

*Kim Day*

I'm Kim Day. Professionally, I've been working for about 35 years as a nurse and in the last 15 years of my career, I've been a sexual assault nurse examiner. I work in a local, community based program but I'm coming to you today with a perspective of knowing very well the national protocol for sexual assault forensic exams of adults and adolescents that was developed by the US Department of Justice which is very much referred to in the Prison Rape Elimination Act standards. And also from working on the original Prison Rape Elimination Act commissions protocol development in the very beginning, back in 2007. So I bring you those perspectives and hopefully we can have some conversation here about the actual exam and some of the standard requirements for physical evidence preservation.

Some of the things that we're going to talk about today are ways that you as a provider can facilitate maximizing evidence potential, which is exactly how the standard says it. And I want to give you some examples of ways to meet the PREA standards to access victim advocates and make sure evidence is not destroyed and recognizing medical care follow-up for the inmate who has experienced sexual abuse.

Another disclaimer here: I told you I'm a nurse. I talk about patients... you'll notice that Karla talked a lot about survivors and victims. So I use the word "patient," "inmate," "survivor," "victim" ... kind of interactively... I kind of use them the same way throughout my discussion, so forgive me if I flip terms as I go along. Different documents have them noted in different ways.

But the first part of the standard that I'm going to talk about is the one about protocol. That your agency has a protocol in place that maximizes the potential for useable physical evidence. And we're going to talk as we go along about what that means.

So I'm going to actually summarize these as I go along but they're on the screen for you and we will give you links as to where to actually get the standards so you can have them in your hands, print them out, keep them by your desk, know them. And there is no test at the end of this so we're not going to test you on what the standards are.

Ok so you're going to have a protocol and it shall be developmentally appropriate for youth and adapted from the Department of Justice's National Protocol... and that's actually why I'm here. Or similarly comprehensive or authoritative protocols developed after 2011. Well the National Protocol is currently in revision. We're hoping that the revised edition or edition number 2 will be out this month so that will be available. There are also... the Office of Violence on Women has worked on developing protocols for prisons, jails, and community corrections and those resources are waiting for the National Protocol revisions to come out and will be released shortly- they're in approval process.

So that was A and B. Section C assures examination access and you'll see here that it means they have access to the medical forensic exam, whether it's on site or outside of the facility, that it's free where medically and evidentiarily appropriate, and the exam shall be performed by specially trained examiners where possible. If they cannot be made available than we need to document, or you all, need to document that you've tried to find some.

This section actually might be a major concern to you. Number one- where do I find trained examiners? And you may be getting pressure as internal medical staff to check people before they send them out for exams. Have you ever had that experience? Like, "I want you to see if they have been abused..."

Well, this is actually really common and I can tell you as a community based SANE, I see patients all the time that have been... that come in reporting that they've been sexually assaulted and it is very clear to me that, from my perspective, law enforcement wants you to have an answer. They want you to be able to look at something and tell them whether or not a rape has occurred. You simply can't do that. And the best practice is that they have an exam done. And there may be findings but 2-10% of people that come in that are acutely sexually assaulted have actual physical findings. And that is when we're a trained examiner using magnification equipment to be able to visualize the genitalia. So for somebody to ask you to check somebody to determine whether or not they should go for an exam is kind of a moot point. And I just want to support you in the fact that you need to say, "No, we don't do that. We're going to send people out for the exam" if that is your protocol... some of you may be having people come in. It's human nature I think to want signs or concrete injury to validate somebody's claim... to be able to tell if they're lying, but that's actually not what we do. And a little later on in my talk I'm going to talk about what we can and cannot tell you during the exam.

OK the next section of this, section D, is about advocacy access. So the first several sections assured that there is a protocol, there's access to exams and trained examiners, that evidence is maximized and this portion says that they need to have an advocate made available. Traditionally, advocacy is an integral part of the response to sexual assault victims. In community-based programs, they are a piece of the response team. This standard recognizes the importance of that support for the victim throughout the investigative processes, the interview, and even the exam itself. Advocates are seen as a critical part of the response and they're necessary for the person who's experienced abuse to understand the processes that they will follow and, in a sense, to stand by them as they navigate systems that they're very unfamiliar with.

One of the key things for you to understand as the health care provider is that in community-based rape crisis centers in many jurisdictions around the country, advocates have a very special relationship with the patient or client that they serve. And in many places this is a relationship of privilege or of confidentiality, specialized

confidentiality, much the same as a physician or a priest would have with somebody. So their interaction and their communication with them is confidential and privileged. If you are using staff from within a correctional facility, they will not have that same relationship and so that is important to remember and important for the client or victim to know also. What is the relationship that the advocate will have with them? Is it confidential? Are things that they tell the victim advocate confidential? That's one of the actual drawbacks to using in-house staff as the advocate response.

This next section, E, is also about advocacy access and, as you can see from the language here, this section assures that the advocate is able to be with the inmate throughout all the processes. And I want to tell you as a SANE, the advocate is my best friend. When I do an exam, I really hope there's an advocate there with the patient all the time. Now they always have the option to decline that service but those patients are not grounded and they don't know what to do, what the next step is.

One of the things that's pretty amazing that we ask people to do, in light of what Karla has just told you about trauma, we ask people to make massive decisions after they've been sexually assaulted. We ask them to do things that can impact their health, their life... for the rest of their lives. We ask them to make decisions about reporting and cooperating with law enforcement, we ask them to make decisions about sexually transmitted infection prophylaxis, HIV prophylaxis, pregnancy prevention, things that can impact their lives in a really long-term way- in the aftermath of trauma. And from what Karla has just told you, their brains are actually not ready to take in that information. They trust us, as health care providers, to help them navigate that process. If they have an advocate with them who's been with lots of people who have experienced this in the past, it really is helpful to the healing process for the victim (patient, victim, inmate.)

So their brains don't work right but yet we ask them to make all these decisions. In fact, we demand they make the decisions, whether or not to sign the paper, whether or not to go out for an exam, whether or not to decline an exam, whether or not to talk about what's happened to them- we ask them to do all these things. And if you think about an inmate that has just come into your facility and may be experiencing an act of sexual abuse, they may even be unfamiliar with how to report, what happens when they report, as well as you as a provider. So it's really important that they have someone that they can, in a sense, walk by them through the process.

Ok, so what is this exam that we're talking about in the standard? I thought I'd take some time to talk about the actual exam itself and why it's important for the victim to have it and what does it do? Why do we care? Has anybody ever been or done a medical forensic exam?

*She looks to the audience*

Ok, one person. Two people. Ok, three. All right.

There's a lot of stuff that we do during the exam but the primary purpose of the exam is the medical care and treatment of the patient who has experienced sexual abuse. The care is specialized and the treatment is specifically targeted for sexual abuse patients. And as it says on the slide, there's also another component of that care- and that is the collection of forensic evidence in the form of samples, photographs, and documentation that can be used in the criminal justice or administrative proceedings and that was actually talked about in the standard.

The exam can be done at the point when the evidence is viable and retrievable, even when the patient or the victim or the inmate decides not to participate in the process any further than just having the exam done. Assuring that the patient has access to the medical care and treatment that they need in the aftermath of an episode of abuse can help prevent long-term health sequelae that can result from the abuse... and there are long-term health consequences. Some of the signs that Karla was talking about- abdominal pain, chronic pain, suicide, depression, substance abuse- all those things we see in the aftermath of sexual violence. In the youth population we also see them acting out sexually, becoming promiscuous. Those sort of things all go along with those long-term effects.

14:00

*Referring to the slide*

This is called a word cloud. I'm a really visual person and it helps me to see concretely in front of me. These are all the pieces of and the different facets of the medical exam. Some of the parts of it are: the physical assessment, the treatment of injury, the medical treatment such as sexually transmitted infection prevention and treatment, HIV prophylaxis and, when appropriate, emergency contraception, psychological treatment, crisis intervention, suicide risk assessment- these are all things that we do at the time of the exam. And the exam takes about, on average, 4 hours. 2-4 hours. Just so you know, like, if you're sending somebody out, when can I expect them to come back? It usually takes about 2-4 hours. If the patient has a lot of physical injury, it can take a little longer than that because we document every single injury.

This exam, though, is only a piece of the puzzle. It is one component that can be used in the criminal justice system but the main focus is the care and well-being of the individual. This is another reason why it's important to get patients to the care that they need by someone who's experienced instead of somebody reading directions in a box, which is what often happens. People can report to a facility where there are not people that are trained in specialized care of people who have experienced this and they may get emergency department staff nurse who has 10 other patients who is basically reading directions in the box. And I'm sure that all of you would like to facilitate getting your clients to care that is specialized and timely, they're not sitting in an emergency department waiting room waiting for who gets to draw the low straw to see who will care of them, which also happens, I've been in that position.

Some common misperceptions about the exam. Now 3 people answered that they've done the exam before so you guys are exempt from these questions- I don't want you to answer. Can you tell me what you think is the result or the final result of the exam? What do we do when we're done?

*She looks to the audience*

Well I kind of already cheated, didn't I? I told you that we don't tell you whether or not the person's been raped. That is actually a determination that's made by a court of law. So we don't do that. Do you think I can tell you if the patient has had sex? All those who think yes, raise your hand. Don't be afraid, raise your hand if you think that I can tell you during the medical forensic exam if that patient has had sex. Raise your hand.

*Waits for audience to guess*

Ok, the answer is no. The answer is no. Unless there is a glaring, huge, injury... and remember I told you 2-10% and some of that 2-10% is really microscopic trauma... I'm not going to be able to tell you and nobody should be able to tell you whether or not the patient has had sex. Can the exam tell you if the patient is a virgin? If you think yes, raise your hand. Don't be afraid.

*She looks to the audience again*

Ok. Uh, no. We cannot tell you that. Contrary to public opinion and lots of genital reconstruction physicians who will tell you that they can make you into a virgin, the hymen is not a membrane that covers the vaginal opening in a female that can be broken like a balloon. That's not the way it is. It's more like a scrunchie, a hair scrunchie... how many people know what that is? Raise your hand. Ok, you know what it looks like? It's got a hole in the center. And if the hymen totally covers the vaginal opening, it is a medical... it needs surgical intervention. Because the hymen must be open so that the contents during the menstrual cycle can come outside the body. So the hymen is not a membrane that covers the opening of the vagina, it is an opening into the vagina. And it may be injured during an assault but in most cases, 90%, it is not.

Will there always be observable evidence that sex has taken place? You've probably got it already, no. And this is another one that I want to ask you- there are always trained examiners onsite ready anytime a patient comes in that's complained of sexual assault? That's correct, there is not. There is not. Really important. We'll go on later to understand why we need to know that.

Ok who is a trained examiner? What does that mean? And who does the exam? Although I like to go in who/what/when/where fashion, I'm kind of out of order. But I want to talk about who here. The exams in the standards say they should be performed by sexual assault forensic examiners, or SAFES, or sexual assault nurse

examiners where possible. A SAFE, a sexual assault forensic examiner, is a physician or a physicians assistant or a nurse that has been trained, specially trained, to do medical forensic exams. A SANE, a sexual assault nurse examiner, is a nurse, a registered nurse, minimum level, and has received specialized training in the care of patients who have experienced sexual abuse. Trained examiners are those who usually take specialty training that's about 40 hours, of a classroom, sitting in a classroom... we actually look at vaginas and penises on the wall, all day, for 40 hrs- you can imagine how that is. And then we take a clinical piece which is actually hands-on, taking care of patients, performing the exam head-to-toe, collecting specimens in a box, using cameras, riding along with police for interviews... all kinds of different things go into that training. But not all hospitals have trained examiners.

In setting up a protocol to send people out for exams, you'll see on the bottom here, ER staff is listed. You will need to find out- first: is there a specialized place where exams are performed? Because if the exams are performed at a non-contract facility, for example, if you are a corrections facility and you always send your patients that need more intense medical intervention than you can deliver to one certain facility but there's three hospitals in town and only one does SANE exams, you'll need to know that. You'll need to know which facility you need to send the patient to. Otherwise, you may have people getting bounced around from facility to facility or you'll have somebody sitting there for a really long time with nobody seeing them.

So if there's a trained examiner in your community you need to know it and where do they go. Some examiners respond to every facility in a community; some live in one hospital only. So those are really important things for you to find out and in the resources, actually, we have a listing of sexual assault nurse examiner programs- there are approximately 900 on this list that you can actually click on your state and search, search for programs and it will give you contact information about those programs.

Exam sites may differ for juveniles. That's another added chunk in there. How many of you are from juvenile facilities? Ok, so you may have to go to a different site than even the other correctional facilities in your area because... some sexual assault nurse examiners... like Jaye said, I'm dual certified so I see both- I see from zero and I've seen my youngest patient's been 2 months old up to 99 years old. So we see all at my facility but there's facilities that only see pediatrics or children and they have certain age cut-offs so you need to know that. Some adult programs see 14 and over, some see it based on developmental age or menarche, the onset of menarche or puberty and some do it by an age cutoff- those will all be important things for you to note, for those of you that are working with juveniles.

One of the things that you, as the healthcare provider or people that will be interacting with the victim or the person who has experienced the sexual abuse, is that you need to prepare them for what's going to happen. There will be some necessary steps to take after the report is made and if you are the first responder you may be called upon to do these interventions. So I want to talk about two

different types of preparation- one is the actual physical preparation of the patient and the other is psychological. Under psychological- advocacy. I've already talked a little bit about how important that is but it should be offered to the patient early in the process and if you're using an on-site person, you need to notify them that their services are needed so that they can come and function in the role that they're needed in.

Options. This is one thing that Karla kind of touched on a little bit but we need to talk about, really, what are the options that the patient has? Once they've reported the abuse, do they have the option to even not have the exam? That's always one of the alternatives that you need to consider. The patient prefers not to have the medical forensic exam, they just want to make sure they're OK. And then that would fall back on you as the healthcare staff to provide them then with post-exposure prophylaxis for STIs, HIV, evaluate for pregnancy, and provide emergency contraception. So options- the patient needs to know what their options are

And one thing that you absolutely need to know is: that if the patient is not willing to have the medical forensic exam done, don't bother sending them out to us. We never force someone to have the exam. Contrary to what many parents believe because we get people brought in all the time to be checked to see if they've had sex. And this is really in the juvenile population, we get this a lot. Parents want to know... they ran away so they bring them in and they want to force them to have the exam. We don't do that. The National Protocol is actually very clear on this. It is assault if you do something against the person's will to them. So we don't force them so it's important that you know before you send the patient out if they're going to cooperate with us. So we never force them.

Do we do exams on unconscious patients? That's another question you may have. If you have somebody that's been really severely assaulted and has a head injury and then perhaps is in a coma and you're worried that sexual assault is something that happened to them that actually precipitated this severe injury, there are usually institutional policies in place about obtaining or doing the medical forensic evaluation on a patient who is unconscious... and it's important that you know what those are. For example, in New Hampshire, where Bob lives, there actually is a protocol about examining unconscious patients- so you would need to know about that. In Maine, they also are following a protocol to be able to examine unconscious patients. But in many places there is not that policy in place. They will wait until the patient wakes up to consent to the exam being done. And a lot of this comes out from some of the controversy that's been around for, actually, years where they used to have residents going into the O.R. and doing speculum exams on unconscious females- so a lot of that has come out of that. But, in general, unless there's a protocol that's specifically in place or a policy at the facility, if you suspect that somebody that's unconscious and being transferred out has been a victim of sexual assault, you need to let the examiner know at the facility and they will follow their protocol.

Another section here under the psychological preparation of the patient is the examination prep. One of the things that I always like is that things are repeated to people over and over again. Because remember the effect of trauma on the brain- we don't remember things. You may be getting through a very small percentage of the information that you're trying to give somebody in the aftermath of assault. So I would like for the patient to know, before they come, that there is a special examiner who will do the exam, you will have an advocate who can stay with you during the exam, and yes, the advocate can stay with the patient during the exam.

Another thing that I think they need to be prepared for is that custody staff will stay with them during the exam. We do the exam with custody staff in there. We're not with the prisoner by ourselves, so they don't get there and get released to the SANE, the custody staff stays with them. We make all efforts to make the exam private, to be able to shield the victim's genitalia. We do have actually big screens that we use when we're visualizing the genitalia that, you know, it's like a vagina blown up this big... we will turn it away from custody staff but they need to be prepared that this will happen.

They may also be handcuffed to the stretcher, that's another thing that can possibly happen. Really important that you're communicating with your SANE staff about how they're going to be doing the exam when the patient leaves.

The exam on a female is done with a speculum. We use specialized equipment throughout- they may have dye put on their genitals for us to be able to see injury that we can't see with our eyes. We do use magnification equipment in most cases. We use a thing called a colposcope, which actually blows the genitalia up on a screen. *She gestures to the powerpoint screen* Not this big but on a television screen and some patients like to see what's happened to them, some don't. So they will be asked... anytime anything is done during the exam, they're asked for permission to do it before we do it. "I'm going to swab your skin now so I'd like to ask you, 'Is that Ok?'" and we get written consent in the beginning but we also get consent as we go along in the process of the exam. And that there may or may not be a kit used. There may or may not be a kit used. So an evidence collection kit is utilized a lot of the time but sometimes the patient may fall outside the time limits for evidence collection, which we'll talk about in a couple of slides. But also in the case of male assault an anal speculum or anoscope may be used. It's good to prepare them ahead of time for that possibility.

Ok the physical prep. Now this is important because what we want to do here, according to the standard and according to all of us wanting to find out who's done this- we want to minimize evidence loss. Now how could we do that? We're actually going to talk about that in a little bit more detail in the slides coming up. But we also have to notify custody staff that the patient has made a report and if they are going to leave for an exam, that they're going to need to be transferred. And then you notify the exam site because there are programs that see very high volumes of sexual abuse patients, like thousands a year, and those sites may have examiners on



staff all the time but if you have a patient in custody going to a facility, it is courtesy to let them know so that they can institute the procedures that they need. For instance, at my facility we do see patients from our local jail and we need to know because our security needs to know that the staff is coming in with the patient because there's different procedures that they institute and the receiving facility should need to know.

Ok, so some of the options for the exam- I'm back on track here, actually. Who/what/when/where. Where are the exams done? Each facility will have to determine where the exams are done and the standard does not tell you have to send people out for the exam. It actually doesn't. Sometimes it's nicer to have them direct you, but it doesn't. Some options here are: transfer to a local exam site or have the exams done in house. On this one I'm going to talk about transferring the patient.

I can't emphasize to you enough how important it is to find out where the exams are done before you send people out. I am on a project for, actually, for Indian Health Service and they are much like a correctional facility, in that they contract a certain, another site when they have people that are beyond their capability. And I spent one whole day calling around to different facilities in a particular area to find out where I would go if I was a sexual assault patient. So you could do it that way, you can look on the listing of sites, you can... hopefully your custody staff has already been starting working with them... or you can even, if you as a medical provider in a facility always send people to one particular facility, you can call them and find out, "Do you have examiners on site? If not, what do you do in your community? Where do we send people?" And that you understand the exam site notification process. A lot of times if you're sending a patient out for medical care, it's medical provider to medical provider that you transfer. Are you all familiar with that? Yeah. So I want to talk to a medical provider. I really prefer to talk to you all rather than custody staff about things I need to know about as a healthcare provider- like allergies, like treatment that you've done... those sort of things are really important to me when I receive a patient to my exam site.

And then again, advocacy accompaniment. There may be a procedure in place at the facility where they notify the advocacy agency when the patient gets there. You may have already had somebody on site doing internal advocacy and then need to also have advocates in the community ready.

Ok, so the second option is to do the exam at your facility. You may have examiners who are on site already who are your custody... your health care staff, trained as sexual assault nurse examiners or sexual assault forensic examiners or you may have outside agency examiners respond into your facility. And then, of course, there always was the "I don't want to leave and have this exam done" option.

I've seen lots of different models. One community I know contracts with a community-based SANE program to come into their site and do exams in the health clinic. So they actually come from the community- they call them if they have a

report and that nurse comes to their facility, she's contracted, she does the exam, she actually takes the evidence box, takes it with her and gets it to where it needs to go. I know another facility that actually... it's a really large, very rurally isolated, huge correctional facility and they've put up a trailer on site and specialists, medical specialists come to this trailer all the time for things like dermatology, post-op visits... so they already have a trailer. And what they've done is they have examiners respond to the site. They don't do the exams in the health care facility; they actually do it in this trailer, this consultation trailer and they have saved a lot of money. They actually documented how much money they saved by not having to send people out to a facility because you're thinking about the transfer staff, the custody staff that has to go and how much money that costs. All of those are important to mention.

Before you go on and say that all of your correctional health care staff must be trained to be a sexual assault nurse examiner or a sexual assault examiner, you might want to think hard about that. There may be some conflict of interest with you treating all the patients and the perpetrators and having to... if you remember, half of all incidents reported were custody staff. You have to work with those people, ok? You have to continue to work with those people. And you need to really seriously take a hard look at... because you may end up getting some outside pressure for you to train your staff. And I know when I was on the Prison Rape Elimination Commission, there was... the wardens were really clear that they did not want their health care staff to be doing these exams- and I can totally understand that. But also, if you decide that you're going to have your staff be trained, you must evaluate with your medical department legal any conflict of interest because you remember, actually, I talked about the exam; one thing I didn't talk about was testimony. Those trained examiners testify, in court, about their findings from the exam, and their interaction with the patient. So would you be having your custody staff have to be acting in that role also.

Now I want to let you know that in a very small percentage of the cases do we actually go to court, very much a handful. That's kind of the inverse pyramid of whether or not cases actually get to prosecution that are reported in a very small percentage... but that's one of the things that you need to do.

Ok, so. Back here. In this section we actually want to make sure that physical evidence is not destroyed... if the abuse happened within a timeframe that allows for collection of physical evidence- and I'm going to talk about that. Forensic evidence- what is it? We're going to talk about what evidence is and how can we make sure that we maximize the potential of getting what we want- DNA? That's really basically it.

*Referring to the slide*

Ok this is Mr. Locard and I am going to start a old guy with white hair because we're talking about principles of science. Don't we always start there? Really...

Locard's principle is one of the fundamental reasons that we look for evidence where we do. He basically says that every time somebody comes in contact with another person, or materials come in contact with you, there's an exchange. So no matter how hard... physical evidence cannot be absent. We might not be able to find it, but there is evidence that indicates whether or not something has taken place. And I can't see it with my eyes, generally, I can't touch it...

So basically, evidence types: physical evidence is any object that can connect an offender or a victim to a crime scene. So that can [connect] offender to victim or victim to crime scene. There's different things- other things are debris, leaves, products of conception- even though that's a biologic thing it still is a physical evidence- tampons, condoms, latex gloves, plastic wrap, all those things that you see... baggies... those things all are physical evidence. And biological evidence is... contains DNA. It's a type of physical evidence also but things like saliva, semen, body fluids, urine, stool- all those things are biological evidence.

Actually, I wanted to talk about chain of custody because chain of custody is another one of those scientific principles and I have... I actually had a form up there that we use to document. What chain of custody is is it assures that the evidence has not been tampered with from the time that it was collected at the site or from the patient to the time that it actually gets into the courtroom and is presented.

So we actually sign when we take the evidence from a patient... or what we think is evidence because, again, we may be blind-swabbing where something's happened... and then we package it up and once we package it we sign it, we seal it, and then we give it off to somebody else who then signs so it's a... it's kind of a picture of where that evidence has been. Now it's really important because if it sits in the trunk of a car for 5 years... which I've had a box that I collected have that happen... then the court will deem that it has not been maintained under chain of custody and they throw it out. Ok.

So this minimizing evidence loss actually is to assure that both the victim and the perpetrator do not do things, or you as a health care provider don't do things, that might wash away evidence or lose evidence. And some of the things are up here on the slide... and another thing I want to point out to you as health care staff is another big potential loss of evidence is through injuries. We, as nurses and physicians, want to always fix it up and put a band-aid on it before we send them off. Right? We don't like bleeding people in the car, custody staff doesn't like wounds, they want them covered... well what you could be doing when you're cleaning up that victim or perpetrator (because they may both have injuries)... what you may have to do is defer and not clean up that wound because we want to swab it, we want to swab it when it gets to us.

So what you can do- what can you do? Don't clean it but dress it and make sure that when you report off to the receiving facility you say, "they have a cover on the wound but it has not been cleaned or dressed, you know it's just basically a cover..."

so that you can protect that evidence. So you can leave the wound to be cleaned at the exam site. If you have to clean it you can collect the materials you used and give it to investigators. If you have people that come into your site and do the investigation, you can hand it to them and they can make sure it's maintained under chain of custody and... During the exam we swab scratches, abrasions, suck marks, everything. We do that for biological evidence. And the person who has been assaulted often wants to go in, take a shower, wash themselves, get it off of them.

Another thing that you may see is that people may save, in custodial settings, may save something. Like they spit into a cup, they save it. That they save the plastic bag.

*Someone on the panel talks to her*

Ok- I've run out of time. So I also wanted to talk about strip searches- that you may preserve evidence by sending the clothing that you make them change out of with them to the exam site- and you may want to consider changing your policies.

And quickly here, because I've gone way over, I want to talk about time frames for evidence collection. It used to be, in years past, that 72 hours was the automatic cutoff for any evidence collection. It is no longer that. It is recommended in the National Protocol that the timeframes be extended. Now it is up to, usually, 5-7 days that states are doing evidence collection, but it very much varies. This is why it's important for you to know what the timeframe is in your locality. DNA evidence has been found on cervixes in current research and research that is ongoing up to 14 days after an assault, OK. But people don't always have a cervix that have been assaulted. But things like saliva DNA and that sort of DNA doesn't last as long so it's really kind of important for you to be able to know those timeframes and what testing should be done.

At discharge, when you get a patient back after an assault, you should know these things: you should know who saw them, you should know what they did to them, and what they gave them. And you need to know also what your responsibility is as a provider from now on. For instance, you may be needing to give HIV medications after the assault, you may be needing for them to have follow-up for photography... sometimes if we see injury and we're not sure if it's part of the patient or if it's really injury, we want to do serial photographs... that sort of thing. You should get a sheet of paper that actually has all of this dictated out and you should get it back to you at the site.

This is my contact information. If you have any questions about the medical forensic exam, please feel free to contact me.