual Assault Discharge Planning Form

Victim Name: _____

Hospital Name: _____

Date of Examination: _____

Examining Physician: _____

Hospital Telephone

No: _____

(Patient Stamp)

A number of specimens were collected from you to provide evidence in court should your attacker be caught and you decide to prosecute. Additional tests were conducted as follows:

3. Pregnancy test to determine pre-existing pregnancy only

Yes No

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

Name of Medication: _____ Dosage: _____

Name of Medication: _____ Dosage: _____

Name of Medication: _____ Dosage: _____

You were not given treatment to prevent gonorrhea or any other venereal disease because: _____

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

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

No appointment was made for follow-up treatment

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

I have received this Victim Discharge Planning Form _____
(Victim/Parent/Guardian Signature)

I do not wish to receive this Form _____
(Victim/Parent/Guardian Signature)

*Healthcare Professionals see STI Guideline

2 copies: Patient, Medical Record

Appendix J

North Dakota Resources/Support Services Information

Sexual Assault Crisis Programs in North Dakota

Abused Adult Resource Center	Bismarck	222-8370
Family Crisis Center	Bottineau	228-2028
SAFE Alternatives for Abused Families	Devils Lake	662-7378
Domestic Violence & Rape Crisis Cntr.	Dickinson	225-4506
Kedish House	Ellendale	349-4729
Rape & Abuse Crisis Center	Fargo	293-7273
Coalition Against Domestic Violence	Ft. Berthold	627-4171
Tri-County Crisis Center	Grafton	352-4242
Community Violence Intervention Cntr.	Grand Forks	746-0405
S.A.F.E. Shelter	Jamestown	251-2300
McLean Family Resource Center	Washburn	462-8643
Women's Action & Resource Center	Beulah	873-2274
Domestic Violence Crisis Center	Minot	852-2258
Abuse Resource Network	Lisbon	683-5061
Spirit Lake Victim Assistance	Ft. Totten	766-1816
Domestic Violence Program	Stanley	628-3233
Abused Persons Outreach Center	Valley City	845-0078
Three Rivers Crisis Center	Wahpeton	642-2115
Family Crisis Shelter	Williston	572-0757

Please note: The area code for all crisis programs in North Dakota is 701.

State and National Resources

ND Council on Abused Women's Services/ Coalition Against Sexual Assault in ND	(701) 255-6240 1-888-255-6240
Crime Victims' Compensation	1-800-472-2286
ND Attorney General's Office	(701) 328-3404
National Sexual Assault Hotline (RAINN)	1-800-656-HOPE
National Sexual Violence Resource Center	1-877-739-3895

Child Forensic Centers in North Dakota

Children's Advocacy Center	Bismarck	(701) 323-5626
Coordinated Treatment Center	Fargo	(701) 234-6600

Child Protective Services in North Dakota (by county)

Adams	576-2967	Barnes	845-8521
Benson	473-5302	Billings	872-4121
Bottineau	228-3613	Bowman	523-3285
Burke	377-2313	Burleigh	222-6622
Cass	241-5761	Cavalier	256-2175
Dickey	349-3271	Divide	965-6521
Dunn	764-5385	Eddy	947-2960
Emmons	254-4502	Foster	652-2221
Golden Valley	872-4121	Grand Forks	787-8535
Grant	622-3706	Griggs	797-2127
Hettinger	824-3276	Kidder	475-2551
La Moure	883-5301	Logan	754-2283
McHenry	537-5944	McIntosh	288-3343
McKenzie	444-3661	McLean	462-3235
Mercer	745-3384	Morton	667-3395
Mountrail	628-2925	Nelson	247-2945
Oliver	794-3212	Pembina	265-8441
Pierce	776-5818	Ramsey	662-7050
Ransom	683-5661	Renville	756-6374
Richland	642-7751	Rolette	477-3141
Sargent	724-6241	Sheridan	363-2281
Sioux	854-3821	Slope	523-3285
Stark	456-7675	Steele	524-2584
Stutsman	252-7172	Toumen	968-4355
Traill	636-5220	Walsh	352-5111
Ward	852-3552	Wells	547-3694
Williams	774-6300		

Please note: The area code for all Child Protective Service programs in North Dakota is 701.

Appendix K

**Crime Victim Reparation Forensic-Medical Exam
Payment Agreement Letter**

CRIME VICTIM SPECIALIST
Paul J. Coughlin
REGIONAL SUPERVISOR/
INTERSTATE COMPACT COORDINATOR
Charles R. Placek
701-328-6198
DIRECTOR
Warren R. Emmer
701-328-6193



**Crime Victims Compensation
Field Services Division**
P.O. Box 5521
Bismarck, North Dakota 58506-5521
701-328-6195
1-800-445-2322 (in-state)
Fax 701-328-6186

July 6, 2005

MEDICAL PROVIDER
NAME & ADDRESS

Dear Medical Provider:

As a result of limited funding for the Crime Victims Compensation Program, we have approved payment at the rate of 80% of your billed charges or 80% of the balances after insurances have made payment.

This program, by law, is a last resort payor and other resources such as Medicare, Medicaid or insurances must be explored first. We trust that you will accept this as payment in full and not bill the victim for the balance.

Thank you for your cooperation.

Sincerely,

Paul J. Coughlin
Administrator
Crime Victims Compensation

***** PLEASE RETURN ACKNOWLEDGEMENT *****

We acknowledge our cooperation with your plan.

Signature: _____

Medical provider: _____

Address: _____

Appendix L

North Dakota Century Code Statutory Law Related to Sexual Assault

1. Chapter 12.1-17-06	Criminal Coercion
2. Chapter 12.1-17-08	Consent as a Defense
3. Chapter 12.1-20	Sex Offenses
4. Chapter 21.1-27.2	Sexual Performance by Children
5. Chapter 21.1-31	Miscellaneous Offenses
6. Chapter 21.1-32	Penalties and Sentencing
7. Chapter 21.1-32-09	Dangerous Special Offenders-Habitual Offenders- Extended Sentence
8. Chapter 21.1-32-15	Offenders against Children and Sexual Offenders- Sexually Violent Predator-Registration Requirement- Penalty
9. Chapter 21.1-34	Fair Treatment of Victims and Witnesses
10. Chapter 21.1-38	Assumption of Risk in Crime
11. Chapter 14-10	Minors
12. Chapter 23-07	Reportable Diseases
13. Chapter 23-07.7	Court-Ordered Testing for Sexually Transmitted Diseases
14. Chapter 29-04	Limitations
15. Chapter 31.13	DNA Analysis
16. Chapter 43-12.1	Nurse Practices Act
17. Chapter 43-17	Occupations and Professions
18. Chapter 43-17-41	Duty of Physicians and Others to Report Injury- Penalty
19. Chapter 50-25.1	Child Abuse and Neglect
20. Chapter 50-25.1-03	Persons Required and Permitted to Report
21. Chapter 50-25.2	Vulnerable Adult Protection Services
22. Chapter 54-23.4	Crime Victims' Compensation

For more information:

<http://www.state.nd.us/lr/information/statutes/cent-code.html>

Appendix M

Facts about Sexual Assault in North Dakota 2004

- 825 primary victims and 370 secondary victims were served by 18 crisis intervention centers throughout North Dakota.
- Between 2003 and 2004, there was a 7% increase in the number of victims served by crisis centers.
- At least 408 (50%) of primary victims were under the age of 18 years old at the time of the assault/s.
- At least 759 (92%) of the victims were female.
- At least 782 (95%) of the perpetrators were male.
- At least 2% of the perpetrators were female.
- Sixty-six percent of the crimes were reported to law enforcement.
- At least 35% of adult victims contacted a sexual assault crisis center about the crime within 2 days of the assault. Twenty-seven percent of adult victims contacted sexual assault crisis centers within 3 to 30 days after the assault.
- At least 89% (731) of the cases were male assailant/female victim.
- At least 6% (51) of the cases were male assailant/male victim.
- At least 66% of the adult assaults were rape, 13% attempted rape, and 21% were sexual contact other than rape or attempted rape.
- In adult cases 12% of the assailants were strangers. In child cases 2% of assailants were strangers.
- In at least 38% of all cases the assailant was a friend/acquaintance/date of the victim.
- At least 31% of all cases were incest or indicated a history of incest. In at least 15% of adult sexual assault cases reported, the victim also experienced sexual abuse/incest as a child.
- At least 7,244 services to primary victims were provided by crisis center advocates in 2004.
- At least 59% of the sexual assaults occurred in the victim's or assailant's home.
- At least 43% of victims were referred to sexual assault services by themselves, friends, or family members.