West Virginia
Protocol
for Responding to Victims of Sexual Assault

A Multidisciplinary,
Victim-centered Response for:

Victim Advocates
Law Enforcement
Medical Providers
SANEs
Prosecution

Revised 2016 - 6th Edition

**West Virginia Foundation for
Rape Information & Services, Inc.**

304.366.9500
www.fris.org

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PREFACE

This protocol was developed to assist first responders who are part of a multidisciplinary response in West Virginia to provide compassionate and comprehensive care for victims of sexual assault. This kind of team approach is essential to promote both healing for victims of sexual violence and accountability for perpetrators of violence.

An effective multidisciplinary response takes into account the well-being and needs of victims. It allows for responders to put the needs of victims at the center of the process. Providing victim-centered care ensures that victims' autonomy and dignity are preserved. It plays a critical role in an understanding that there can be significant health consequences associated with sexual violence, both acute and chronic.

Coordination across disciplines and agencies is crucial to addressing the needs of victims who disclose being sexually assaulted. Best practice guidelines for collecting forensic evidence include offering emotional support, crisis intervention, education and advocacy.

WEST VIRGINIA SEXUAL ASSAULT PROTOCOL PROJECT

The West Virginia Foundation for Rape Information and Services (WVFRIS), established as a non-profit corporation in 1982, served as a statewide task force for rape prevention. In 1993 it was awarded a Federal Preventive Health and Health Services Block Grant, managed by the Centers for Disease Control and Prevention and delivered through the West Virginia Department of Health and Human Resources' Bureau of Public Health, to develop a protocol for responding to victims of sexual assault in West Virginia.

The United States Department of Justice, Office for Victims of Crime, had earlier developed a model protocol that addresses the physical and emotional needs of sexual assault victims, reasonably balanced with the basic requirements of the criminal justice system. More recently, the National Center for Victims of Crime produced a guidebook that outlines the importance of a multidisciplinary approach to developing and implementing a victim-centered protocol for responding to sexual assault that expands the role of the victim from that of a witness to an active participant in case-related decision making.

The West Virginia Foundation for Rape Information and Services formed a Sexual Assault Protocol Project Advisory Committee with members representing the medical, legal, law enforcement and victim advocacy communities. The advisory committee and the WV Foundation for Rape Information and Services utilized the model protocol, the guidebook, and other resources to develop a protocol for the state of West Virginia. Revisions to the protocol were made in February 2002, January 2008, August 2009, October 2010, May 2011 and in September 2016.

The West Virginia Protocol for Responding to Victims of Sexual Assault can be found online at www.fris.org.

West Virginia Sexual Assault Protocol Committee Original Members

Project Coordinator: **Paula Finley Mangum**

Mary Sesta Cogswell
Upper Ohio Valley Sexual Assault Help Center

Julie Damewood
CONTACT Rape Crisis Counseling Team

Marcia R. Drake
Women's Aid in Crisis

Marla Willcox Eddy
Family Service of Kanawha Valley

Nancy Hoffman
Task Force on Domestic Violence, "HOPE, Inc."

Gloria Martin
Family Refuge Center

Ann Smith
Shenandoah Women's Center, Inc.

Cheryl B. Smith
CONTACT Rape Crisis Counseling Team

Judy King Smith
Rape & Domestic Violence Information Center, Inc.

Leslie Anne Woods
Upper Ohio Valley Sexual Assault Help Center

West Virginia Sexual Assault Protocol Project Advisory Committee Original Members

Margaret Phipps Brown
Cabell County Assistant Prosecuting Attorney

Chief Fred Gaudet
Buckhannon Police Department

Virginia Hopkins
Preston County Prosecuting Attorney

The Honorable Nancy Kessel
West Virginia House of Delegates

R. Michael Mangum
Director, Criminal Justice Program
College of West Virginia

Sergeant Gayle Midkiff
West Virginia Division of Public Safety

Winnie Morano
West Virginia State Medical Association

Corporal Chuck Moses
President, West Virginia
Fraternal Order of Police

Alexander M. Ross
Coordinator, West Virginia Prosecuting AttorneysAssociation

Tom Todd
Coordinator, Criminal Justice
Program Glenville State College

Robert D. Whitler
West Virginia Hospital Association

Adrienne Worthy
Executive Director, West Virginia Women's Commission

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West Virginia Foundation for Rape Information and Services Member Agencies

CONTACT Huntington Inc.
Serving Cabell, Wayne, Lincoln, Logan, Mason and Mingo Counties
Huntington
304-399-1111 / 304-523-3447

Family Crisis Intervention Center
Serving Calhoun, Pleasants, Ritchie, Roane, Tyler, Wirt and Wood Counties
Parkersburg
1-800-794-2335 / 304-428-2333

Family Refuge Center
Serving Greenbrier, Mercer, Monroe and Pocahontas Counties
Lewisburg
304-645-6334

Rape and Domestic Violence Information Center (RDVIC)
Serving Monongalia, Preston and Taylor Counties
Morgantown
304-292-5100

REACH The Counseling Connection
Serving Kanawha, Jackson and Putnam Counties
Charleston
304-340-3676

Shenandoah Women's Center
Serving Berkeley, Jefferson and Morgan Counties
Martinsburg
304-263-8292 / 304-725-7080 / 304-258-1078

HOPE, Inc.
Serving Marion, Harrison, Doddridge, Lewis and Gilmer Counties
Fairmont
304-367-1100

Upper Ohio Valley Sexual Assault Help Center
Serving Ohio, Marshall, Brooke, Wetzel and Hancock Counties
Wheeling
304-234-1783 / 304-234-8519 / 1-800-884-7242

Women's Aid In Crisis
Serving Randolph, Upshur, Barbour, Tucker, Webster and Braxton Counties
Elkins
1-800-339-1185 / 304-636-8433

Women's Resource Center
Serving Raleigh, Fayette, Summers and Nicholas Counties
Beckley
304-255-2559 / TTY 1-888-825-7835

National Sexual Assault Hotline **1-800-656-HOPE**

PROTOCOL INTRODUCTION

It is critical to respond to individuals disclosing sexual assault in a timely, culturally appropriate, sensitive and respectful manner. This means that each action taken by medical personnel, law enforcement, prosecutor and advocacy help facilitate the victim's care and healing, protect the victim's autonomy and preserve their dignity with the understanding that significant acute and long-term health consequences are associated with sexual violence. For these reasons victims of sexual assault should be viewed as "priority emergency cases."

As with all traumas, each individual has her/his way of coping in accordance to her/his cultural beliefs, values and norms. Sexual assault is certainly no different, and in the aftermath of an assault a victim may present exhibiting a wide range of emotions.

Some victims may appear calm, indifferent, submissive, angry, uncooperative or even hostile to those trying to help. They may also giggle or laugh at seemingly inappropriate times. Because everyone reacts differently following a sexual assault, a victim should be allowed to express their emotions in a non-judgmental and supportive environment.

It is vital that all first responders understand that there isn't any "right" or "wrong" way for a victim to respond following an assault.

While reactions to a sexual assault may vary significantly for each individual, there are certain common feelings and fears that many patients face including:

- Fear of not being believed
- Fear of being blamed for the assault
- Fear that the offender may return and/or retaliate
- Fear of loss of support by primary caregiver or personal care attendant if either is the perpetrator
- Fear of unknown medical and/or criminal justice processes
- Fear of friends and family finding out
- Fear of being labeled a 'victim'
- Feelings of shame and/or embarrassment
- Feelings of guilt
- Feeling suspicious and/or hyper-vigilant
- Feeling unsafe or scared
- Feeling a loss of control

A victim's emotional reaction should in no way influence the quality of care given, be taken as evidence that an assault did or did not occur or be used to make decisions about a victim's credibility.

It is equally important for every discipline to be informed about the effects of trauma on an individual. Because of the changes that occur in the brain and the interruption of the brain's ability to encode memories as a result of the trauma, victims are often not capable of thinking clearly and making decisions.

Trauma can affect an individual's emotional response, memory, and ability to give detailed information about their experience. Some victims may find it difficult, if not impossible, to remember what happened. Asking victims to recall details and timelines or to write a statement may lead to timeline gaps, minimization of details, and the appearance of inconsistencies. When a person is stressed or traumatized, inconsistent statements are the norm.

Ensuring access to care for victims and services that are victim-centered and trauma-informed are key goals for all multidisciplinary teams.

West Virginia Sex Crime Laws and Definitions

Sexual Abuse and Sexual Assault

West Virginia laws are very specific about sexual abuse and sexual assault. Sexual abuse occurs when a person subjects another person to sexual contact without their consent, and that lack of consent is due to physical force, threat or intimidation. In West Virginia, sexual assault includes penetration, defined as sexual intercourse or sexual intrusion.

§61-8B-1. Definition of terms.

In this article, unless a different meaning plainly is required:

1. "**Forcible compulsion**" means:
   (a) Physical force that overcomes such earnest resistance as might reasonably be expected under the circumstances; or
   (b) Threat or intimidation, expressed or implied, placing a person in fear of immediate death or bodily injury to himself or herself or another person or in fear that he or she or another person will be kidnapped; or
   (c) Fear by a person under sixteen years of age caused by intimidation, expressed or implied, by another person who is at least four years older than the victim. For the purposes of this definition "resistance" includes physical resistance or any clear communication of the victim's lack of consent.
2. "**Married**," for the purposes of this article in addition to its legal meaning, includes persons living together as husband and wife regardless of the legal status of their relationship.
3. "**Mentally defective**" means that a person suffers from a mental disease or defect which renders that person incapable of appraising the nature of his or her conduct.
4. "**Mentally incapacitated**" means that a person is rendered temporarily incapable of appraising or controlling his or her conduct as a result of the influence of a controlled or intoxicating substance administered to that person without his or her consent or as a result of any other act committed upon that person without his or her consent.
5. "**Physically helpless**" means that a person is unconscious or for any reason is physically unable to communicate unwillingness to an act.
6. "**Sexual contact**" means any intentional touching, either directly or through clothing, of the breasts, buttocks, anus or of any part of the sex organs of another person, or intentional touching of any part of another person's body by the actor's sex organs, where the victim is not married to the actor and the touching is done for the purpose of gratifying the sexual desire of either party.

7. “**Sexual intercourse**” means any act between persons involving penetration, however slight, of the female sex organ by the male sex organ or involving contact between the sex organs of one person and the mouth or anus of another person.
8. “**Sexual intrusion**” means any act between persons involving penetration, however slight, of the female sex organ or of the anus of any person by an object for the purpose of degrading or humiliating the person so penetrated or for gratifying the sexual desire of either party.
9. “**Bodily injury**” means substantial physical pain, illness or any impairment of physical condition.
10. “**Serious bodily injury**” means bodily injury which creates a substantial risk of death, which causes serious or prolonged disfigurement, prolonged impairment of health or prolonged loss or impairment of the function of any bodily organ.
11. “**Deadly weapon**” means any instrument, device or thing capable of inflicting death or serious bodily injury, and designed or specially adapted for use as a weapon, or possessed, carried or used as a weapon.
12. “**Forensic medical examination**” means an examination provided to a possible victim of a violation of the provisions of this article by medical personnel qualified to gather evidence of the violation in a manner suitable for use in a court of law, to include: An examination for physical trauma; a determination of penetration or force; a patient interview; and the collection and evaluation of other evidence that is potentially relevant to the determination that a violation of the provisions of this article occurred and to the determination of the identity of the assailant.

§61-8B-2. Lack of consent.

(a) Whether or not specifically stated, it is an element of every offense defined in this article that the sexual act was committed without the consent of the victim.

(b) Lack of consent results from:

1. Forcible compulsion; or
2. Incapacity to consent; or
3. If the offense charged is sexual abuse, any circumstances in addition to the forcible compulsion or incapacity to consent in which the victim does not expressly or impliedly acquiesce in the actor’s conduct.

(c) A person is deemed incapable of consent when such person is:

1. Less than sixteen years old; or
2. Mentally defective; or
3. Mentally incapacitated; or
4. Physically helpless.

§61-8B-3. Sexual assault in the first degree.

(a) A person is guilty of sexual assault in the first degree when:

1. The person engages in sexual intercourse or sexual intrusion with another person and, in so doing:
   (i) Inflicts serious bodily injury upon anyone; or
   (ii) Employs a deadly weapon in the commission of the act; or
2. The person, being fourteen years old or more, engages in sexual intercourse or sexual intrusion with another person who is younger than twelve years old and is not married to that person.

(b) Any person violating the provisions of this section is guilty of a felony and, upon conviction thereof, shall be imprisoned in a state correctional facility not less than fifteen nor for more than thirty-five years, or fined not less than one thousand dollars nor more than ten thousand dollars and imprisoned in a state correctional facility not less than fifteen nor more than thirty- five years.

(c) Notwithstanding the provisions of subsection (b) of this section, the penalty for any person violating the provisions of subsection (a) of this section who is eighteen years of age or older and whose victim is younger than twelve years of age, shall be imprisonment in a state correctional facility for not less than twenty-five nor more than one hundred years and a fine of not less than five thousand dollars nor more than twenty-five thousand dollars.

§61-8B-4. Sexual assault in the second degree.

(a) A person is guilty of sexual assault in the second degree when:

1. Such person engages in sexual intercourse or sexual intrusion with another person without the person's consent, and the lack of consent results from forcible compulsion; or
2. Such person engages in sexual intercourse or sexual intrusion with another person who is physically helpless.

(b) Any person who violates the provisions of this section shall be guilty of a felony, and, upon conviction thereof, shall be imprisoned in the penitentiary not less than ten nor more than twenty-five years, or fined not less than one thousand dollars nor more than ten thousand dollars and imprisoned in the penitentiary not less than ten nor more than twenty-five years.

§61-8B-5. Sexual assault in the third degree.

(a) A person is guilty of sexual assault in the third degree when:

1. The person engages in sexual intercourse or sexual intrusion with another person who is mentally defective or mentally incapacitated; or
2. The person, being sixteen years old or more, engages in sexual intercourse or sexual intrusion with another person who is less than sixteen years old and

who is at least four years younger than the defendant and is not married to the defendant.

(b) Any person violating the provisions of this section is guilty of a felony and, upon conviction thereof, shall be imprisoned in a state correctional facility not less than one year nor more than five years, or fined not more than ten thousand dollars and imprisoned in a state correctional facility not less than one year nor more than five years.

§61-8B-7. Sexual abuse in the first degree.

(a) A person is guilty of sexual abuse in the first degree when:

1. Such person subjects another person to sexual contact without their consent, and the lack of consent results from forcible compulsion; or
2. Such person subjects another person to sexual contact who is physically helpless; or
3. Such person, being fourteen years old or more, subjects another person to sexual contact who is younger than twelve years old.

(b) Any person who violates the provisions of this section shall be guilty of a felony, and, upon conviction thereof, shall be imprisoned in a state correctional facility not less than one year nor more than five years, or fined not more than ten thousand dollars and imprisoned in a state correctional facility not less than one year nor more than five years.

(c) Notwithstanding the provisions of subsection (b) of this section, the penalty for any person violating the provisions of subsection (a) of this section who is eighteen years of age or older and whose victim is younger than twelve years of age, shall be imprisonment for not less than five nor more than twenty-five years and fined not less than one thousand dollars nor more than five thousand dollars.

§61-8B-8. Sexual abuse in the second degree.

(a) A person is guilty of sexual abuse in the second degree when such person subjects another person to sexual contact who is mentally defective or mentally incapacitated.

(b) Any person who violates the provisions of this section shall be guilty of a misdemeanor, and, upon conviction thereof, shall be confined in the county jail not more than twelve months, or fined not more than five hundred dollars and confined in the regional jail not more than twelve months.

§61-8B-9. Sexual abuse in the third degree.

(a) A person is guilty of sexual abuse in the third degree when he subjects another person to sexual contact without the latter's consent, when such lack of consent is due to the victim's incapacity to consent by reason of being less than sixteen years old.

(b) In any prosecution under this section it is a defense that:

1. The defendant was less than sixteen years old; or
2. The defendant was less than four years older than the victim.

(c) Any person who violates the provisions of this section shall be guilty of a misdemeanor, and, upon conviction thereof, shall be confined in the county jail not more than ninety days, or fined not more than five hundred dollars and confined in the county jail not more than ninety days.

§61-8B-9a. Mandatory sentence for person committing certain sex offenses against children.

(a) Notwithstanding the provisions of section one-a, article eleven-a, section four, article eleven-b and section two, article twelve of chapter sixty-two of this code, a person shall not be eligible for probation, home incarceration or an alternative sentence provided under this code if they are convicted of an offense under section three, four, five, seven, eight or nine, article eight-b, chapter sixty-one of this code, are eighteen years of age or older, the victim is younger than twelve years of age and the finder of fact determines that one of the following aggravating circumstances exists:

1. The person employed forcible compulsion in commission of the offense;
2. The offense constituted, resulted from or involved a predatory act as defined in subsection (m), section two, article twelve, chapter fifteen of this code;
3. The person was armed with a weapon or any article used or fashioned in a manner to lead the victim to reasonably believe it to be a dangerous weapon and used or threatened to use the weapon or article to cause the victim to submit; or
4. The person removed the victim from one place to another and did not release the victim in a safe place. For the purposes of this section, “release the victim in a safe place” means release of a victim in a place and manner which realistically conveys to the victim that he or she is free from captivity in circumstances and surroundings wherein aid is readily available.

(b) (1) The existence of any fact which would make any person ineligible for probation under subsection (a) of this section because of the existence of an aggravating circumstance shall not be applicable unless such fact is clearly stated and included in the indictment or presentment by which such person is charged and is either:

(i) Found by the court upon a plea of guilty or nolo contendere; or

(ii) found by the jury, if the matter be tried before a jury, upon submitting to such jury a special interrogatory for such purpose; or

(iii) found by the court, if the matter be tried by the court, without a jury.

(2) Insofar as the provisions of this section relate to mandatory sentences without probation, home incarceration or alternative sentences, all such matters

requiring such sentence shall be proved beyond a reasonable doubt in all cases tried by the jury or the court.

§61-8B-9b. Enhanced penalties for subsequent offenses committed by those previously convicted of sexually violent offenses against children.

(a) Not withstanding any provision of this article to the contrary, any person who has been convicted of a sexually violent offense, as defined in section two, article twelve, chapter fifteen of this code, against a victim under the age of twelve years old and thereafter commits and thereafter is convicted of one of the following offenses shall be subject to the following penalties unless another provision of this code authorizes a longer sentence:

1. For a violation of section three of this article, the penalty shall be imprisonment in a state correctional facility for not less than fifty nor more than one hundred fifty years;
2. For a violation of section four of this article, the penalty shall be imprisonment in a state correctional facility for not less than thirty nor more than one hundred years;
3. For a violation of section five of this article, the penalty shall be imprisonment in a state correctional facility for not less than five nor more than twenty-five years;
4. For a violation of section seven of this article, the penalty shall be imprisonment in a state correctional facility for not less than ten nor more than thirty-five years; and
5. Notwithstanding the penalty provisions of section eight of this article, a violation of its provisions by a person previously convicted of a sexually violent offense, as defined in section two, article twelve, chapter fifteen of this code, shall be a felony and the penalty therefore shall be imprisonment in a state correctional facility for not less than three nor more than fifteen years.

(b) Notwithstanding the provisions of section two, article twelve, chapter sixty-two of thiscode, any person sentenced pursuant to this section shall not be eligible for probation.

(c) Notwithstanding the provisions of section one-a, article eleven-a and section four, article eleven-b of chapter sixty-two of this code, a person sentenced under this section shall not be eligible for home incarceration or an alternative sentence.

§61-8B-10. Imposition of sexual intercourse or sexual intrusion on incarcerated persons; penalties

(a) Any person employed by the Division of Corrections, any person working at a correctional facility managed by the Commissioner of Corrections pursuant to contract or as an employee of a state agency, any person working at a

correctional facility managed by the Division of Juvenile Services pursuant to contract or as an employee of a state agency, any person employed by a jail or by the Regional Jail and Correctional Facility Authority, any person working at a facility managed by the Regional Jail and Correctional Facility Authority or a jail or any person employed by, or acting pursuant to, the authority of any sheriff, county commission, or court to ensure compliance with the provisions of article eleven-b, chapter sixty-two of this code who engages in sexual intercourse or sexual intrusion with a person who is incarcerated in this state is guilty of a felony and, upon conviction thereof, shall be confined in a state correctional facility under the control of the Commissioner of Corrections for not less than one nor more than five years or fined not more than five thousand dollars.

(b) Any person employed by the Division of Corrections as a parole officer or by the West Virginia Supreme Court of Appeals as an adult or juvenile probation officer who engages in sexual intercourse or sexual intrusion with a person said parole officer or probation officer is charged as part of his or her employment with supervising, is guilty of a felony and, upon conviction thereof, shall be confined in a state correctional facility under the control of the Commissioner of Corrections for not less than one nor more than five years or fined not more than five thousand dollars, or both.

(c) The term "incarcerated in this state" for purposes of this section includes in addition to its usual meaning, offenders serving a sentence under the provisions of article eleven-b, chapter sixty-two of this code.

West Virginia Laws Specifically Involving Minors

§61-8C-1. Definitions.

For the purposes of this article:

(a) "Minor" means any child under eighteen years of age.

(b) "Knowledge" means knowing or having reasonable cause to know which warrants further inspection or inquiry.

(c) "Sexually explicit conduct" includes any of the following, whether actually performed or simulated:

1. Genital to genital intercourse;
2. Fellatio;
3. Cunnilingus;
4. Anal intercourse;
5. Oral to anal intercourse;
6. Bestiality;
7. Masturbation;
8. Sadomasochistic abuse, including, but not limited to, flagellation, torture or

bondage;

9. Excretory functions in a sexual context; or
10. Exhibition of the genitals, pubic or rectal areas of any person in a sexual context.

(d) "Person" means an individual, partnership, firm, association, corporation or other legal entity.

§61-8C-2. Use of minors in filming sexually explicit conduct prohibited; penalty.

(a) Any person who causes or knowingly permits, uses, persuades, induces, entices or coerces such minor to engage in or uses such minor to do or assist in any sexually explicit conduct shall be guilty of a felony when such person has knowledge that any such act is being photographed or filmed. Upon conviction thereof, such person shall be fined not more than ten thousand dollars, or imprisoned in the penitentiary not more than ten years, or both fined and imprisoned.

(b) Any person who photographs or films such minor engaging in any sexually explicit conduct shall be guilty of a felony, and, upon conviction thereof, shall be fined not more than ten thousand dollars, or imprisoned in the penitentiary not more than ten years, or both fined and imprisoned.

(c) Any parent, legal guardian or person having custody and control of a minor, who photographs or films such minor in any sexually explicit conduct or causes or knowingly permits, uses, persuades, induces, entices or coerces such minor child to engage in or assist in any sexually explicit act shall be guilty of a felony when such person has knowledge that any such act may be photographed or filmed. Upon conviction thereof, such person shall be fined not more than ten thousand dollars, or imprisoned in the penitentiary not more than ten years, or both fined and imprisoned.

§61-8C-3. Distribution and exhibiting of material depicting minors engaged in sexually explicit conduct prohibited; penalty.

(a) Any person who, knowingly and willfully, sends or causes to be sent or distributes, exhibits, possesses, electronically accesses with intent to view or displays or transports any material visually portraying a minor engaged in any sexually explicit conduct is guilty of a felony.

(b) Any person who violates the provisions of subsection (a) of this section when the conduct involves fifty or fewer images shall, upon conviction, be imprisoned in a state correctional facility for not more than two years or fined not more than $2,000 or both.

(c) Any person who violates the provisions of subsection (a) of this section when the conduct involves more than fifty but fewer than six hundred images shall, upon conviction, be imprisoned in a state correctional facility for not less than two nor

more than ten years or fined not more than $5,000, or both.

(d) Notwithstanding the provisions of subsections (b) and (c) of this section any person who violates the provisions of subsection (a) of this section when the conduct involves six hundred or more images or depicts violence against a child or a child engaging in bestiality shall, upon conviction, be imprisoned in a state correctional facility for not less than five nor more than fifteen years or fined not more than $25,000, or both.

(e) For purposes of this section each video clip, movie or similar recording of five minutes or less shall constitute seventy- five images. A video clip, movie or similar recording of a duration longer than five minutes shall be deemed to constitute seventy-five images for every two minutes in length it exceeds five minutes

§61-8C-3a. Prohibiting child erotica; penalties.

(a) Any person age eighteen or over who knowingly and intentionally produces, possesses, displays or distributes, in any form, any visual portrayals of minors who are partially clothed, where the visual portrayals are: (1) Unrelated to the sale of a commercially available legal product; and (2) used for purely prurient purposes, is guilty of a misdemeanor and, upon conviction thereof, shall be confined in jail for not more than one year or fined not more than $1,000, or both confined and fined.

(b) As used in this section only:

(1) "Purely prurient purposes" means for the specific purpose of sexual gratification or sexual arousal from viewing the visual portrayals prohibited by this section; and

(2) "Commercially available" means for sale to the general public.

(3) A "minor" is a child under the age of sixteen years, or a person who is sixteen years of age or older but less than eighteen years old and who is mentally defective or mentally incapacitated.

§61-8C-3b. Prohibiting juveniles from manufacturing, possessing and distributing nude or partially nude images of minors; creating exemptions; declaring a violation to be an act of juvenile delinquency; and providing for the punishment thereof.

(a) Any minor who intentionally possesses, creates, produces, distributes, presents, transmits, posts, exchanges, or otherwise disseminates a visual portrayal of another minor posing in an inappropriate sexual manner or who distributes, presents, transmits, posts, exchanges or otherwise disseminates a visual portrayal of himself or herself posing in an inappropriate sexual manner shall be guilty of an act of delinquency and upon adjudication disposition may be made by the circuit court pursuant to the provisions of article five, chapter forty-nine of this

code.

(b) As used in this section:

(1) "Posing in an inappropriate sexual manner" means exhibition of a bare female breast, female or male genitalia, pubic or rectal areas of a minor for purposes of sexual titillation.

(2) "Visual portrayal" means:

(A) A photograph;

(B) A motion picture;

(C) A digital image;

(D) A digital video recording; or

(E) Any other mechanical or electronic recording process or device that can preserve, for later viewing, a visual image of a person that includes, but is not limited to, computers, cellphones, personal digital assistance and other digital storage or transmitting devices;

(c) It shall be an affirmative defense to an alleged violation of this section that a minor charged with possession of the prohibited visual depiction did neither solicit its receipt nor distribute, transmit or present it to another person by any means.

(d) Notwithstanding the provisions of article twelve, chapter fifteen of this code, an adjudication of delinquency under the provisions of this section shall not subject the minor to the requirements of said article and chapter.

§61-8C-4. Payment of treatment costs for minor.

In addition to any penalty provided under this article and any restitution which may be ordered by the court under article eleven-a of this chapter, the court may order any person convicted under the provisions of this article to pay all or any portion of the cost of medical, psychological or psychiatric treatment of the minor resulting from the act or acts for which the person is convicted, whether or not the minor is considered to have sustained bodily injury.

§61-8C-5. Limits on interviews of children eleven years old or less; evidence.

(a) In any prosecution under this article, the court may provide by rule for reasonable limits on the number of interviews to which a victim who is eleven years old or less must submit for law enforcement or discovery purposes. The rule shall to the extent possible protect the mental and emotional health of the child from the psychological damage of repeated interrogation and at the same time preserve the rights of the public and the defendant.

(b) At any stage of the proceedings, in any prosecution under this article, the court may permit a child who is eleven years old or less to use anatomically correct dolls, mannequins or drawings to assist such child in testifying.

§61-8D-1. Definitions.

In this article, unless a different meaning plainly is required:

1. "**Abuse**" means the infliction upon a minor of physical injury by other than accidental means.
2. "**Child**" means any person under eighteen years of age not otherwise emancipated by law.
3. "**Controlled substance**" means controlled substance as that term is defined in subsection (d), section one hundred one, article one, chapter sixty-a of this code.
4. "**Custodian**" means a person over the age of fourteen years who has or shares actual physical possession or care and custody of a child on a full-time or temporary basis, regardless of whether such person has been granted custody of the child by any contract, agreement or legal proceeding. "Custodian" shall also include, but not be limited to, the spouse of a parent, guardian or custodian, or a person cohabiting with a parent, guardian or custodian in the relationship of husband and wife, where such spouse or other person shares actual physical possession or care and custody of a child with the parent, guardian or custodian.
5. "**Guardian**" means a person who has care and custody of a child as the result of any contract, agreement or legal proceeding.
6. "**Neglect**" means the unreasonable failure by a parent, guardian, or any person voluntarily accepting a supervisory role towards a minor child to exercise a minimum degree of care to assure said minor child's physical safety or health.
7. "**Parent**" means the biological father or mother of a child, or the adoptive mother or father of a child.
8. "**Sexual contact**" means sexual contact as that term is defined in section one, article eight- b, chapter sixty-one of this code.
9. "**Sexual exploitation**" means an act whereby:

(A) A parent, custodian, guardian or other person in a position of trust to a child, whether for financial gain or not, persuades, induces, entices or coerces the child to engage in sexually explicit conduct as that term is defined in section one, article eight-c, chapter sixty-one of this code; or

(B) A parent, guardian, custodian or other person in a position of trust in relation to a child persuades, induces, entices or coerces the child to display his or her sex organs for the sexual gratification of the parent, guardian, custodian, person in a position of trust or a third person, or to display his or her sex organs under circumstances in which the parent, guardian, custodian or other person in a position of trust knows such display is likely to be observed by others who would be affronted or alarmed.

10. "**Sexual intercourse**" means sexual intercourse as that term is defined in section one, article eight-b, chapter sixty-one of this code.
11. "**Sexual intrusion**" means sexual intrusion as that term is defined in section one, article eight-b, chapter sixty-one of this code.
12. A "**person in a position of trust in relation to a child**" refers to any person who is

acting in the place of a parent and charged with any of a parent's rights, duties or responsibilities concerning a child or someone responsible for the general supervision of a child's welfare, or any person who by virtue of their occupation, or position is charged with any duty or responsibility for the health, education, welfare, or supervision of the child.

§61-8D-5. Sexual abuse by a parent, guardian, custodian or person in a position of trust to a child; parent, guardian, custodian or person in a position of trust allowing sexual abuse to be inflicted upon a child; displaying of sex organs by a parent, guardian, or custodian; penalties.

(a) In addition to any other offenses set forth in this code, the Legislature hereby declares a separate and distinct offense under this subsection, as follows: If any parent, guardian or custodian of or other person in a position of trust in relation to a child under his or her care, custody or control, shall engage in or attempt to engage in sexual exploitation of, or in sexual intercourse, sexual intrusion or sexual contact with, a child under his or her care, custody or control, notwithstanding the fact that the child may have willingly participated in such conduct, or the fact that the child may have consented to such conduct or the fact that the child may have suffered no apparent physical injury or mental or emotional injury as a result of such conduct, then such parent, guardian, custodian or person in a position of trust shall be guilty of a felony and upon conviction thereof, shall be imprisoned in the penitentiary not less than ten nor more than twenty years, or fined not less than five hundred nor more than five thousand dollars and imprisoned in the penitentiary not less than ten years nor more than twenty years.

(b) Any parent, guardian, custodian or other person in a position of trust in relation to the child who knowingly procures, authorizes, or induces another person to engage in or attempt to engage in sexual exploitation of, or sexual intercourse, sexual intrusion or sexual contact with, a child under the care, custody or control of such parent, guardian, custodian or person in a position of trust when such child is less than sixteen years of age, notwithstanding the fact that the child may have willingly participated in such conduct or the fact that the child may have suffered no apparent physical injury or mental or emotional injury as a result of such conduct, such parent, guardian, custodian or person in a position of trust shall be guilty of a felony and, upon conviction thereof, shall be imprisoned in a correctional facility not less than five years nor more than fifteen years, or fined not less than one thousand nor more than ten thousand dollars and imprisoned in a correctional facility not less than five years nor more than fifteen years.

(c) Any parent, guardian, custodian or other person in a position of trust in relation to the child who knowingly procures, authorizes, or induces another person to engage in or attempt to engage in sexual exploitation of, or sexual intercourse, sexual intrusion or sexual contact with, a child under the care, custody or control of such parent, guardian, custodian or person in a position of trust when such child

is sixteen years of age or older, notwithstanding the fact that the child may have consented to such conduct or the fact that the child may have suffered no apparent physical injury or mental or emotional injury as a result of such conduct, then such parent, guardian, custodian or person in a position of trust shall be guilty of a felony and, upon conviction thereof, shall be imprisoned in a correctional facility not less than one year nor more than five years.

(d) The provisions of this section shall not apply to a custodian or person in a position of trust whose age exceeds the age of the child by less than four years.

§61-8D-6. Sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, guardian or custodian, depicting a child engaged in sexually explicit conduct; penalty.

Any parent, guardian or custodian who, with knowledge, sends or causes to be sent, or distributes, exhibits, possesses, displays or transports, any material visually portraying a child under his or her care, custody or control engaged in any sexually explicit conduct, is guilty of a felony, and, upon conviction thereof, shall be imprisoned in the penitentiary not more than two years, and fined not less than four hundred dollars nor more than four thousand dollars.

§61-8-12. Incest; penalty.

(a) For the purposes of this section:

1. "**Aunt**" means the sister of a person's mother or father;
2. "**Brother**" means the son of a person's mother or father;
3. "**Daughter**" means a person's natural daughter, adoptive daughter or the daughter of a person's husband or wife;
4. "**Father**" means a person's natural father, adoptive father or the husband of a person's mother;
5. "**Granddaughter**" means the daughter of a person's son or daughter;
6. "**Grandfather**" means the father of a person's father or mother;
7. "**Grandmother**" means the mother of a person's father or mother;
8. "**Grandson**" means the son of a person's son or daughter;
9. "**Mother**" means a person's natural mother, adoptive mother or the wife of a person's father;
10. "**Niece**" means the daughter of a person's brother or sister;
11. "**Nephew**" means the son of a person's brother or sister;
12. "**Sexual intercourse**" means any act between persons involving penetration, however slight, of the female sex organ by the male sex organ or involving contact between the sex organs of one person and the mouth or anus of another person;
13. "**Sexual intrusion**" means any act between persons involving penetration, however slight, of the female sex organ or of the anus of any person by an object

for the purpose of degrading or humiliating the person so penetrated or for gratifying the sexual desire of either party;

14. "**Sister**" means the daughter of a person's father or mother;
15. "**Son**" means a person's natural son, adoptive son or the son of a person's husband or wife; and
16. "**Uncle**" means the brother of a person's father or mother.

(b) A person is guilty of incest when such person engages in sexual intercourse or sexual intrusion with his or her father, mother, brother, sister, daughter, son, grandfather, grandmother, grandson, granddaughter, nephew, niece, uncle or aunt.

(c) Any person who violates the provisions of this section shall be guilty of a felony, and, upon conviction thereof, shall be imprisoned in the penitentiary not less than five years nor more than fifteen years, or fined not less than five hundred dollars nor more than five thousand dollars and imprisoned in the penitentiary not less than five years nor more than fifteen years.

(d) In addition to any penalty provided under this section and any restitution which may be ordered by the court under article eleven-a of this chapter, the court may order any person convicted under the provisions of this section where the victim is a minor to pay all or any portion of the cost of medical, psychological or psychiatric treatment of the victim, the need for which results from the act or acts for which the person is convicted, whether or not the victim is considered to have sustained bodily injury.

(e) In any case where a person is convicted of an offense described herein against a child and further has or may have custodial, visitation or other parental rights to the child, the court shall find that the person is an abusing parent within the meaning of article six, chapter forty- nine of this code, and shall take such further action in accord with the provisions of said article.

§61-8-13. Incest; limits on interviews of children eleven years old or less; evidence.

(a) In any prosecution under the provisions of section twelve of this article, the court may provide by rule for reasonable limits on the number of interviews to which a victim who is eleven years old or less must submit for law enforcement or discovery purposes. To the extent possible the rule shall protect the mental and emotional health of the child from the psychological damage of repeated interrogation and at the same time preserve the rights of the public and the defendant.

(b) At any stage of the proceedings, in any prosecution under this article, the court may permit a child who is eleven years old or less to use anatomically correct dolls, mannequins or drawings to assist such child in testifying.

(c) In any prosecution under this article in which the victim's lack of consent is based solely on the incapacity to consent because such victim was below a critical age, evidence of specific instances of the victim's sexual conduct, opinion evidence of the victim's sexual conduct and reputation evidence of the victim's sexual

conduct shall not be admissible. In any other prosecution under this article, evidence of specific instances of the victim's prior sexual conductwith the defendant shall be admissible on the issue of consent: *Provided,* that such evidence heard first out of the presence of the jury is found by the judge to be relevant.

(d) In any prosecution under this article evidence of specific instances of the victim's sexual conduct with persons other than the defendant, opinion evidence of the victim's sexual conductand reputation evidence of the victim's sexual conduct shall not be admissible: *Provided,* that such evidence shall be admissible solely for the purpose of impeaching credibility, if the victim first makes his or her previous sexual conduct an issue in the trial by introducing evidence with respect thereto.

(e) In any prosecution under this article, neither age nor mental capacity of the victim shall preclude the victim from testifying.

§49-1-201. Definitions related, but not limited, to child abuse and neglect.

When used in this chapter, terms defined in this section have the meanings ascribed to them that relate to, but are not limited to, child abuse and neglect, except in those instances where a different meaning is provided or the context in which the word is used clearly indicates that a different meaning is intended.

"Abandonment" means any conduct that demonstrates the settled purpose to forego the duties and parental responsibilities to the child;

"Abused child" means a child whose health or welfare is being harmed or threatened by:

(A) A parent, guardian or custodian who knowingly or intentionally inflicts, attempts to inflict or knowingly allows another person to inflict, physical injury or mental or emotional injury, upon the child or another child in the home. Physical injury may include an injury to the child as a result of excessive corporal punishment;

(B) Sexual abuse or sexual exploitation;

(C) The sale or attempted sale of a child by a parent, guardian or custodian in violation of section fourteen-h, article two, chapter sixty-one of this code; or

(D) Domestic violence as defined in section two hundred two, article twenty-seven, chapter forty-eight of this code.

"Abusing parent" means a parent, guardian or other custodian, regardless of his or her age, whose conduct has been adjudicated by the court to constitute child abuse or neglect as alleged in the petition charging child abuse or neglect.

"Battered parent," for the purposes of part six, article four of this chapter, means a respondent parent, guardian, or other custodian who has been adjudicated by the

court to have not condoned the abuse or neglect and has not been able to stop the abuse or neglect of the child or children due to being the victim of domestic violence as defined by section two hundred two, article twenty-seven, chapter forty-eight of this code which was perpetrated by the same person or persons determined to have abused or neglected the child or children.

"Child abuse and neglect services" means social services which are directed toward:

(A) Protecting and promoting the welfare of children who are abused or neglected;

(B) Identifying, preventing and remedying conditions which cause child abuse and neglect;

(C) Preventing the unnecessary removal of children from their families by identifying family problems and assisting families in resolving problems which could lead to a removal of children and a breakup of the family;

(D) In cases where children have been removed from their families, providing time-limited reunification services to the children and the families so as to reunify those children with their families or some portion thereof;

(E) Placing children in suitable adoptive homes when reunifying the children with their families, or some portion thereof, is not possible or appropriate; and

(F) Assuring the adequate care of children or juveniles who have been placed in the custody of the department or third parties.

"Condition requiring emergency medical treatment" means a condition which, if left untreated for a period of a few hours, may result in permanent physical damage; that condition includes, but is not limited to, profuse or arterial bleeding, dislocation or fracture, unconsciousness and evidence of ingestion of significant amounts of a poisonous substance.

"Imminent danger to the physical well-being of the child" means an emergency situation in which the welfare or the life of the child is threatened. These conditions may include an emergency situation when there is reasonable cause to believe that any child in the home is or has been sexually abused or sexually exploited, or reasonable cause to believe that the following conditions threaten the health, life, or safety of any child in the home:

(A) Nonaccidental trauma inflicted by a parent, guardian, custodian, sibling or a babysitter or other caretaker;

(B) A combination of physical and other signs indicating a pattern of abuse which may be medically diagnosed as battered child syndrome;

(C) Nutritional deprivation;

(D) Abandonment by the parent, guardian or custodian;

(E) Inadequate treatment of serious illness or disease;

(F) Substantial emotional injury inflicted by a parent, guardian or custodian;

(G) Sale or attempted sale of the child by the parent, guardian or custodian;

(H) The parent, guardian or custodian's abuse of alcohol or drugs or other controlled substance as defined in section one hundred one, article one, chapter sixty-a of this code, has impaired his or her parenting skills to a degree as to pose an imminent risk to a child's health or safety; or

(I) Any other condition that threatens the health, life, or safety of any child in the home.

"Neglected child" means a child:

(A) Whose physical or mental health is harmed or threatened by a present refusal, failure or inability of the child's parent, guardian or custodian to supply the child with necessary food, clothing, shelter, supervision, medical care or education, when that refusal, failure or inability is not due primarily to a lack of financial means on the part of the parent, guardian or custodian; or

(B) Who is presently without necessary food, clothing, shelter, medical care, education or supervision because of the disappearance or absence of the child's parent or custodian;

(C) "Neglected child" does not mean a child whose education is conducted within the provisions of section one, article eight, chapter eighteen of this code. "Petitioner or co-petitioner" means the Department or any reputable person who files a child abuse or neglect petition pursuant to section six hundred one, article four, of this chapter.

"Permanency plan" means the part of the case plan which is designed to achieve a permanent home for the child in the least restrictive setting available.

"Respondent" means all parents, guardians, and custodians identified in the child abuse and neglect petition who are not petitioners or co-petitioners.

"Sexual abuse" means:

(A) Sexual intercourse, sexual intrusion, sexual contact, or conduct proscribed by section three, article eight-c, chapter sixty-one, which a parent, guardian or custodian engages in, attempts to engage in, or knowingly procures another person to engage in with a child notwithstanding the fact that for a child who is less than

sixteen years of age the child may have willingly participated in that conduct or the child may have suffered no apparent physical injury or mental or emotional injury as a result of that conduct or, for a child sixteen years of age or older the child may have consented to that conduct or the child may have suffered no apparent physical injury or mental or emotional injury as a result of that conduct;

(B) Any conduct where a parent, guardian or custodian displays his or her sex organs to a child, or procures another person to display his or her sex organs to a child, for the purpose of gratifying the sexual desire of the parent, guardian or custodian, of the person making that display, or of the child, or for the purpose of affronting or alarming the child; or (C) Any of the offenses proscribed in sections seven, eight or nine of article eight-b, chapter sixty-one of this code.

"Sexual assault" means any of the offenses proscribed in sections three, four or five of article eight-b, chapter sixty-one of this code.

"Sexual contact" means sexual contact as that term is defined in section one, article eight-b, chapter sixty-one of this code.

"Sexual exploitation" means an act where:

(A) A parent, custodian or guardian, whether for financial gain or not, persuades, induces, entices or coerces a child to engage in sexually explicit conduct as that term is defined in section one, article eight-c, chapter sixty-one of this code; or

(B) A parent, guardian or custodian persuades, induces, entices or coerces a child to display his or her sex organs for the sexual gratification of the parent, guardian, custodian or a third person, or to display his or her sex organs under circumstances in which the parent, guardian or custodian knows that the display is likely to be observed by others who would be affronted or alarmed.

"Sexual intercourse" means sexual intercourse as that term is defined in section one, article eight-b, chapter sixty-one of this code.

"Sexual intrusion" means sexual intrusion as that term is defined in section one, article eight-b, chapter sixty-one of this code. "Serious physical abuse" means bodily injury which creates a substantial risk of death, which causes serious or prolonged disfigurement, prolonged impairment of health or prolonged loss or impairment of the function of any bodily organ.

§49-2-803. Persons mandated to report suspected abuse and neglect; requirements.

(a) Any medical, dental or mental health professional, Christian Science practitioner, religious healer, school teacher or other school personnel, social service worker,

child care or foster care worker, emergency medical services personnel, peace officer or law-enforcement official, humane officer, member of the clergy, circuit court judge, family court judge, employee of the Division of Juvenile Services, magistrate, youth camp administrator or counselor, employee, coach or volunteer of an entity that provides organized activities for children, or commercial film or photographic print processor who has reasonable cause to suspect that a child is neglected or abused or observes the child being subjected to conditions that are likely to result in abuse or neglect shall immediately, and not more than forty-eight hours after suspecting this abuse or neglect, report the circumstances or cause a report to be made to the Department of Health and Human Resources. In any case where the reporter believes that the child suffered serious physical abuse or sexual abuse or sexual assault, the reporter shall also immediately report, or cause a report to be made, to the State Police and any law-enforcement agency having jurisdiction to investigate the complaint. Any person required to report under this article who is a member of the staff or volunteer of a public or private institution, school, entity that provides organized activities for children, facility or agency shall also immediately notify the person in charge of the institution, school, entity that provides organized activities for children, facility or agency, or a designated agent thereof, who may supplement the report or cause an additional report to be made.

(b) Any person over the age of eighteen who receives a disclosure from a credible witness or observes any sexual abuse or sexual assault of a child, shall immediately, and not more than forty-eight hours after receiving that disclosure or observing the sexual abuse or sexual assault, report the circumstances or cause a report to be made to the Department of Health and Human Resources or the State Police or other law-enforcement agency having jurisdiction to investigate the report. In the event that the individual receiving the disclosure or observing the sexual abuse or sexual assault has a good faith belief that the reporting of the event to the police would expose either the reporter, the subject child, the reporter's children or other children in the subject child's household to an increased threat of serious bodily injury, the individual may delay making the report while he or she undertakes measures to remove themselves or the affected children from the perceived threat of additional harm and the individual makes the report as soon as practicable after the threat of harm has been reduced. The law-enforcement agency that receives a report under this subsection shall report the allegations to the Department of Health and Human Resources and coordinate with any other law-enforcement agency, as necessary to investigate the report.

(c) Any school teacher or other school personnel who receives a disclosure from a witness, which a reasonable prudent person would deem credible, or personally observes any sexual contact, sexual intercourse or sexual intrusion, as those terms are defined in article eight-b, chapter sixty-one, of a child on school premises or on school buses or on transportation used in furtherance of a school purpose shall immediately, but not more than 24 hours, report the circumstances or cause a report to be made to the State Police or other law-enforcement agency having jurisdiction to investigate the report: Provided, That this subsection will not impose any reporting duty upon school teachers or other school personnel who observe, or receive a disclosure of any consensual sexual contact, intercourse, or intrusion occurring between students who would not otherwise be subject to section three, five, seven or nine of article eight-8, chapter sixty-one of this code: Provided, however, That any teacher or other school personnel shall not be in violation of this section if he or she makes known immediately, but not more than 24 hours. to the principal, assistant principal or similar person in charge, a disclosure from a witness, which a reasonable prudent person would deem credible, or personal observation of conduct described in this section: Provided further, That a principal, assistant principal or similar person in charge made aware of such disclosure or observation from a teacher or other school personnel shall be responsible for immediately, but not more than 24 hours, reporting such conduct to law enforcement.

(d) County boards of education and private school administrators shall provide all employees with a written statement setting forth the requirement contained in this subsection and shall obtain and preserve a signed acknowledgment from school employees that they have received and understand the reporting requirement.

(e) The reporting requirements contained in this section specifically include reported, disclosed or observed conduct involving or between students enrolled in a public or private institution of education, or involving a student and school teacher or personnel. When the alleged conduct is between two students or between a student and school teacher or personnel, the law enforcement body that received the report under this section is required to make such a report under this section shall additionally immediately, but not more than 24 hours, notify the students' parents, guardians, and custodians about the allegations.

(f) Nothing in this article is intended to prevent individuals from reporting suspected abuse or neglect on their own behalf. In addition to those persons and officials specifically required to report situations involving suspected abuse or neglect of children, any other person may make a report if that person has reasonable cause to suspect that a child has been abused or neglected in a home or

institution or observes the child being subjected to conditions or circumstances that would reasonably result in abuse or neglect.

§49-2-809. Reporting procedures.

(a) Reports of child abuse and neglect pursuant to this article shall be made immediately by telephone to the local department child protective service agency and shall be followed by a written report within forty-eight hours if so requested by the receiving agency. The state department shall establish and maintain a twenty-four hour, seven-day-a-week telephone number to receive those calls reporting suspected or known child abuse or neglect.

(b) A copy of any report of serious physical abuse, sexual abuse or assault shall be forwarded by the department to the appropriate law-enforcement agency, the prosecuting attorney or the coroner or medical examiner's office. All reports under this article are confidential. Reports of known or suspected institutional child abuse or neglect shall be made and received as all other reports made pursuant to this article.

§49-2-810. Immunity from liability.

Any person, official or institution participating in good faith in any act permitted or required by this article are immune from any civil or criminal liability that otherwise might result by reason of those actions.

§49-2-811. Abrogation of privileged communications; exception.

The privileged quality of communications between husband and wife and between any professional person and his or her patient or his or her client, except that between attorney and client, is hereby abrogated in situations involving suspected or known child abuse or neglect.

§49-2-812. Failure to report; penalty.

(a) Any person, official or institution required by this article to report a case involving a child known or suspected to be abused or neglected, or required by section eight hundred nine of this article to forward a copy of a report of serious injury, who knowingly fails to do so or knowingly prevents another person acting reasonably from doing so, is guilty of a misdemeanor and, upon conviction, shall be confined in jail not more than ninety days or fined not more than $5,000, or both fined and confined.

(b) Any person, official or institution required by this article to report a case involving a child known or suspected to be sexually assaulted or sexually abused, or student known or suspected to have been a victim of any non-consensual sexual contact, sexual intercourse or sexual intrusion on school premises, who

knowingly fails to do so or knowingly prevents another person acting reasonably from doing so, is guilty of a misdemeanor and, upon conviction thereof, shall be confined in jail not more than six months or fined not more than $10,000, or both.

§49-2-814. Task Force on Prevention of Sexual Abuse of Children.

a) This section may be referred to as "Erin Merryn's Law."

b) The Task Force on Prevention of Sexual Abuse of Children is established. The task force consists of the following members:

1) The Chair of the West Virginia Senate Committee on Health and Human Resources, or his or her designee;
2) The Chair of the House of Delegates Committee on Health and Human Resources, or his or her designee;
3) The Chair of the West Virginia Senate Committee on Education, or his or her designee;
4) The Chair of the House of Delegates Committee on Education, or his or her designee;
5) One citizen member appointed by the President of the Senate;
6) One citizen member appointed by the Speaker of the House of Delegates;
7) One citizen member, who is a survivor of child sexual abuse, appointed by the Governor;
8) The President of the State Board of Education, or his or her designee;
9) The State Superintendent of Schools, or his or her designee;
10) The Secretary of the Department of Health and Human Resources, or his or her designee;
11) The Director of the Prosecuting Attorney's Institute, or his or her designee;
12) One representative of each statewide professional teachers' organization, each selected by the leader of his or her respective organization;
13) One representative of the statewide school service personnel organization, selected by the leader of the organization;
14) One representative of the statewide school principals' organization, appointed by the leader of the organization;
15) One representative of the statewide professional social workers' organization, appointed by the leader of the organization;
16) One representative of a teacher preparation program of a regionally accredited institution of higher education in the state, appointed by the Chancellor of the Higher Education Policy Commission;
17) The Chief Executive Officer of the Center for Professional Development, or his or her designee;
18) The Director of Prevent Child Abuse West Virginia, or his or her designee;

19) The Director of the West Virginia Child Advocacy Network, or his or her designee;
20) The Director of the West Virginia Coalition Against Domestic Violence, or his or her designee;
21) The Director of the West Virginia Foundation for Rape Information and Services, or his or her designee;
22) The Administrative Director of the West Virginia Supreme Court of Appeals, or his or her designee;
23) The Executive Director of the West Virginia Sheriffs' Association, or his or her designee;
24) One representative of an organization representing law enforcement, appointed by the Superintendent of the West Virginia State Police; and
25) One practicing school counselor appointed by the leader of the West Virginia School Counselors Association.

(c) To the extent practicable, members of the task force shall be individuals actively involved in the fields of child abuse and neglect prevention and child welfare.

(d) At the joint call of the House of Delegates and Senate Education Committee Chairs, the task force shall convene its first meeting and by majority vote of members present elect presiding officers. Subsequent meetings shall be at the call of the presiding officer.

(e) The task force shall make recommendations for decreasing incidence of sexual abuse of children in West Virginia. In making those recommendations, the task force shall:

1) Gather information regarding sexual abuse of children throughout the state;
2) Receive related reports and testimony from individuals, state and local agencies, community-based organizations, and other public and private organizations;
3) Create goals for state education policy that would prevent sexual abuse of children;
4) Create goals for other areas of state policy that would prevent sexual abuse of children; and
5) Submit a report with its recommendations to the Governor and the Legislature.

(f) The recommendations may include proposals for specific statutory changes and methods to foster cooperation among state agencies and between the state and local governments. The task force shall consult with employees of the Bureau for Children and Family Services, the Division of Justice and Community Services, the West Virginia State Police, the State Board of Education, and any other state

agency or department as necessary to accomplish its responsibilities under this section.

(g) Task force members serve without compensation and do not receive expense reimbursement.

West Virginia Related Laws

Article 3C—AIDS-Related Medical Testing and Records Confidentiality Act

§16-3C-2. Testing.

(f) Mandated testing:
The performance of any HIV-related testing that is or becomes mandatory by court order or other legal process described herein does not require consent of the subject but will include counseling.

(1) The court having jurisdiction of the criminal prosecution shall order that an HIV-related test be performed on any persons charged with any of the following crimes or offenses:

(i) Prostitution; or

(ii) Sexual abuse, sexual assault, incest or sexual molestation.

(2) HIV-related tests performed on persons charged with prostitution, sexual abuse, sexual assault, incest or sexual molestation shall be confidentially administered by a designee of the bureau or the local or county health department having proper jurisdiction. The commissioner may designate health care providers in regional jail facilities to administer HIV-related tests on such persons if he or she determines it necessary and expedient.

(4) Costs associated with tests performed on persons charged with prostitution, sexual abuse, sexual assault, incest or sexual molestation may be charged to the defendant or juvenile respondent unless a court determines that the person charged with prostitution, sexual abuse, sexual assault, incest or sexual molestation is pecuniary unable to pay.

(A) If a person charged with prostitution, sexual abuse, sexual assault, incest or sexual molestation who is ordered to be tested is unable to pay, the cost of the HIV testing may be borne by the regional jail or other correctional or juvenile facility, the bureau or the local health department.

(B) If persons charged with prostitution, sexual abuse, sexual assault, incest or sexual molestation who is ordered to be tested has health insurance, the local health department or other providers performing the test may bill the health insurance of the person charged with prostitution, sexual abuse, sexual assault, incest or sexual molestation for the cost of the test.

(C) A person charged with prostitution, sexual abuse, sexual assault, incest or sexual molestation ordered to submit to a HIV-related test may not be permitted to remain anonymous and a local health department may administer and bill for the test.

(5) When the Commissioner of the Bureau of Public Health knows or has reason to believe, because of medical or epidemiological information, that a person, including, but not limited to, a person such as an IV drug abuser, or a person who may have a sexually transmitted disease, or a person who has sexually molested, abused or assaulted another, has HIV infection and is or may be a danger to the public health, he or she may issue an order to:

(i) Require a person to be examined and tested to determine whether the person has HIV infection;

(ii) Require a person with HIV infection to report to a qualified physician or health worker for counseling; and

(iii) Direct a person with HIV infection to cease and desist from specified conduct which endangers the health of others.

(6) If any person violates a cease and desist order issued pursuant to this section and, by virtue of that violation, the person presents a danger to the health of others, the commissioner shall apply to the circuit court of Kanawha County to enforce the cease and desist order by imposing any restrictions upon the person that are necessary to prevent the specific conduct that endangers the health of others.

(7) The prosecuting attorney shall inform the victim, or parent or guardian of the victim, at the earliest stage of the proceedings of the availability of voluntary HIV-related testing and counseling conducted by the bureau and that his or her best health interest would be served by submitting to HIV-related testing and counseling. HIV-related testing for the victim shall be administered at his or her request on a confidential basis and shall be administered in accordance with the Centers for Disease Control and Prevention guidelines of the United States Public Health Service in effect at the time of such request. The victim who obtains an HIV-related test shall be provided with pre- and post-test counseling regarding the nature, reliability and significance of the HIV-related test and the confidential nature of the test. HIV- related testing and counseling conducted pursuant to this subsection shall be performed by the designee of the commissioner of the bureau or by any local or county health department having proper jurisdiction.

Visit www.legis.state.wv.us to view the entire statute.

Article 8. Personal Safety Orders.
§53-8-1. Definitions.

In this article the following words have the meanings indicated.

(1) *Final personal safety order*. -- "Final personal safety order" means a personal safety order issued by a magistrate under section seven of this article.

(2) *Incapacitated adult*. -- "Incapacitated adult" means any person who by reason of physical, mental or other infirmity is unable to physically carry on the daily activities of life necessary to sustaining life and reasonable health.

(3) *Law-enforcement officer*. -- "Law-enforcement officer" means any duly authorized member of a law-enforcement agency who is authorized to maintain public personal safety and order, prevent and detect crime, make arrests and enforce the laws of the state or any county or municipality thereof, other than parking ordinances.

(4) *Petitioner*. -- "Petitioner" means an individual who files a petition under section four of this article.

(5) *Place of employment*. -- "Place of employment" includes the grounds, parking areas, outbuildings and common or public areas in or surrounding the place of employment.

(6) *Residence*. -- "Residence" includes the yard, grounds, outbuildings and common or public areas in or surrounding the residence.

(7) *Respondent*. -- "Respondent" means an individual alleged in a petition to have committed an act specified in subsection (a), section four of this article against a petitioner.

(8) *School*. -- "School" means an educational facility comprised of one or more buildings, including school grounds, a school bus or any school-sponsored function or extracurricular activities. For the purpose of this subdivision, "school grounds" includes the land on which a school is built together with such other land used by students for play, recreation or athletic events while attending school. "Extracurricular activities" means voluntary activities sponsored by a school, a county board or an organization sanctioned by a county board or the State Board of Education and include, but are not limited to, preparation for and involvement in public performances, contests, athletic competitions, demonstrations, displays, organizations and clubs.

(9) *Sexual offense*. -- "Sexual offense" means the commission of any of the following sections:

(A) Section nine, article eight, chapter sixty-one of this code;

(B) Section twelve, article eight, chapter sixty-one of this code;

(C) Section two, article eight-a, chapter sixty-one of this code;

(D) Section four, article eight-a, chapter sixty-one of this code;

(E) Section five, article eight-a, chapter sixty-one of this code;

(F) Section three, article eight-b, chapter sixty-one of this code;

(G) Section four, article eight-b, chapter sixty-one of this code;

(H) Section five, article eight-b, chapter sixty-one of this code;
(I) Section seven, article eight-b, chapter sixty-one of this code;
(J) Section eight, article eight-b, chapter sixty-one of this code;
(K) Section nine, article eight-b, chapter sixty-one of this code;
(L) Section two, article eight-c, chapter sixty-one of this code;
(M) Section three, article eight-c, chapter sixty-one of this code;
(N) Section three-a, article eight-d, chapter sixty-one of this code;
(O) Section five, article eight-d, chapter sixty-one of this code; and
(P) Section six, article eight-d, chapter sixty-one of this code.

(10) *Temporary personal safety order*. - "Temporary personal safety order" means a personal safety order issued by a magistrate under section five of this article.

See Appendix B – Protective Orders for additional information.

ADULT PROTOCOL
CHAPTER 1

RESPONDING TO VICTIMS' NEEDS

I. Coordinated Response to Victims of Sexual Assault

Sexual assault is one of the most under-reported crimes in our country. Sexual assault is a brutal crime of power, control, and violence. It can result in mental anguish and suffering for victims. It can also cause physical trauma from bruises, abrasions, internal injuries, sexually transmitted diseases or unwanted pregnancy.

Victims choose not to report sexual assaults or seek medical care for a variety of reasons, including fear, trauma, embarrassment, self-blame and/or concern that they will not be believed. Victims may also lack the ability or emotional strength to access services. Victims may not have health insurance and believe it would be too costly to get the medical care they need. However, as a crime victim, they could be eligible for financial reimbursement for certain expenses. Victims are often reluctant to participate in the medical, investigative and prosecutorial procedures thinking it too difficult and intimidating. For many victims, it seems easier at the time to try to forget what happened to them rather than seek assistance.[1]

Communities should ensure that victims, regardless of their backgrounds or circumstances, have access to medical, legal, and advocacy services. The use of a coordinated, multidisciplinary approach for responding to victims of sexual assault can provide victims access to comprehensive immediate care and help minimize trauma they may be experiencing. This increases the likelihood that victims will seek follow-up services, thereby promoting healing.

A. Sexual Assault Response Teams (SARTs)

Many communities in West Virginia have developed coordinated responses by establishing Sexual Assault Response Teams (SARTs). A SART is comprised of professionals (first responders) who work to coordinate an immediate, confidential, victim-centered multidisciplinary response to sexual assaults in a community. This response prioritizes the needs of sexual assault victims and can enhance public safety by facilitating investigation and prosecution, thereby increasing the likelihood that offenders will be held accountable for their behavior and further sexual assaults will be prevented.[2]

B. Benefits of SARTs

Many SARTs provide interagency cross-training, develop guidelines and protocols for consistent responses, and consult with a network of government/community-based service providers to increase their expertise.

Cases that involve SARTs may have the following benefits:

- Victims are more likely to report.
- Better evidence is collected.
- The likelihood that charges will be filed in adult female sexual assault cases is increased.
- More evidence is collected and available for prosecution than cases in which no SANE or SART interventions occurred.
- There is increased victims' cooperation throughout the criminal justice process.[3]

C. Goals of a SART

The goal of a SART is to ensure a seamless, coordinated, victim-centered response to sexual assault victims and their loved ones. A SART provides a venue for first responders to:

- Develop professional/trusting relationships.
- Gain an understanding of individual roles and responsibilities of first responders.
- Share information and resources.
- Identify gaps in the service delivery system.
- Increase awareness on issues of sexual assault and stalking in the community.
- Increase victim and community safety.
- Increase reporting of sexual assault and stalking.
- Increase arrests and hold offenders accountable.

D. Members of a SART

A SART typically includes representatives from the hospital, law enforcement, the rape crisis center and the prosecuting attorney's office.

Other partners may include representatives from state forensic labs, public health departments, victim-witness programs, Child/Adult Protective Services, emergency medical services, college campuses, disability service providers, senior services, organizations serving victims from under-served populations, CACs and other social service agencies.

Responsibilities of SART members:

- Law enforcement conducts the investigation and provides emergency assistance if a victim chooses to report the assault to law enforcement.
- Emergency Department medical staff or SANEs conduct the forensic medical examination. (Some communities utilize specially trained nurses called Sexual Assault Nurse Examiners or SANEs.)
- Rape crisis center advocates provide emotional support, information, and referrals to the victim during the examination, law enforcement interviews and throughout the healing process.

- Prosecutors review the evidence and make informed decisions about whether or not to pursue the prosecution of the suspect. They work with members of the SART to coordinate support for the victim during the criminal justice process.

E. How a SART Works

Regardless of who the victim first contacts, SARTs have a protocol to follow that alerts other members of the team, depending on the victim's wishes.

A victim advocate should be involved at the earliest possible time after the sexual assault, if the victim has given consent for services, regardless of whether or not the victim chooses to report the assault to law enforcement.

At any licensed medical facility, the treatment of a sexual assault victim should be considered a medical emergency. When a sexual assault victim goes to the Emergency Department and decides to report the assault, law enforcement should be notified immediately in order to begin the investigation.

The physician, SANE *(a nurse specially trained to collect forensic evidence)* or other medical personnel will be contacted to conduct the forensic medical examination. A physical examination is suggested in all cases of sexual assault, regardless of the length of time that has elapsed since the sexual assault.

With the advocate present to provide support, the examining physician, SANE and law enforcement can coordinate questioning to reduce repetition. The advocate can remain in the exam room, with the victim's permission, to provide support during the exam. Law enforcement waits outside the exam room while evidence is collected. The sex crime evidence collection kit is released to law enforcement or locked in a secure area for law enforcement to pick up at a later time.

When the exam is completed, the SANE assists the victim in arranging for any follow-up medical care. The advocate makes arrangements to contact the victim for supportive counseling and legal advocacy. Law enforcement works with the victim and/or victim advocate to schedule a follow-up, more in-depth interview.

If the victim has chosen **not** to make a report to law enforcement at this time, a forensic medical examination should still be conducted and the examining physician or SANE will send the sex crime evidence collection kit to Marshall University Forensic Science Center (MUFSC), where the collected evidence will be stored for potential future use. It is important to note that if liquid samples were collected as a part of the toxicology kit (blood and urine), the samples will have a limited life span and will degrade over time. Other samples collected as part of the forensic medical examination (e.g., swabs, smears, etc.) will have an unlimited lifespan if collected and dried properly.

Should the decision be made later to initiate an investigation in a non-reported case, the victim would need to contact law enforcement and provide the kit tracking number for law enforcement to secure the sexual assault evidence collection kit from MUFSC. The kit tracking number was given to the victim after the forensic medical exam.

If an investigation has not been initiated within 24 months from the time of collection, the sexual assault evidence collection kit will be categorized as "non-active." Samples collected as part of the forensic medical examination in "non-active" kits may be used for training purposes once all identifying information has been removed.

After the 24 month time period, if the "non-active" sexual assault evidence collection kit has not been used for training purposes, the victim can still request that an investigation be initiated. There is no statute of limitations on reporting sexual assault in West Virginia.

F. Why is a SART Important to a Community?

In West Virginia, 1 in 6 women and 1 in 21 men will experience an attempted or completed forcible rape in their lifetimes.[4] Few assaults (16–40%) will ever be reported to law enforcement.[5] Reasons for the lack of reporting include systemic breakdowns within service delivery systems, low arrest rates, low conviction rates, and lack of available medical care.

SARTs and SANE programs impact all of these issues, ensuring that survivors of sexual assault receive immediate, accessible and comprehensive services by trained and caring professionals to meet the unique needs of each victim.

II. Sensitivity to the Needs of Victims

Anyone can become a victim of sexual assault—children, teenagers, persons with intellectual and physical disabilities, the elderly, gays, lesbians and heterosexual men and women. Sexual assault is a crime of violence, not sex. The offender uses sex to inflict violence and humiliation and to exert control and power over the victim.

Sexual offenses can include many kinds of crimes: sexual assault, sexual abuse, incest, internet solicitation of children, sexual harassment, indecent exposure, possession of child pornography, child molestation and marital sexual assault. The offender may be a stranger, but more likely the victim knows the offender. In most cases, the offender may be an acquaintance, partner, husband, or family member. Being sexually assaulted by an acquaintance does not make the crime any less serious or traumatic for the victim and may have a longer lasting effect. In fact, there is additional trauma associated with acquaintance rape due to the violation of trust, shared social space and common friends.

Victims of sexual assault experience varying degrees of both physical and psychological trauma. Some sexual assault victims suffer severe physical injuries, contract sexually transmitted or other communicable diseases, or become pregnant as a result of the assault. Many others do not. The effects, however, of psychological trauma may be more difficult to recognize than those of physical trauma.

Perceptions about how sexual assault victims should look, dress or act and the way those perceptions are conveyed can have a major effect on the victim's recovery process in the weeks and months following the crime. Each person has an individualized method of coping with sudden stress. When severely traumatized, victims can appear to be calm, indifferent, submissive, angry, or even uncooperative and hostile

toward those who are trying to help. Victims may also exhibit nervous laughter or giggle at seemingly inappropriate times. Because everyone reacts differently following a sexual assault, all of these responses are within the normal range of anticipated reactions.

A common reaction victims may experience after being sexually assaulted is fear: of the offender returning, of being alone, of crowds, of anyone or anything that reminds them of the offender, or fear of family or friends finding out about the assault. Reactions to the assault may also include embarrassment, guilt, withdrawal, suspicion, denial, a strong aversion to touch and disruption of a normal sex life. Professionals working with sexual assault victims must be aware of societal barriers that may also interfere with the evaluation, medical examination and collection of evidence in these cases.

Additionally, for some victims, the problems of poverty and discrimination may have already resulted in a high incidence of victimization, as well as inadequate access to quality medical treatment. There may be a mistrust of medical and law enforcement personnel, particularly if there has been a history of unpleasant experiences with these professionals in the past.

III. Impact on Victims

For many victims, sexual assault is a life-changing event. Every aspect of a victim's life may be impacted due to the nature of the violation, the meaning of sexual assault to them, and the range and intensity of the resulting trauma symptoms.[6]

Initially following a sexual assault, the way that victims typically act is often the opposite of what is expected. Most people expect to see a victim who is upset, crying, angry, or agitated. Although some victims do respond that way, others react with shock and disbelief. They may have a flat affect and appear to be distracted or distant. Others may appear calm or find it difficult to focus and concentrate.

It's not uncommon for the shock and disbelief to be followed by periods of denial. Victims may try to forget what happened. They may delay in reporting the incident, attempt to resume normal or usual activities, and avoid things that remind them of the assault, including interacting with anyone who may be able to provide help and support.

For example, a victim may immediately contact authorities, indicating interest in taking legal action and pursuing prosecution of the offender, but when contacted days or weeks later, she/he may be distant and quiet or unwilling to cooperate in the tasks at hand.[7]

When victims are immersed in trauma following a sexual assault, they may have nightmares, flashbacks, preoccupation with the assault, and a sense that they are reliving it. They may become hyper-vigilant (constantly on guard) and experience intense emotions and acute distress. In striking contrast, some victims may appear outwardly unaffected. They may attempt to ignore their feelings and avoid or deny the significance and meaning of the trauma. Withdrawing from activities and relationships is not uncommon.[8]

All of these behaviors can mask the presence and severity of the trauma the victim has experienced. These dramatic changes in behaviors and shifts in moods should be recognized as “normal” behavior following a traumatic event, rather than using the changes and inconsistencies in their behavior to discredit the credibility of the victim.[9]

IV. Special Considerations

Sexual assault victims will vary not only in ethnicity and culture, but also in religion, socioeconomic status, sexual orientation, gender, age, and intellectual development. All victims can suffer and experience universal reactions *(e.g., fear, humiliation, blame),* yet some distinctions among groups are necessary.

A. Cultural Beliefs

Some victims may be apprehensive about interacting with responders from ethnic and racial backgrounds different from their own.

Be aware that cultural beliefs may preclude a member of the opposite sex from being present when victims disrobe. Also, it may be uncomfortable for victims from some cultures to speak about the assault with members of the opposite sex.

Victims may not report or discuss the assault because the stigma associated with it is so overwhelmingly negative. In some cultures, for example, the loss of virginity prior to marriage can be devastating and may make a victim unacceptable for an “honorable marriage.”

Beliefs about women, men, sexuality, sexual orientation, race, ethnicity, and religion may vary greatly among victims of different cultural backgrounds. Also, what helps one victim deal with a traumatic situation, like sexual assault, may not be the same for another victim.

Victims may benefit from culturally specific assistance and/or referrals when needed. Service providers should be patient and understanding toward victims’ language skills and barriers, which may worsen in a crisis. They also should make every attempt to provide interpretation services and translated materials for victims whose first language is not English. Certified interpreters should be used when possible, not victims’ family members or friends.

B. Elderly Victims

Elderly victims of sexual assault, as well as most other victims, may experience extreme humiliation, shock, disbelief and denial. Often the full emotional impact of the assault may not be felt until after their initial contact with medical, law enforcement, legal and advocacy groups. It is usually when older victims are alone that they deal with having been violated. They become more aware of their physical vulnerability, reduced resilience, and mortality. Fear, anger or depression can be especially severe in older victims, who many times are isolated, have no confidants or family and live on limited incomes.

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

Hearing disabilities and other physical conditions common to advancing age, coupled with the initial reaction to the crime, often make elderly victims unable to make their needs known. This may result in prolonged or inappropriate treatment. It is also not unusual for service providers to mistake this confusion and distress for senility. Without encouragement and assistance in locating services, many older victims may be reluctant to proceed with the prosecution of their offenders.

Medical and social follow-up services must be easily accessible to older victims or they may not be willing or able to seek and receive assistance. The offender might be a service provider in a nursing home or a family member.

If an assault occurs in a health care facility, a law enforcement agency *(city, county or state)* must be notified, and the law enforcement agency is responsible for reporting the incident to the Department of Health and Human Resources, Adult Protective Services (1-800-352-6531). **Refer to Chapter 4, section VI, subsection A—Mandated Reports to Law Enforcement for additional information.**

C. Persons With Disabilities Who Are Victims

Persons with disabilities represent an extremely vulnerable population, often dependent on the assistance of others for access to transportation, health care, or assistive devices. As a result, criminal and sexual acts committed against persons with physical, intellectual or communication disabilities tend to occur at substantially higher rates than in the general population, while reporting rates are even lower than in the general population. Offenders often are family members, caretakers or friends who repeat the abuse because their victims are not able to report the crimes against them.

The difficulty of providing adequate responses is compounded when the sexual assault victims are persons with disabilities. Some victims have limited mobility, intellectual disabilities that affect perceptions or reduce the capacity to comprehend questions, or limited language/ communication skills to tell what has happened. They may be confused or frightened, unsure of what has occurred, or they may not even understand that they have been exploited and are victims of a crime.

Additional time should be allotted for the evaluation, the forensic medical examination and the collection of evidence. Deviation from standard protocol may be necessary if any accommodations are needed. Victims with a physical disability may need special assistance to assume physical positions necessary for a complete forensic medical examination and collection of evidence.

An intellectual disability, resulting from a mental illness, developmental disability, traumatic brain injury, neurodegenerative condition such as Alzheimer's disease, or a

stroke, will impact each person differently. Not all disabilities affect intellectual ability *(e.g., cerebral palsy may result in physical rather than intellectual disability).* Be aware that victims with intellectual disabilities may be easily distracted and have difficulty focusing.

Always speak directly to a victim, even when interpreters, family members, or guardians are present. Speak in a clear and calm voice and ask very specific and concise questions. Be exact when explaining what will happen during the exam process and why. Care should be given, after gaining permission, when moving or touching victims' wheelchairs or other assistive devices.

Assess a victim's abilities and needs for assistance during the exam process. Explain the exam procedures to the victim and ask what assistance they require, if any *(e.g., persons with physical disabilities may need help to get on and off the exam table or to assume positions necessary for the exam).* Do not assume they will need special aid.

Because so much of the post-assault care involves an exchange of information *(providing details of the assault, discussing feelings, explaining the exam, teaching about common symptoms of rape-related post-traumatic stress disorder and means of coping, etc.),* it is imperative to ensure that victims who are deaf or hard of hearing have access to interpreters or assistive technology, if needed.

Not all individuals who are deaf or hard of hearing understand sign language or can read lips. When treating victims who are deaf, service providers should be prepared to offer a variety of communication options in order to ensure victims are provided effective health care services.

Not all people who are blind can read Braille. Communication equipment that may be beneficial to victims with sensory disabilities includes TTY machines, word boards, speech synthesizers, anatomically correct dolls, materials in alternate formats and access to interpreter services.

D. Lesbian, Gay, Bisexual and Transgender (LGBT) Victims

LGBT is an acronym used to refer to individuals who identify as gay, lesbian, bisexual, or transgender. Transgender is commonly used as an umbrella term to refer to individuals whose gender identity and/or behaviors do not conform to traditional binary gender norms or that cross gender lines. It is important to understand that not all individuals are accepting of these labels.

Individuals who are gay, lesbian, bisexual or transgender may have additional fears and concerns following a sexual assault specifically related to their sexual orientation or gender identity. These concerns may be not only about the assault but also about how they will be treated by health care professionals, law enforcement, legal professionals, their friends and family and/or their partner. They may fear that their sexual orientation or gender identity will be seen as the central issue to first responders, instead of the assault. Some may fear losing custody of their children if family or a former partner learns of their sexual orientation or gender identity.

In addition to a sexual assault that occurs within the context of a relationship, people who are gay, lesbian, bisexual or transgender also experience high levels of violent acts perpetrated by people who are not tolerant or accepting of individuals who are 'non-conforming.' When sexual assaults are perpetrated against people who are gay, lesbian, bisexual or transgender as a way of "punishing" them because of their sexual orientation or gender identity, these assaults tend to be more violent and often cause more injuries than non-biased sexual assaults.[10] These acts are also hate crimes, and victims may experience a high level of guilt and should not be unfairly blamed for contributing to the assault.

Assumptions about an LGBT victim's sexual orientation or gender identity may cause further trauma, hindering the interview and evidence collection process. First responders should not assume the gender of the offender. LGBT victims who do not want to share details of their sexual orientation or gender identity may not wish to disclose the identity of the offender for fear of being "outed." These factors may prevent victims from seeking advocacy services, medical treatment and involving the criminal justice system. It is important to remember that an assault is never the victim's fault. The initial response to victims should be based on victims' self-identified needs rather than professional opinions and/or family members' concerns.

E. Male Victims

Although sexual assault is most often a crime against women, men are also victims of sexual assault. It is estimated that 1 in 6 boys will be sexually assaulted before age 16.[11] In West Virginia, 1 in 21 men *(18 and older)* will be a victim of attempted or completed forcible rape in his lifetime.[12] Forty-one percent of males who experience rape are under the age of 12 and 28% are between the age of 12 and 17.[13]

Like female sexual assault victims, male victims experience fear, anger and an overwhelming sense of loss of control over their bodies and themselves. Male victims may feel ashamed, embarrassed and/or guilty. Many males are extremely disturbed by the fact that they were unable to protect themselves from the assault. This can result in self-blame, extreme mood changes and depression. Some offenders use victims' feelings of confusion and shame to maintain control and discourage reporting of the crimes. Male victims may be reluctant to report and seek services due to the following:

- Fear of being judged
- Fear of their sexuality and/or masculinity being questioned
- Fear of threats being made against their families by the offender
- Trying to protect their families against societal scrutiny
- Intense feelings of shame, guilt or humiliation
- Confusion if they were physically aroused
- Stigma associated with stereotypes that "males are not victims"
- Unsure of available services or if services are available for males
- Fear of being "outed" if they are gay, bisexual or transgender

Gay, bisexual, or transgender males may feel that they are to blame for the assault because of their sexual orientation or gender identity. Homo/bi/transphobia *(fear or hatred of gays, lesbians, and transgender people)* keeps many male survivors from reporting the assault and seeking services. One of the most persistent myths about rape *(that it is a sexual act and not an act of power and dominance)* is particularly damaging to male survivors because it becomes intertwined with homo/bi/transphobia. Sexual assault is not the result of a male's sexual orientation nor will it change his orientation afterward.

Male victims of sexual assault often suffer significant physical injury. Acute treatment of male victims should proceed in a manner that closely parallels that of female victims, including providing appropriate medical and prophylactic services based on the medical and sexual history and physical examination. Maintenance of an open, non-judgmental attitude is important throughout the forensic medical examination.

Men who experience an erection and/or ejaculation during the sexual assault may be specifically concerned, thinking that these normal physical responses are not possible in the absence of sexual arousal. It is important to note that just because a victim's body may have had a physiological response during the assault does not mean that he enjoyed the abuse. Erections and ejaculation are physiological responses that can occur even in traumatic or stressful situations.

It is just as important for males, as it is for females, to be reassured that they were victims of a violent crime that was not their fault. The examiner should remind male victims that whatever they did to survive was the right thing to do.

F. Assault by an Intimate Partner

Intimate partner violence (IPV) is pervasive in our society. Sexual assault by intimate partners is a difficult issue to address because of misconceptions and biases about sexual assault perpetrated by someone intimate with the victim.

Sexual assault does not distinguish among victims; spouses, partners, and lovers may be either victims or offenders of sexual assault. Giving consent in the past for sexual intimacy does not mean that the consent is irrevocable. Responsibility for the sexual assault rests with the offender, not with the victim.

Because of the intimate and often dependent relationship between offenders and victims, concerns about factors other than the crime itself may affect the response to the crime, both by victims and the criminal justice system. Many victims who have been sexually assaulted by intimate partners refuse to cooperate with criminal investigations due to concerns about:

- The system's ability to protect them from future assaults,
- Living arrangements for them and their families,
- Economic dependency for their families' financial support, or
- The well-being and safety of their children.

Immediate services needed by those who have been sexually assaulted by an intimate partner may include shelter, temporary care of children, crisis counseling, and protection from retaliation by the partner for reporting the assault. In the case of college students, safety issues about returning to the campus setting, as well as concerns about informing their families, need to be addressed. Long-term needs may include establishing economic viability for the family, determining child custody, obtaining counseling and/or legal assistance, and possibly obtaining a divorce. A victim-centered approach helps victims to address both their immediate and long- term needs.

G. Adolescent Victims

Adolescence is a time when individuals are struggling to find their independence and individuality. This is challenged by extreme peer pressure to conform. The body is going through many physical changes that may be frightening and confusing. All of these existing issues are compounded if adolescents are victims of sexual assault. Health care providers must assess the physical development of adolescent victims and take their age into consideration when determining appropriate methods of examination and evidence collection.

Adolescent victims of sexual assault are among the most difficult populations to work with because of many extenuating circumstances. Adolescents are often brought into the emergency room by a parent or guardian. This creates an additional challenge for the examiner because the parents may also be traumatized by the victimization of their child. If adolescents have disobeyed their parents in some way, such as breaking curfew, lying about where they were going, or experimenting with drugs or alcohol, parents may blame their child for what has happened.

Reassurance that the sexual assault was not their fault is necessary, regardless of what the child was wearing or doing.

Many adolescents experiment with sex. If parents or guardians are unaware that their children have been sexually active, this may present a challenge to the examiner. In all cases, the examiner should interview adolescent victims alone to determine whether or not they want their parents/guardians in the room during the examination. Adolescents should make the decision.

For adolescent victims of sexual assault who have not been sexually active, the loss of virginity is often an issue of concern. The examining physician or SANE should assure victims that sexual assault is a crime of violence, not sex. When the sexual assault involves an acquaintance,it is not only a violation of the victim’s body but a violation of trust as well.

Referrals to available agencies with advocates or counselors with expertise in the area of sexual assault are vital to the recovery of adolescent victims.

H. Secondary Victims

Sexual assault affects everyone involved with the primary victim of the crime. Family and friends may experience feelings similar to the actual victim. Secondary victims will each react differently and it may be hard to predict their responses.

Parents and/or the partner of the victim often feel guilty because they were unable to protect their loved one from the assault. Some parents and partners are outraged about what has happened and may express a desire to harm the offender. Some may direct their anger at the victim and blame the assault on whatever she/he was doing prior to the assault.

Secondary victims often experience a sense of helplessness about their concern for the victim. They want to be able to “fix” the situation and to figure out how to help the victim deal with the trauma that has occurred. Secondary victims often feel a loss of control, both about the crime that has occurred and about what will happen following the assault.

Secondary victims who are at the hospital with the victim often have their own questions and concerns about the forensic medical examination and what is involved in the criminal justice process. They may express frustration toward hospital personnel at the length of time it is taking to conduct the forensic medical examination.

All rape crisis centers provide support and services to secondary victims. When the victim advocate is contacted, the examining physician or SANE should make the rape crisis center aware of any secondary victims who may need services. Family and friends are usually better able to support and respond to the needs of the primary victim when they themselves are receiving support and services.

CHAPTER 2

THE ADVOCATE RESPONSE

A community-based victim advocate from a rape crisis center has a minimum of 32 hours of specialized training to provide free, confidential and non-judgmental emotional support, information, social service referrals and guidance following a sexual assault. The victim is usually more cooperative and better able to respond to procedures when feeling supported, believed and safe.

The victim advocate's involvement should begin at the time the victim reports the sexual assault and extend beyond the point when other agencies have terminated their involvement. Unlike other agencies (i.e., law enforcement, the prosecutor's office or health care professionals), which serve the victim at specific points in the response system, local rape crisis centers serve and assist the victim from "start to finish." The advocate offers the victim the information and support needed to make informed decisions.

It is important for Emergency Department staff and service providers to be familiar with the local rape crisis center and the services that they offer to victims and their families. A county-wide protocol should be developed to streamline the response process among first responders. Victims are more likely to accept advocacy services if the advocate is present when the services are offered, rather than calling an advocate once services have been accepted.

I. Initial Report of Sexual Assault

Once a sexual assault victim makes the decision to report an assault, one of the first questions is "Who should I call?" Typically, the options are a law enforcement agency, a hospital, or a hotline operated by a rape crisis center. Each of these agencies should have an immediate concern for the safety and well-being of the victim.

Rape crisis centers provide the following services:

- Advocacy and support during the medical exam, law enforcement investigations, and court proceedings;
- Crisis intervention and/or emotional support to victims and their families;
- Safety planning and assistance obtaining a Personal Safety Order/Domestic Violence Protective Order;
- Assisting with referrals and coordinating services with other agencies; and
- Explaining the criminal justice system and providing support throughout the process.

The victim advocate should be involved at the earliest possible time after a sexual assault when the victim has given consent for services, regardless of whether or not the victim chooses to report to law enforcement.

WV Code §61-8B-16(5c) states that a victim of sexual assault is NOT required to participate in the criminal justice system or cooperate with law enforcement in order to have a forensic medical examination.

Sexual assault evidence collection kits collected from victims who choose not to report the sexual assault to law enforcement will be sent to Marshall University Forensic Science Center (MUFSC), where the collected evidence will be stored for potential future use. It is important to note that if liquid samples were collected as a part of the toxicology kit (blood and urine), the samples will have a limited life span and will degrade over time. All other samples collected as part of the medical forensic examination (*e.g., swabs, smears, etc.*) will have an unlimited lifespan if collected and dried properly.

Should the decision be made later to initiate an investigation in a non-reported case, the victim would need to contact law enforcement and provide the kit tracking number for law enforcement to be able to secure the sex crime evidence collection kit from MUFSC.

If an investigation has not been initiated within 24 months from the time of collection, the sex crime evidence collection kit will be categorized as "non-active". Samples collected as part of the medical forensic examination in "non-active" kits may be used for training purposes once all identifying information has been removed.

After the 24 month time period, if the "non-active" sexual assault evidence collection kit has not been used for training or research purposes, the victim can still request that an investigation be initiated. There is no statute of limitations on reporting sexual assault in West Virginia.

II. Responding to the Victim

The treatment of a victim of sexual assault should be considered a medical emergency. Although many victims may not have visible signs of physical injury, they may be experiencing emotional trauma. When a victim decides to get medical treatment the hospital should immediately call an advocate, working from a mutual protocol, from the nearest rape crisis center to respond to the hospital when a victim presents. When advocacy services are fully explained, most victims agree to speak to the advocate. Once consent is obtained advocates should explain their role and provide necessary services. The immediate involvement of the victim advocate at the hospital is crucial to the recovery and support needed by most sexual assault victims.

When either a sexual assault victim or another agency first contacts a rape crisis center or other victim advocacy organization, the first concern is for the safety and well-being of the victim. In this capacity, the victim advocate should:

- Help identify and address the immediate concerns of the victim.
  a. Is the victim in a safe place?
  b. Are there family members or friends who should be contacted?

c. Does the victim need/want medical attention?
d. Is medical care or transportation to the hospital needed?

- Caution the victim against destroying evidence prior to receiving medical attention *(e.g., urinating, rinsing mouth, showering, changing clothes, combing hair, etc.).*
- Provide emotional support and/or crisis counseling to the victim and the family.
- Help the victim understand the importance of the medical forensic examination.
- Explain that a victim of sexual assault is NOT required to participate in the criminal justice system in order to have a medical forensic exam.
- Offer information to the victim about non-reports to law enforcement, law enforcement interviews, the medical forensic examination, medical concerns, drugs used to facilitate sexual assault, emergency shelter, and/or potential court proceedings. Answer any questions about these procedures.
- Provide support during the medical forensic examination.
- Provide support during interviews with law enforcement.
- Help arrange transportation to and from the hospital or other medical facility.
- Help to ensure that clothing is provided for the victim, should it be necessary.

It is important to note that, for safety reasons, the victim advocate should not go to the scene of a recent sexual assault unless accompanied by a law enforcement officer. Before a victim advocate makes the initial contact with a sexual assault victim, the role of the advocate should be explained and sufficient information provided to help the victim understand the services the victim advocate can provide. **The advocate should not assume that the victim wants advocacy services until consent is given.**

III. Victim Support and Advocacy

Victim support and advocacy may be needed at many different stages, from immediately after the crime occurs to days, weeks, or even months or years later. The victim advocate can provide free, confidential and non-judgmental services for victims following a sexual assault.

For cases that are reported immediately or shortly after the crime occurs, victim advocates can provide victims with support and advocacy by:

- Helping identify any immediate concerns related to safety, medical care, crisis intervention and support.
- Asking about preserving evidence. *(Have you bathed, showered, brushed your teeth, laundered your clothes since the sexual assault?)*
- Offering information about the option of reporting/not reporting to law enforcement.

- Answering any questions and providing detailed information about the medical forensic examination and evidence collection. *(For information about the Medical Forensic Examination, go to Chapter 5 in this protocol.)*
- Providing support during the examination. (The immediate involvement of the victim advocate at the hospital can be crucial to the victim's recovery.)
- Helping victims understand the range of psychological impacts that sexual assault can cause and providing referrals for counseling.
- Providing information about and referrals to other services—including medical services, support groups, and supportive resources for partners and friends.

A. Trauma-Informed Care

Emotional trauma—caused by events such as sexual and physical violence, emotional abuse or neglect, natural disasters, serious accidents and acts of war and terrorism—can shatter an individual's sense of security. However, any situation that leaves a person overwhelmed, frightened and feeling alone can be traumatic. It is not the objective facts that determine whether an event is traumatic, but a person's subjective emotional experience of the event.[14]

Traumatic reactions may include physical, emotional and cognitive symptoms. Additional symptoms—intrusive re-experiencing of the trauma, emotional numbing and avoidance, and arousal (e.g., hyper-vigilance and overreactions) are key indicators of post-traumatic stress disorder (PTSD). PTSD symptoms can adversely impact an individual's everyday life, and victims should be encouraged to seek professional help.

Rape crisis center advocates can help victims understand how sexual violence can cause traumatic reactions and the impact of trauma. Advocates should support victims by helping to identify triggers, develop safety plans, manage feelings, and establish grounding techniques (i.e., ways to remain calm before reaching a state of crisis). It is imperative that the emotional needs of victims be addressed in addition to any physical or medical injuries.

A listing of the rape crisis centers in WV can be found at www.fris.org.

IV. Coordination of Services

The victim advocate is in a key position to encourage and support efforts and actions that are victim-centered. Advocacy services are unique because it brings advocates into contact with other agencies and organizations at all stages of the case.

Perhaps the most difficult challenge for the victim advocate is to promote a victim-centered approach and to serve as a liaison between the victim and the criminal justice system and related agencies. The victim advocate strives to achieve an effective balance between representing the victim and working within the criminal justice system's legal and traditional functions. The victim advocate can assist by:

- Maintaining constant communication with the victim regarding the case status.

- Helping prepare the victim for court.
- Keeping the victim informed of any changes in the accused's detention status, location or bail.
- Encouraging and supporting the victim as an active participant in the case.
- Advocating for the victim's rights and services.
- Communicating the victim's views and opinions to the police, prosecution and court.
- Working to protect and ensure the victim's privacy.
- Helping to prevent additional trauma or injury to the victim.
- Encouraging all systems to respond to the victim and the family in an appropriate and timely manner.

The victim advocate is important at each phase of the criminal justice system's process, from the initial report of the sexual assault through the investigation, arrest, prosecution and sentencing. If law enforcement, prosecution and medical providers are the building blocks of the response system for sexual assault cases, victim advocates are the cement that holds the system together for victims.

Recommended guidelines for providing advocacy services to adult/adolescent sexual assault victims can be found in *Appendix A – Advocacy Services Flowchart*.[1]

V. Checklist: The Advocate Response

INITIAL REPORT

O Determine if the victim is in immediate danger.

O If the victim is a minor or incapacitated adult, follow the reporting requirements of a mandated reporter.

O Determine the need/willingness for emergency medical care.

O Help identify and address the victim's immediate concerns.

O Determine whether accommodations are needed (*e.g., communication, mobility, language, culture, religion, gender or age*) to ensure that the victim has full and equal access to all services. Make arrangements as necessary.

O Answer the victim's questions about law enforcement and the criminal justice system.

O Offer crisis intervention services and referral resources.

O Ask if the victim wants to report the crime to law enforcement. If the victim chooses not to report the sexual assault to law enforcement, support her/his decision.

O Explain that a victim of sexual assault is not required to participate in the criminal justice system or cooperate with law enforcement in order to have a medical forensic exam. [WV Code§61-8B-16]

O Explain to the victim that changing clothes, washing/showering, urinating, brushing hair or teeth, or drinking can inadvertently destroy valuable evidence.

- O Arrange transportation to and from hospital, if requested.
- O Answer the victim's questions about the medical forensic exam, evidence collection and possible reimbursement from the WV Crime Victims Compensation Fund.
- O Offer long-term support.
- O Assist the victim in developing a plan to address any safety needs.

NON-REPORT TO LAW ENFORCEMENT

- O Explain that when a sex crime evidence collection kit has been collected but not released to law enforcement, the evidence will be sent to MUFSC where the collected evidence will be stored for potential future use. It is important to note that if liquid samples were collected as a part of the toxicology kit (blood and urine), the samples will have a limited life span and will degrade over time. All samples collected as part of the medical forensic examination (*e.g., swabs, smears, etc.*) will have an unlimited lifespan if collected and dried properly.
- O Remind the victim that to initiate an investigation, the local law enforcement agency must be contacted. The kit tracking number will be needed to be able to identify the sex crime kit. The kit tracking number was given to the victim at the hospital on the pink copy of the "non-report" consent form.
- O If the victim does not have the kit tracking number, it will be necessary for the victim to contact the medical records department at the facility where the medical forensic examination was completed to secure the kit tracking number.
- O If an investigation has not been initiated within 24 months from the time of collection, the sex crime evidence collection kit will be categorized as "non-active." Samples collected as part of the medical forensic l examination in "non-active" kits may be used for training purposes once all identifying information has been removed.
- O After the 24 month time period, if the "non-active" sexual assault crime evidence collection kit has not been used for training purposes, the victim can still request that an investigation be initiated. There is no statute of limitations on reporting sexual assault in West Virginia.

MEDICAL FORENSIC EXAMINATION

- O Use language appropriate to the age and emotional condition of the victim. Since the victim is in crisis, it may be necessary to speak clearly and concisely in simple sentences.
- O Check to be sure the victim understands what was said. Try not to overwhelm the victim with too much information. Focus on one concern at a time.
- O With the victim's consent, provide emotional support and crisis intervention during the medical forensic examination.
- O With the victim's consent, discuss recovery issues of sexual assault with family and provide crisis intervention to secondary victims.
- O Arrange for clothing, if needed, to assure that the victim does not leave the examination wearing a hospital gown.
- O Provide toiletries, as needed, for use after the medical forensic examination is completed.

- O Ask if the victim needs any accommodations *(e.g., interpreters, special positioning).*
- O Provide services to the sexual assault victim even if the she or he chooses not make a report to law enforcement.

INITIAL INTERVIEW WITH LAW ENFORCEMENT

- O Establish a clear understanding about the confidentiality of case-related information gained during the interview.
- O Define the role of the victim advocate during the interview (*e.g., provide emotional support, pay attention to the victim's needs and help inform the victim about procedures*).

WV CRIME VICTIMS COMPENSATION FUND

- O Inform the victim about the WV Crime Victims Compensation Fund and offer to help in completing the application when the victim is ready.
- O To be eligible to file a claim to the fund, a report to law enforcement is required within 72 hours (*some exceptions may apply on a case by case basis*).
- O If the 72 hour time frame has expired and if a victim later decides to initiate an investigation in a non-report to law enforcement, encourage the victim to complete the application and submit it for a review with an explanation of why it was submitted after the required time frame.
- O Inform the victim about payment for medical treatment from the fund.
- O Follow-up on the application to ensure that it is processed in a timely manner.

INVESTIGATION

- O Facilitate communication between law enforcement and the victim.
- O Provide support for the victim during the investigation.
- O Discuss precautionary measures for easing fears about safety and security.

ARREST

- O Notify the victim when an arrest is made.
- O Notify the victim of any changes in the custody status of the accused.
- O Provide support, with the victim's consent, during police line-ups and other proceedings.

PRE-TRIAL

- O Establish procedures for notifying the victim of the status of the case.
- O Coordinate communication among agencies providing services to the victim.
- O Provide guidance for facilitating communications between the victim and the prosecutor concerning plea negotiations and the victim's needs.
- O Accompany the victim, with victim's consent/request, to pre-trial proceedings.

TRIAL

- O Work with the advocate in the prosecutor's office *(if available)* to provide accommodations to meet the victim's needs. **Remember that unlike victim advocates who work at rape crisis centers, system-based advocates who work in the criminal justice system may not have the ability to maintain confidentiality under certain circumstances. It is important to discuss these different professional obligations ahead of time.**
- O Establish procedures for accompanying the victim to court.
- O Support development of different waiting areas in the courthouse to completely separate the victim from access by the defendant and defense witnesses.
- O Provide on-going emotional support to the victim.

SENTENCING

- O Assist the victim with the preparation of a victim impact statement.
- O Support the victim's right to speak at the sentencing hearing.
- O Accompany the victim, with the victim's consent, to court proceedings.

POST-SENTENCING

- O Inform the victim of the right to seek redress through civil litigation, if warranted.
- O Keep the victim informed about the status of appeals, if the information is available.
- O Keep the victim informed about parole hearings and changes in incarceration status.
- O Help the victim prepare or update the victim impact statement for parole hearings.
- O Provide guidance to the victim for enforcing restitution requirements, protection orders, and for reporting harassment.
- O Encourage the victim to register to find custody status information on inmates incarcerated by the WV Division of Corrections or to register to receive automatic phone notification when the accused status changes by calling 1-866-WV4-VINE.

ON-GOING VICTIM SERVICES

- O Establish guidelines for continuing services as long as the victim requires emotional support or counseling.
- O Provide referrals and resources for other available community services.
- O **Remember that the effects of trauma can last for months or years after a sexual assault. Continuously assess the victim for traumatic symptoms like PTSD, suicidal ideation, substance abuse, and depression. It is incredibly important that victim advocates refer victims to therapists whenever doing so would help ease the victim's recovery.**

CHAPTER 3

LAW ENFORCEMENT RESPONSE

I. The Role of Law Enforcement—Responding to Victims

Because of the extremely personal nature of the crime, a sexual assault victim may be reluctant to report the offense to police. The fear of investigative and prosecutorial procedures can add to the victim's hesitancy to report, and/or inability to assist in the investigation.

An emerging science of the brain, termed the neurobiology of trauma, helps practitioners understand victim behavior in response to trauma. Victims of sexual assault are likely to experience a flood of trauma-induced chemicals in their brains that can make initial recollection of a sexual assault less organized or coherent. They may express emotions in a way that is confusing to law enforcement officers and even to themselves. For example, it is normal for victims of trauma to exhibit a calm, flat affect or even laughter. These responses have a clear origin in the brain's automatic trauma response. Therefore, it is imperative that law enforcement officers understand the impact of trauma to help guide the investigative process.[14]

WV Code §61-8B-16(5c)—States that a victim of sexual assault is NOT required to participate in the criminal justice system or cooperate with law enforcement in order to have a forensic medical exam.

Law enforcement and criminal investigators play a significant role in the victim's willingness to cooperate in the investigation, as well as the victim's ability to cope with the emotional and psychological effects of the crime. Therefore, it is critical that law enforcement officers compassionately provide victims with necessary information and assistance. Treating victims with compassion will increase their participation in the legal process, thereby improving prosecutorial outcomes.

II. Initial Response

A. Emergency Communication

Emergency communication personnel play a critical role in focusing the initial police response by compiling the necessary information concerning the victim and the suspect and providing initial aid and comfort to the victim. This includes:

- Determining the medical condition, needs and location of the victim, time of the incident, description of the suspect and direction/mode of travel. Because of health implications associated with a sexual assault, the victim should be encouraged to seek medical care as soon as possible.
- Reminding the victim not to eat, drink, change clothing, shower, go to the

bathroom, brush hair or teeth or touch anything in the immediate area where the assault occurred, because it could inadvertently destroy important evidence.

- Staying on the telephone with the victim to provide assistance and comfort until law enforcement or emergency medical personnel arrive on the scene.

***See Appendix C – 911 Flowchart*.**

B. Responding Officer(s)

The first contact for many victims of sexual assault will be with a law enforcement officer. The primary responsibilities of the responding officer is to ensure the immediate safety and security of the victim, to obtain basic information about the assault in order to apprehend the suspect, and to facilitate transportation for the victim to a designated medical facility for examination and treatment.

If the assault was recent, the responding officer should avoid immediately taking a detailed written statement from the victim. As a result of trauma, victims are likely to experience initial disorganization in memory. Therefore, taking a written statement directly after the assault occurred will only create the false impression that a victim is "changing their story" going forward. Though collecting basic information about the crime scene is imperative at the earliest possible moment, a detailed statement should not be obtained until the victim has at least two night's sleep, allowing the victim's brain to recover from the flood of chemicals that the natural trauma response produces.

1. Victim Assistance

To render assistance to the victim, the responding officer should:

a. Speak softly and gently. Forceful and aggressive actions can intensify anxiety for the victim.

b. Remember that the victim may have an aversion to touch. Minimize the amount of touch and moving when transporting a victim.

c. Administer necessary first aid and request emergency medical assistance, if required.

d. Attempt to gain the victim's trust and confidence by showing understanding, patience and respect for personal dignity. Know that the victim may display a variety of reactions—crying, laughing, shaking, anger, silence, etc. The victim may rock back and forth, appear catatonic, or may demonstrate no reaction at all. All of these responses are normal.

e. Use language appropriate to the age and emotional condition of the victim. Because the victim is in crisis, it may be necessary to speak clearly and concisely, using simple sentences. Ask the victim if she or he understands what was said. Do not overwhelm the victim with information; focus on one problem or concern at a time.

f. Encourage the victim to make small decisions, as appropriate, as a way of helping to regain control.

g. Inform the victim that an officer of the same gender will be provided, if desired and available.

h. Help locate the victim's family or friends, if desired.

i. Contact the victim advocate at the local rape crisis center.

j. Inform the victim that participation in the criminal justice system or cooperation with law enforcement is not required in order to have a medical forensic exam. [WV Code §61-8b-16(5c)]

2. Initial Investigation

In many rural counties in West Virginia, the responding officer will also be the officer responsible for the sexual assault case investigation and follow-up as outlined in this protocol.

West Virginia Code §62-6-8—Prohibits any law enforcement officer, prosecutor or other government official from asking or requiring an adult, youth or child victim of an alleged sexual offense to submit to a polygraph examination or other truth-testing examination as a condition for proceeding with the investigation of the alleged offense. No law enforcement officer, prosecutor or any other government official may refuse to proceed with an investigation, warrant, indictment, information or prosecution of the alleged offense because the alleged victim refused to submit to such an examination.

(Effective July 2007)

The responding officer should:

a. Limit investigative questioning to those matters necessary to identify the victim and to describe and locate the suspect. Avoid asking detailed, intimate questions regarding the assault. The preliminary interview should elicit the following:
   - The extent of injuries, if any, to the victim;
   - A brief description of what happened;
   - The location of the assault;
   - The identity or description of the suspect(s), if known;
   - The home or work address of the suspect(s), if known;
   - The direction in which the suspect(s) left and by what means; and
   - Whether or not a weapon was involved.

b. Relay any pertinent information to the dispatcher/emergency communications personnel.

c. Determine the victim's emotional and physical ability to answer questions concerning the assault and limit questions accordingly; show compassion and consideration when asking questions.

d. Conduct questioning in private with one officer at a time. The victim may have a support person present during questioning.

e. Explain to the victim that washing/showering, brushing teeth/using mouthwash, drinking, combing hair, urinating or douching can inadvertently destroy valuable physical evidence.

f. Explain if a drug-facilitated sexual assault is suspected, toxicology tests need to be conducted. Determine whether ingestion of the drug occurred within the last 96 hours (4 days). If so, the victim should save the first voided urine or be encouraged not to urinate until a urine specimen can be collected at the hospital.

   - The first urine after the assault needs to be saved in a clean container. Preferably the urine should be collected at the hospital. The likelihood of detecting drugs used to commit the assault lessens each time the victim urinates.

g. Protect the crime scene and preserve potentially valuable evidence that may be present on clothing worn during the assault, or on bedding or other materials involved at the crime scene. The officer should recommend that a change of clothes be brought to the hospital in the event clothing is collected for evidentiary purposes. In suspected drug-facilitated sexual assaults, save any other materials that might provide evidence, such as the glass or container that held the drink.

h. Encourage the victim to immediately seek a medical forensic examination, emphasizing its importance to investigative and apprehension efforts, in addition to the victim's physical condition. If the victim declines an exam, DO NOT use guilt or other means to pressure her or him. Ultimately, investigations can only work if victims are allowed to make their own choices; pressing a victim too hard will only result in alienating them.

i. Accompany the victim to the hospital and relay any pertinent information concerning the sexual assault to medical personnel.

j. Inform the victim upon arrival to the medical facility that the WV Forensic Medical Examination Fund will pay for the cost of the forensic part of the examination, whether or not law enforcement is involved.

k. Remain at the hospital until family members, the victim advocate or an investigator arrives.

l. If the victim has given consent to release the evidence, law enforcement should pick up the sexual assault evidence collection evidence collection kit for transport to the WVSP Forensic Lab.

m. Arrange for the victim to provide a statement to the investigative officer.

III. Follow-up Interview

If the victim decides to make a report to law enforcement, an investigative officer will be assigned to the case as soon as possible after the initial complaint and should remain responsible for the case until it is closed or removed from his/her assignment.

This officer's responsibilities are to:

- Compile the basic investigative information contained in the initial interview, criminal complaint and medical forensic examination.
- Determine the victim's emotional and physical ability to participate in an in-depth follow-up interview and schedule the interview as soon as possible after the incident. Remember, a detailed statement should not be obtained until the victim has at least two night's sleep. The investigator should be empathetic of the victim's trauma, while at the same time effective in collecting all necessary information about the case.
- Explain why more detailed information about the crime is needed—including details of the sexual act; the suspect's modus operandi; clothing; means of restraining the victim, if applicable; the use or threat of weapons; words or instructions given to the victim; marks, scars, tattoos, deformities or other unusual physical features or body odors of the suspect; and any witnesses, participants or accomplices that may be described or identified by the victim. It is important to remember that intimate details of the assault may be traumatic and embarrassing for the victim to recall and describe.
- Document the victim's actions in response to the assault to include the type and degree of any resistance offered, the nature of any acquaintance with the suspect, and the state of mind of the victim during the attack.

General guidelines for this interview include the following:

- The interview should be conducted at a time and location agreed upon by the victim and officer. It is also suggested that the interview be conducted after the victim has had at least two sleep cycles.
- With the consent of the victim, it is appropriate that a victim advocate from the local rape crisis center be present during the interview.
- Information pertaining to the victim's past sexual history is relevant only for the purpose of DNA analysis. Even when this information is necessary, the investigator should restrict questions to sexual encounters in the recent past.
- The investigator's personal opinions, such as the credibility of the victim, should **NOT** interfere with the interview or be included in the report.

IV. Procedures for Handling a Non-Report to Law Enforcement

WV Code §61-8B-16(5c)—States that a victim of sexual assault is NOT required to participate in the criminal justice system or cooperate with law enforcement in order to have a forensic medical examination.

See Appendix F – Processing of the Sexual Assault Evidence Collection Kit (SAECK).

Sexual assault evidence collection kits collected from victims who choose not to report the sexual assault to law enforcement will be sent to Marshall University Forensic Science Center (MUFSC); the evidence will be stored for potential future use. It is important to note that if liquid samples were collected as a part of the toxicology kit (blood and urine) the samples will have a limited life span and will degrade over time. All samples collected as part of the medical forensic examination (e.g., swabs, smears, etc.) will have an unlimited lifespan if collected and dried properly.

Should the decision be made later to initiate an investigation in a non-reported case, the victim would need to contact law enforcement and provide the kit tracking number for law enforcement to be able to secure the sex assault evidence collection kit from MUFSC.

If an investigation has not been initiated within 24 months from the time of collection, the sexual assault evidence collection kit will be catalogued as "non-active." Samples collected as part of the medical forensic examination in "non-active" kits may be used for training purposes once all identifying information has been removed.

After the 24 month time period, if the "non-active" sexual assault evidence collection kit has not been used for training purposes, the victim can still request that an investigation be initiated. There is no statute of limitations on reporting sexual assault in West Virginia.

a. **If the victim does NOT have the kit tracking number, it will be necessary for the following to happen**:

1. The victim will need to contact the medical record department at the hospital where the medical forensic exam was completed to secure the kit tracking number for law enforcement.

OR

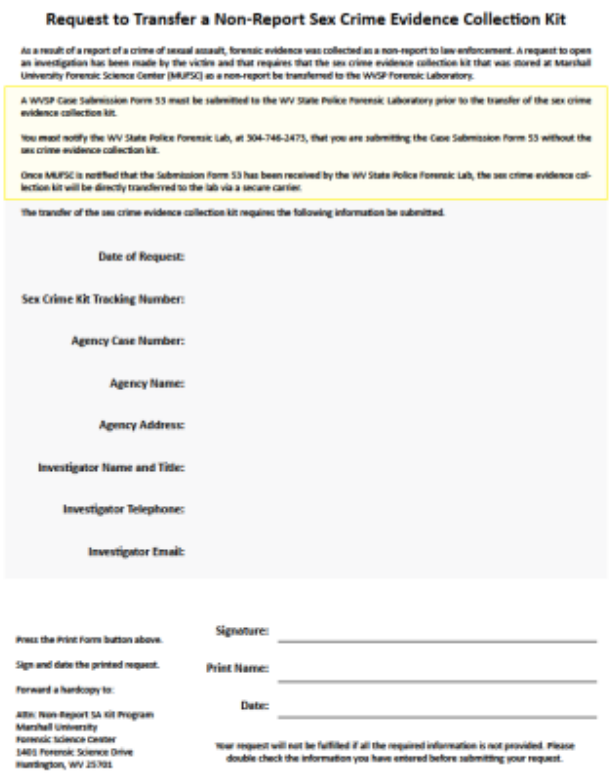
2. Law Enforcement will need to submit a written request for the sexual assault evidence collection kit number on agency letterhead including the victim's name, the officer's name, agency, contact number and badge number to MUFSC explaining that a victim (ex. Jane Doe) wants to initiate an investigation but does not have the sex crime kit tracking number. The request should be addressed to:

MUFSC
Attn: Non-Report SA Kit Program
1401 Forensic Science Drive
Huntington, WV 25701

3. The contact at MUFSC will check to see if there is a kit catalogued for the identified victim. If so, MUFSC will be able to provide the kit tracking number to law enforcement. If law enforcement has additional questions about the kit, they can call MUFSC at 304-691-8959.

b. Once law enforcement has the kit tracking number for the sexual assault evidence collection kit that was collected as a "non-report," the following procedures MUST be followed by law enforcement to initiate the investigation:

1. **Download and print** the "Request to Transfer Sex Crime Evidence Collection Kit" form that can be found at http://forensics.marshall.edu/LabRequest/Form-TransferKitRequest.pdf.
2. **Complete the information** requested on the form to have a direct transfer of the sexual assault evidence collection kit to the WV State Police Forensic Laboratory.
   i. A WVSP Case Submission Form 53 must be submitted to the WV State Police Forensic Laboratory prior to the transfer of the kit.
   ii. Law enforcement must notify the WV State Police Forensic Lab that a Submission Form 53 is being submitted without the evidence. Once MUFSC is notified that Submission Form 53 for the non-reported kit has been received by the WV State Police Forensic Lab, the evidence will be directly transferred to them via FedEx by MUFSC. The request for transfer of evidence form MUST be received before any evidence can be transferred.
   iii. Mail the request to:



Request to Transfer a Non-Report Sex Crime Evidence Collection Kit

As a result of a report of a crime of sexual assault, forensic evidence was collected as a non-report to law enforcement. A request to open an investigation has been made by the victim and that requires that the sex crime evidence collection kit that was stored at Marshall University Forensic Science Center (MUFSC) as a non-report be transferred to the WVSP Forensic Laboratory.

A WVSP Case Submission Form 53 must be submitted to the WV State Police Forensic Laboratory prior to the transfer of the sex crime evidence collection kit.

You must notify the WV State Police Forensic Lab, at 304-746-2473, that you are submitting the Case Submission Form 53 without the sex crime evidence collection kit.

Once MUFSC is notified that the Submission Form 53 has been received by the WV State Police Forensic Lab, the sex crime evidence collection kit will be directly transferred to the lab via a secure carrier.

The transfer of the sex crime evidence collection kit requires the following information be submitted.

Date of Request:

Sex Crime Kit Tracking Number:

Agency Case Number:

Agency Name:

Agency Address:

Investigator Name and Title:

Investigator Telephone:

Investigator Email:

Press the Print Form button above.

Sign and date the printed request.

Forward a hardcopy to:

Attn: Non-Report SA Kit Program
Marshall University
Forensic Science Center
1401 Forensic Science Drive
Huntington, WV 25701

Signature: _____

Print Name: _____

Date: _____

Your request will not be fulfilled if all the required information is not provided. Please double check the information you have entered before submitting your request.

MUFSC
Attn: Non-Report SA Kit Program
1401 Forensic Science Drive
Huntington, WV 25701

See Appendix D – Transfer Form for Non-Reports to Law Enforcement.

V. Ongoing Involvement in the Case

During the investigation of the sexual assault and after the arrest of a suspect, the investigating officer continues to have a responsibility to interact with the victim by:

- Soliciting the victim's continued support in the investigation.
- Apprising the victim of future investigative and prosecutorial activities that may require the victim's involvement.
- Working with the prosecutor's office to develop the case and to familiarize the victim with the kind of questions that may be faced during cross-examination.
- Maintaining continued contact with the victim to ensure that appropriate support services are available.
- Victim advocates can serve as a single point of contact for all of this communication with the victim, but it is *never* acceptable to deny the victim direct access to the investigative officer if that is what the victim prefers.

See Appendix E – Law Enforcement Response for recommended guidelines.

VI. Checklist: Law Enforcement Response

DISPATCHER

O Determine if the suspect is present.

O Determine if emergency medical care is needed.

O Remind the victim not to change clothing, shower, urinate, brush hair or teeth, or touch anything in the immediate area of the assault to inadvertently destroy important evidence.

O Dispatch patrol officer(s) according to departmental policy.

O Keep the victim on the phone until patrol officer(s) arrive.

O Transfer the victim's call to a rape crisis center hotline.

(National Sexual Assault Hotline Number: 1-800-656-HOPE)

FIRST RESPONDER

O Determine need for emergency medical care.

O Administer necessary first aid.

O Arrange transportation to and from the hospital if requested.

O Ask the victim if the suspect is at the crime scene.

O Ask the victim for a description and/or identification of the suspect and broadcast "a-be-on-the-lookout" message for the suspect.

O Advise the victim not to change clothing, shower, urinate, brush hair or teeth, or touch anything in the immediate area to inadvertently destroy important evidence.

O Preserve the crime scene *(if the sexual assault was recent).*

O Inform the victim of the availability of a victim advocate from the local rape crisis center and encourage the victim's acceptance of advocacy services.

INVESTIGATORS

- O Address the victim's concerns for safety and the possibility that the suspect will return.
- O Maintain chain of custody and make arrangements to transport the sex crime evidence collection kit to WVSP Forensic Crime Lab.
- O Accommodate the victim's needs, as much as possible, during investigative processes that require victim participation *(e.g., interviews, hearings, and line-ups).*
- O Notify the victim when the suspect is taken into custody.
- O Advise the victim of the custody status of the suspect and any changes in that status.
- O Allow the victim advocate to be present during line-ups to provide emotional support for the victim.
- O Keep the victim informed about the status of the case.

INITIAL INTERVIEW

- O Determine information needs of law enforcement and the prosecutor from victim interviews to minimize necessity of repetitious interviews.
- O Take appropriate steps to make the victim comfortable with the interview. *(e.g., ask the victim about gender preference for the interviewer and advise the victim that a victim advocate or friend can be present during the interview).*
- O Provide accommodations to meet the victim's needs, including interpreter services for language translation or signing for persons who are deaf or hard of hearing.
- O If there is a stated policy about the use of video and/or audio taping of the interview, inform the victim of this process and how the tape will be used in later proceedings.

FOLLOW-UP INTERVIEW

- O Conduct the follow-up interview after the medical forensic examination.
- O Help provide transportation for the victim, if needed.

ON-GOING INVOLVEMENT IN THE CASE

- O Continue to work with the victim throughout the investigation.
- O Work with the prosecutor's office to help develop the case.

CHAPTER 4

THE MEDICAL RESPONSE

It is important for all victims of sexual assault to have access to specialized medical care and crisis intervention. Ideally, every county in West Virginia should have an accessible and responsive service delivery system that includes providing medical forensic exams by trained medical providers.

Sexual assault is a traumatic event, and victims often experience a loss of control over their own bodies. For this reason, it is imperative that victims be informed about the medical process and every effort be made to help victims regain a sense of control. In all cases, medical examiners should provide support, resources, referrals and information which must be part of the trauma-informed care provided. This kind of response by medical staff can positively affect the long-term recovery of victims.[14]

Because of the trauma they have experienced, it is not uncommon for victims to have difficulty processing questions and providing detailed responses to explain what has happened to them.

Victims of sexual assault often struggle with intense feelings of guilt or self-blame. These feelings can be exacerbated by a number of factors. For example, some victims may feel additional guilt in cases involving alcohol. Victims also often feel ashamed that they were unable to protect themselves from the assault, which can be especially true for male victims. It is important that victims be reassured that the assault was not their fault and whatever they did to survive the assault was the right thing to do.

Some victims may not access medical care for fear of not being believed, prior issues with law enforcement or use of drugs and alcohol at the time of the assault.

Each step of the medical process should be carefully explained, and victims should be encouraged to ask questions so that they can make informed decisions about the care they are receiving

I. Medical Facilities in West Virginia

Hospitals providing medical forensic examinations to adult and adolescent victims of sexual assault should have 24-hour emergency department services with staff trained to conduct medical forensic examinations.

Medical providers need to be able to effectively recognize, collect and preserve evidence. The ideal situation would include the on-call availability of Sexual Assault Nurse Examiners (SANEs) and the community-based advocacy services.

The SAFE Commission has outlined the following "Best Practice Training Recommendations" for medical providers conducting medical forensic examinations:

It is required that nurses complete 40 hours of Sexual Assault Nurse Examiner (SANE) coursework (e.g., training that meets IAFN guidelines **OR** the WV Online SANE Training (24 Hours) **and** 2 day classroom training (16 hours), plus 25 hours of clinical requirements) to practice as a SANE and provide care to patients reporting sexual assault.

It is recommended that physicians, advanced practice registered nurses (APRNs), and physician assistants (PAs) complete, **at a minimum**, specific training modules (specifically modules 7, 10, and 15), available through the WV Online SANE Training and accessed through www.fris.org, when providing care to patients reporting sexual assault.

See Appendix G – Medical Response Flowchart. The flow chart can be used as a guide to develop a medical facility's response to meet the required key service components for responding to an adult/adolescent victim of sexual assault when presenting at a medical facility.

If a victim of sexual assault arrives at a medical facility that is not equipped to provide a medical forensic examination, arrangements should be made to transfer the patient to the nearest designated medical facility that can provide a medical forensic examination.

Each county will need to have a responsive service system to provide transportation for an adult victim of sexual assault, if needed. This will reduce the amount of confusion and additional trauma incurred by victims who are initially taken or referred to a facility not able to provide a medical forensic examination, as well as reduce the loss of valuable evidence.

The transportation protocol will be activated when a victim of sexual assault needs a medical forensic exam and does not have transportation to and from a facility that provides that care. The SAFE Commission requires that this transportation protocol include the following core components:

- Accessible transportation, including the ability to transport victims with disabilities
- Transportation to and from the medical forensic exam regardless of the victim's ability to pay
- Plan for victim confidentiality
- Plan to return the victim to his or her point of origin after the medical forensic examination

If there are acute medical or psychological injuries that must be treated immediately, this should be done at the initial receiving medical facility. A copy of all records, including any X- rays, should be transferred with the victim.

Facilities should familiarize themselves with the Federal Emergency Medical Treatment and Active Labor Act (EMTALA), which has provisions pertaining to the ability of hospitals to transfer patients to other medical facilities for treatment.[18]

II. Intake

A sexual assault victim ***(hereinafter referred to as patient)*** should be considered a priority patient—regardless of whether physical injuries are evident.

A private location within the medical facility should be utilized for the preliminary consultation with the patient.

Medical facilities should develop and use code words to avoid inappropriate references to sexual assault cases and to ensure the privacy of the patient. This eliminates the needless embarrassment to the patient and/or the family of being identified in the emergency department as the "rape" or "sexual assault" patient. Other methods can be devised to avoid inappropriate references to sexual assault cases, and hospitals are encouraged to develop their own sensitive code plans to ensure privacy.

III. Victim Advocacy

In cases of sexual assault, the medical facility shall immediately call a victim advocate from the nearest rape crisis center. The importance of having a victim advocate from the local rape crisis center available to a sexual assault patient cannot be over-emphasized. In sexual assault cases, patients are usually more cooperative and better able to respond to procedures when they feel supported, believed and safe.

Research has shown that when advocates are at the hospital and can explain their role, in most cases, advocacy services are accepted. Advocates are specially trained to provide patients with free, confidential, non-judgment support, information and resources so patients can make informed decisions about their care following a sexual assault. The immediate involvement of victim advocates at the hospital is crucial to the recovery of many sexual assault patients. When consent has been given, advocates stay with the patient in the examining room and throughout their time at the medical facility.

Advocacy services offered by the rape crisis center include:

- Free, confidential crisis intervention and emotional support to the patient/family/friends
- Education about the medical forensic examination
- Help in securing payment for expenses incurred from the assault through the WV Crime Victims Compensation Fund.
- Help and support through the legal process
- Ongoing counseling and referral to support groups, if needed.

If the patient decides not to accept advocacy services, the medical provider or SANE should provide contact information for the local rape crisis center for future reference.

IV. The Role of Medical Providers

It is essential that all patients who present to medical facilities with reports of sexual assault be thoroughly evaluated. Treating injuries alone is not sufficient in these cases. Medical personnel who examine these patients should be trained and clinically prepared to collect evidence using the WV Sexual Assault Evidence Collection Kit (SAECK) and document findings while maintaining the chain of custody.

Medical personnel should be able to provide options for evidence collection and reporting to law enforcement, coordinate crisis intervention and support for patients as well as provide STD prophylaxis and preventive care, pregnancy assessment and discuss treatment options. Medical personnel should be aware of and follow policies for reporting and be able to provide court testimony, if necessary.[15]

In addition to physical trauma and the potential for disease caused by a sexual assault, the emotional impact may be the most significant injury and should also be a concern of medical personnel attending to the needs of these patients.

Sexual Assault Nurse Examiners (SANEs) are helping many health care facilities to carry out these requirements. SANEs are registered nurses who have been specially trained to provide compassionate, comprehensive care to patients of sexual assault and who have demonstrated competency in conducting the medical forensic examination. The SANE also provides appropriate referral for follow-up care and counseling services in an effort to prevent additional trauma. For these reasons, it is recommended that a trained medical provider or SANE should always asses/evaluate any patient reporting sexual assault.

V. Sexual Assault Nurse Examiners (SANEs)

Hospitals in West Virginia are working to meet the needs of patients who have been sexually assaulted, as well as fulfill the medical community's responsibilities for the collection and preservation of evidence.

The role of the SANE, or the medical provider, is to do the following:

- Obtain a medical history.
- Examine the patient thoroughly.
- Describe the findings objectively.
- Document suspicious injuries and describe the findings noting facts such as depth, shape and size, color and location.
- Collect necessary forensic evidence.
- Treat each patient on an individual basis.

By having trained medical providers like SANEs conduct medical forensic exams, hospitals are able to provide comprehensive consistent care that respects the emotional

and physical needs of sexual assault patients while collecting the best possible forensic evidence to promote effective prosecution.[15]

The medical provider or SANE should have knowledge necessary to properly conduct a medical forensic examination and use the sexual assault evidence collection kit.

The following equipment and supplies should be readily available for the medical forensic exam:

- A copy of the *WV Protocol for Responding to Sexual Assault: A Multidisciplinary Response, Victim-Centered Response for Advocates, Law Enforcement, Medical Providers/SANEs, Prosecution*
- Standard exam room equipment and supplies for physical assessment and evidentiary pelvic exam. *(The needs for patients with disabilities must be taken into account to ensure barrier-free access to medical services.)*
- Comfort supplies for patient (*Suggested items: clean and ideally new replacement clothing, toiletries, food and drink.)*
- WVSP Sexual Assault Evidence Collection Kit (SAECK)
- A camera and related supplies (camera card) for forensic photography during the examinations.
- Testing and treatment supplies needed to evaluate and care for the patient medically that are not part of the kit.
- An alternate light source *(Using the most up-to-date technology possible) can aid in examining patients' bodies, hair and clothing. It is used to scan for evidence such as dried or moist secretions, fluorescent fibers not visible in ambient light and subtle injuries.)*
- A locked and secure storage cabinet in a room with limited access *(This maintains chain of custody when the kit is not picked up by law enforcement immediately.)*
- An anoscope for cases involving anal/rectal trauma

WVSP Sexual Assault Evidence Collection Kits (SAECK) ***can be ordered from the WVSP Forensic Laboratory, with no charge to the medical facility, via email to laboratory.kits@wvsp.gov****.* For additional information about SANEs, visit **www.fris.org**.

VI. Informed Consent for Examination

It is standard medical practice to obtain a patient's verbal and written consent before conducting a medical examination, administering any treatment, evidence collection and release of the kit to law enforcement.

Informed consent should be an on-going process that involves more than obtaining a signature on a form. When under stress, a patient may not understand or remember the reason for or the significance of unfamiliar, embarrassing and sometimes intimidating procedures.

All procedures should be explained as much as possible, so the patient can understand what the medical provider or SANE is doing and why. Although portions of the examination and evidence collection process may be explained by the advocate, this function is ultimately the responsibility of the medical provider or SANE.

Written consent cannot be interpreted as a "blank check" for performing tests or pursuing questions. If at any time a patient expresses resistance or non-cooperation, the medical provider or SANE should immediately discontinue that portion of the exam and discuss any concerns or questions the patient may have regarding that procedure. The medical provider or SANE may consider returning to that portion of the exam at a later time, but only if the patient agrees.

Even after written consent is obtained, the patient should always have the right to decline any tests or to decline to answer any questions. The patient may also decline further interaction with the medical provider or SANE, the victim advocate and/or law enforcement. Having a sense of control is an important part of the healing process for the patient.

If the patient withdraws consent for any portion of the exam, this MUST be documented on the sexual assault information forms.

Medical facilities should follow their usual procedures for obtaining consent for all tests and treatment necessary outside the exam, including extraordinary cases *(e.g., for severely injured or incoherent patients*).

The medical provider or SANE must carefully document, on the form provided in the kit, the patient's statements made in the course of the examination relating to the assault. This does not mean that the medical provider should press the patient for information he or she is unable or unwilling to provide freely or challenge the patient's account of what happened.

The medical provider or SANE and the victim advocate should support the patient through the medical forensic examination, while neither urging the patient to pursue prosecution nor giving false assurances that may not exist.

VII. Incoherent/Unconscious Patient

Due to the increasing use of drugs to facilitate sexual assault (DFSA), it is possible that there could be incidents where the patient is unable to give formal informed consent and there is a high degree of suspicion that drugs and/or alcohol were used to incapacitate the patient.

Because timely evidence collection is critical in DFSA cases, it is recommended that medical facilities address how to handle these situations in their policies and procedures. Following are a few possible consent-related options should this situation arise:

- Obtain consent from the patient's legal spouse, parent(s) or guardian.

- Maintain evidentiary integrity *(do not bathe, destroy clothing, etc.)* until patient regains consciousness and can give informed consent.

VIII. Adult Patient Forensic Medical Examination and Reporting Options

Medical providers or SANEs must be aware of the options for victims of sexual assault in relation to having evidence collected and reporting or not reporting to law enforcement.

A. Mandated Reports to Law Enforcement

Medical providers are required by law to report suspected or observed abuse or neglect or risk of imminent danger of adults who are incapacitated.

WV Code §9-6-9 requires that a report be made to the local Department of Health and Human Resources (DHHR), Adult Protective Services (APS) or the 24-hour hotline provided for this purpose (800-352-6513) in suspected or observed abuse or neglect of adults who are incapacitated, or of emergency situations where adults who are incapacitated are at imminent risk. "Incapacitated adult" means any person who by reason of physical, mental or other infirmity is unable to independently carry on the daily activities of life necessary to sustaining life and reasonable health.

§9-6-11. Reporting procedures.

a. A report of neglect or abuse of an incapacitated adult or facility resident or of an emergency situation involving such an adult shall be made immediately by telephone to the department's local adult protective services agency and shall be followed by a written report by the complainant or the receiving agency within forty-eight hours. The department shall, upon receiving any such report, take such action as may be appropriate and shall maintain a record thereof. The department shall receive such telephonic reports on its twenty-four hour, seven-day-a-week, toll-free number established to receive calls reporting cases of suspected or known adult abuse or neglect.

b. A copy of any report of abuse, neglect or emergency situation shall be immediately filed with the following agencies:
    1. The department of health and human resources;
    2. The appropriate law-enforcement agency and the prosecuting attorney, if necessary; or
    3. In case of a death, to the appropriate medical examiner or coroner's office.

c. If the person who is alleged to be abused or neglected is a resident of a nursing home or other residential facility, a copy of the report shall also be filed with the state or regional ombudsman and the administrator of the nursing home or facility.

Medical personnel are required by law to report gunshot wounds and wounds or injuries caused by a knife or sharp or pointed instrument.

WV Code §61-2-27 mandates that any medical provider who provides treatment to a person suffering from a wound caused by a gunshot, knife, or other sharp pointed instrument which would lead a reasonable person to believe resulted from a violation of state criminal laws shall report to the law enforcement agency located in the county in which the wound was treated.

Any person who, in good faith, makes a report of abuse, neglect, or emergency situation involving an incapacitated adult or facility resident or reports gunshot wounds or injuries caused by a knife, shall be immune from any civil or criminal liability that might arise as a result of making such a report.

B. Medical Forensic Examination and a Report to Law Enforcement

Most sexual assault cases of patients over the age of 18 are not required to be reported to the police and it is the victim's decision whether or not to report the crime.

If the patient decides to have a medical forensic examination and **involve law enforcement the following steps must be taken:**

- The patient MUST sign and complete the consent form to authorize the collection of and release of information and evidence to law enforcement.
- The sexual assault evidence kit tracking number must be placed on all of the sexual assault forms and envelopes.
- The sexual assault evidence collection kit will be picked up by law enforcement after the medical forensic exam is completed and transport it to the WV State Police Forensic Laboratory.

C. Medical Forensic Examination and Non-Report to Law Enforcement

Recognizing the dual importance of being sensitive to the needs of the patient and the timely collection and preservation of irretrievable physical evidence, the non-reporting process ensures that victims of sexual assault, who are undecided about whether or not to report the assault, have the opportunity to have forensic samples collected that would otherwise be destroyed through normal activity.

The "non-report" process IS NOT an option for anyone under the age of 18, unless emancipated by law.

WV Code §61-8B-16(5c)—States that a victim of sexual assault is NOT required to participate in the criminal justice system or cooperate with law enforcement in order to have a medical forensic exam.

1. Obtaining Consent in a Non-Report to Law Enforcement

If the patient chooses to have a medical forensic examination but does NOT want to initiate or participate in any investigation, the following steps must be taken:

The medical provider or SANE MUST have the patient sign and complete the consent form for a "non-report to law enforcement". The consent form can be found in the "non-report" envelope located in the manila envelope on the bottom of the kit.

- The kit tracking number MUST be placed on all three (3) copies of the consent form.
- The pink copy of the consent form MUST be given to the patient to locate and identify the sexual assault evidence collection kit should the decision be made at a later time to initiate a report to law enforcement.
- The white copy of the consent form becomes part of the medical record and the yellow copy of the consent form is placed in the kit.

2. Storing the Sexual Assault Evidence Collection Kit (SAECK) in a Non-Report to Law Enforcement

A sexual assault evidence collection kit (SAECK) collected from a victim who chooses not to report the sexual assault to law enforcement will be sent to Marshall University Forensic Science Center, (MUFSC) where the forensic samples will be stored for 24 months. It is important to note that if liquid samples were collected as a part of the toxicology kit (blood and urine), the samples will have a limited life span and will degrade over time. All samples collected as part of the medical forensic examination (e.g., swabs, smears, etc.) will have an unlimited lifespan, if collected and dried properly.

If an investigation has not been initiated within 24 months from the time of collection, the kit will be catalogued as "non-active." Samples in "non-active" kits may be used for training purposes once all identifying information has been removed. After the 24 month time period, if the "non-active" kit has not been used for training purposes, the victim may still request that an investigation be initiated.

There is **no** statute of limitations on reporting sexual assault in West Virginia.

3. Medical Providers/SANEs—Responsibilities for Handling a Non-Report to Law Enforcement

When a sexual assault evidence collection kit has been collected but is not released to law enforcement, the medical provider or SANE will be responsible for preparing the forensic evidence, while maintaining chain of custody, to be shipped by FedEx to Marshall University Forensic Science Center (MUFSC).

These steps must be followed:

- Seal the kit and secure it with evidence tape.
- Call MUFSU at 304-691-8959, Monday through Friday, 8:00a.m.–5:00p.m. to report that a kit is ready to be shipped.

- Complete the information requested on the Fed Ex shipping label. (If additional boxes are needed to package evidence, such as bags of clothing, the physician, SANE or other hospital personnel should be prepared to find additional boxes to use for shipping.)
- Place the sealed kit in the mailing box. (A plain expandable brown mailing box is provided to hospitals when the kits are shipped from the WV State Police Forensic Laboratory.)
- Attach the pre-printed shipping label to the FedEx mailing box making sure that all required information has been completed.
- Take the kit to the FedEx shipping/receiving area in the hospital once the kit has been boxed, sealed and labeled for shipment.
- Record the date/time and initials on the label. (If FedEx does not have a shipping/ receiving area in the hospital, the examiner must contact MUFSC [304-691-8959] for directions on how to proceed.)

See Appendix F – Processing of the Sexual Assault Evidence Collection Kit (SAECK) for a flowchart outlining the process of the sexual assault evidence collection kit for a report or non-report to law enforcement.

4. Initiating an Investigation in a Non-Report

Should the decision be made at a later time to initiate an investigation, the victim would need to contact law enforcement and provide the kit tracking number. Law enforcement would request the kit from MUFSC by submitting a "Request to Transfer" form. *(For information on how patients may initiate an investigation in a non-report, go to Chapter 3, Section IV—Procedures for Handling a Non-Report to Law Enforcement.)*

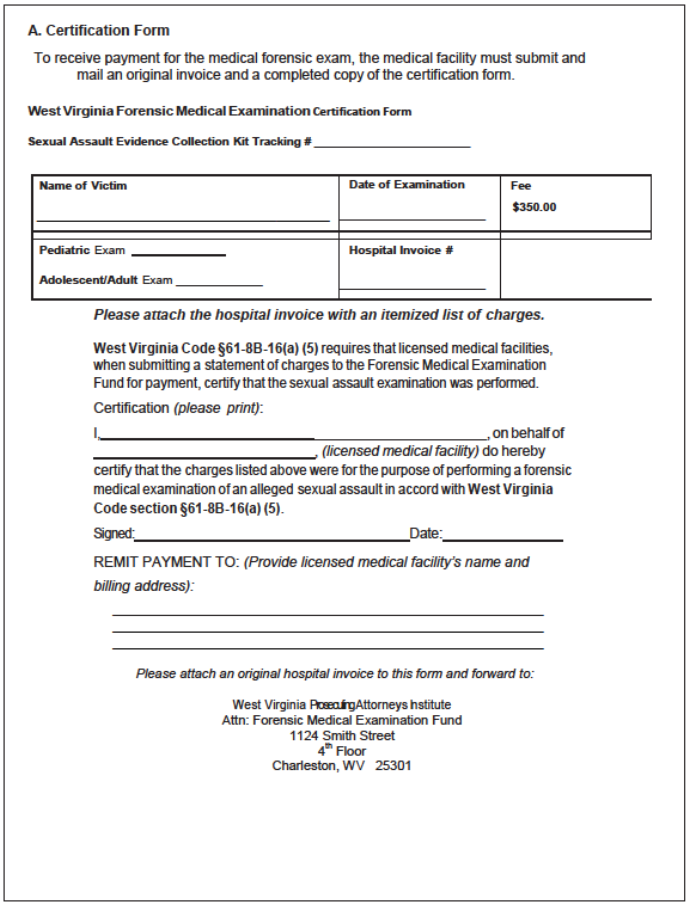
IX. Reimbursement from the Forensic Medical Examination Fund

To receive the $350.00 reimbursement from the fund for the medical forensic examination in sexual assault cases, the medical facility must certify that the medical forensic examination was performed and submit an invoice on letterhead from the medical facility within a reasonable time to the WV Prosecuting Attorneys Institute for payment, along with a completed certification form.

The $350.00 reimbursement to the hospital covers all reasonable, customary and usual costs of the medical forensic examination.

Any non-forensic procedures performed by the medical facility, including treatment of injuries, testing for pregnancy and testing for sexually transmitted diseases (STDs), will **NOT** be paid from the Forensic Medical Examination Fund.

The medical facility can receive reimbursement from the Forensic Medical Examination Fund by submitting an original invoice and a completed copy of the certification form. ***See Appendix H – Certification Form.***



A. Certification Form

To receive payment for the medical forensic exam, the medical facility must submit and mail an original invoice and a completed copy of the certification form.

West Virginia Forensic Medical Examination Certification Form

Sexual Assault Evidence Collection Kit Tracking # _____

Name of Victim	**Date of Examination**	**Fee**
		$350.00
Pediatric Exam _____ **Adolescent/Adult** Exam _____	**Hospital Invoice #**	

Please attach the hospital invoice with an itemized list of charges.

West Virginia Code §61-8B-16(a) (5) requires that licensed medical facilities, when submitting a statement of charges to the Forensic Medical Examination Fund for payment, certify that the sexual assault examination was performed.

Certification *(please print)*:

I,_____, on behalf of _____, *(licensed medical facility)* do hereby certify that the charges listed above were for the purpose of performing a forensic medical examination of an alleged sexual assault in accord with **West Virginia Code section §61-8B-16(a) (5)**.

Signed:_____Date:_____

REMIT PAYMENT TO: *(Provide licensed medical facility's name and billing address):*

_____
_____
_____

Please attach an original hospital invoice to this form and forward to:

West Virginia Prosecuting Attorneys Institute
Attn: Forensic Medical Examination Fund
1124 Smith Street
4th Floor
Charleston, WV 25301

X. Decision to Prosecute

The decision to prosecute a sexual assault is the responsibility of the state. It is not up to the victim to decide to "press charges". Seeing that a suspect is made criminally responsible for the act is not the victim's job, nor should the victim be made to bear the weight of responsibility for criminal consequences to a suspect.

If a prosecution does follow, the victim's responsibility is to appear, if subpoenaed as a witness, and to tell the truth. Even though it is rare for an unwilling victim to be forced to testify, preparing the victim for later steps in the criminal process is best left for another day.

XI. Sexual Assaults That Occur Outside West Virginia Borders

Because West Virginia borders Kentucky, Virginia, Pennsylvania, Ohio and Maryland, it is possible that a victim of sexual assault, who experienced the assault in another state could come to a West Virginia hospital for a medical forensic examination.

Should a sexual assault occur outside the state of West Virginia, the medical provider or SANE should adhere to the recommendations for evidence collection as found in the *WV Protocol for Responding to Victims of Sexual Assault* and the WV Sexual Assault Crime Evidence Collection Kit.

In all cases of reported sexual assault, the law enforcement agency in the jurisdiction where the assault occurred is the agency charged with investigating the assault and making sure that the kit is transferred from the hospital to the WVSP Forensic Crime Laboratory.

In cases of non-reports, medical personnel should follow the procedures as outlined in this chapter, *Section C—Medical Forensic Examination and a Non-Report to Law Enforcement*, on how to handle the kits that are not released to law enforcement.

CHAPTER 5

MEDICAL FORENSIC EXAMINATION

I. The Medical Forensic Examination

A. Examination and Evidence Collection

A physical examination should be performed in all sexual assault cases, regardless of the length of time that may have elapsed between the time of the sexual assault and the examination. Medical issues and treatment should always take priority over forensic evidence collection.

Some patients 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. There may also be areas of tenderness which will later develop into bruises, which are not apparent at the initial examination.

Time Guidelines for Using the WVSP Sexual Assault Evidence Collection Kit (SAECK)

The sexual assault evidence collection kit (SAECK), also referred to as the kit, is designed to assist the medical provider or SANE in the collection and preservation of the evidentiary specimens collected from a victim of sexual assault.

The use of the sexual assault evidence collection kit (SAECK) will be determined by these time frame guidelines:

- ✓ **If the sexual assault occurred within 96 hours of the examination, a kit should be used.**
- ✓ **If it is determined that the sexual assault took place more than 96 hours before the examination, the use of a kit may not be necessary.**
- ✓ **If the time since the assault is more than 96 hours, evidence should still be gathered by documenting findings made during the medical examination (such as bruises or lacerations), by taking photographs and by recording the patient's statements about the assault.**

DNA evidence in the form of saliva, blood, skin tissue, hair, and semen can be left on the patient's body or at the crime scene. Saliva, which contains valuable DNA, may be found on areas of the body where the patient was kissed, licked or bitten. The patient's clothes, especially undergarments that were worn during and/or after the assault, should be collected for evidentiary purposes. In addition, if the patient scratched the suspect, skin tissue should be collected from beneath the patient's fingernails.

Medical providers or SANEs are encouraged to supplement the kit's collection materials when circumstances warrant. A detailed instruction guide, outlining the basic standards recommended for ensuring comprehensive and culturally sensitive care, is provided in the kit to assist the medical provider or SANE.

The court's opinion of medical evidence and testimony has significant implications for the case as well as for the medical provider or SANE who examines the patient after the assault. A **thorough, legible and precisely written record** with accompanying body diagrams is one of the strongest supportive documents of corroborating evidence to the patient's physical and emotional state.

The importance of care and precision in writing such records is essential. What is written or not written may have tremendous legal implications. If the patient's statements match the injuries the medical provider or SANE can document, "There is corroboration between the patient's statements and injuries." Any documented error is likely to be used to discredit a witness and/or the patient.

Documentation for Completing the Kit Paperwork

- ✓ Write legibly and in ink.
- ✓ Complete all of the sexual assault evidence collection kit (SAECK) paperwork.
- ✓ Document the exam date and time.
- ✓ Obtain a thorough medical history.
- ✓ Record verbatim the exact statements given by patients. Do not paraphrase or clean up language.
- ✓ Put statements provided by patients in quotation marks.
- ✓ Use terms like "reported" or "stated."
- ✓ Do NOT use the words "alleged," "probable," or "possible."
- ✓ Opinions, as well as value words such as "normal," "satisfactory," "negative," or "positive" should be avoided.
- ✓ Make sure all copies (9 pages in triplicate) of the sexual assault information forms are legible.
- ✓ Sign and date all forms.

B. Attending Medical Providers

Every effort should be made to limit the number of people in attendance during the medical forensic examination. The only individuals who should be with the adult/adolescent patient in the examining room are the medical provider or SANE and, with the consent of the patient, a victim advocate. There may be instances when a patient requests the presence of a close friend or family member. If possible, these requests should be honored. **There is no medical or legal reason for law enforcement, male or female, to be present during the examination.** However, if the patient is incarcerated, a correctional officer will likely be required to stay in the room.

Subjecting the patient to the observation of law enforcement during this process is an invasion of the patient's privacy and does not follow "best practice" guidelines.

II. Obtaining West Virginia Sexual Assault Evidence Collection Kits from the WVSP Forensic Lab

Every hospital in West Virginia performing medical forensic medical examinations must use the West Virginia State Police (WVSP) Sex Crime Evidence Collection Kit (SAECK).

Hospitals can request the sexual assault evidence collection kit (SAECK) from the WVSP Forensic Laboratory by e-mail at laboratory.kits@wvsp.gov.

Kits are provided by the West Virginia State Police at no cost to medical facilities. When ordering kits, be sure to include the "**kit disposition sheet**" with the request. The "kit disposition sheet" tracks important information about the kits used by the medical facility (e.g., the kit tracking numbers, the date kits were used and which law enforcement agencies took possession of them or if the kits were non-reports and were shipped to MUFSC).

III. Completing the Sexual Assault Information Report Forms

Information collection is important for the investigation of the sexual assault, the collection of the evidence, and the analysis of the evidence.

The medical provider or SANE must complete all nine (9) pages of the requested information on the sexual assault information report forms which are in triplicate. It is extremely important that the third sheet is legible.

Copies of the Sexual Assault Information Report Forms

- The white copies of the report forms stay at the hospital. These report forms **DO NOT** go to Medical Records. They should be stored in a locked and secure file with limited access at the hospital. If hospital policy indicates the storage of the SAECK paperwork will be Medical Records, the SAECK paperwork must be placed in a manila envelope and sealed with an evidence label and signed with the medical provider or SANE's initials across the label to ensure chain of custody and patient confidentiality.
- The pink copies of the report forms **MUST** be given to law enforcement unless it is a Non-Report Kit. In cases that are not reported to law enforcement, the pink copies of the forms are placed in the manila envelope on the bottom of the kit box, and the envelope is sealed with an evidence label and signed with the medical provider or SANE's initials across the label.
- The yellow copies of the report forms are for the WVSP Forensic Crime Laboratory and MUST be place inside the kit to go to the lab.

The following information should be routinely collected and documented as part of the forensic medical examination process.

A. Date and Time of Sexual Assault/Date and Time of Collection

It is essential to know the period of time that has elapsed between the sexual assault and the collection of evidence. The focus of evidence collection will be directed by the time interval since the sexual assault. West Virginia uses a **96 hour** time frame for the collection of forensic evidence. When possible, note the approximate time of the assault. It is NOT sufficient to only note “same day” on the form.

B. Gender and Number of Suspect(s)

Forensic scientists seek evidence of cross-transfer of trace materials among the patient, perpetrator(s) and scene of the crime. These trace materials include foreign hairs and the deposit of fluids from the perpetrator(s) to the patient.

The gender and number of perpetrator(s) may offer guidance to the types and the amounts of foreign materials that might be found on the patient’s body and clothing.

C. History of Sexual Assault

An accurate description of the sexual assault is crucial to the proper collection, detection, and analysis of physical evidence. This includes the discovery of attempted oral, anal, and vaginal penetration of the patient, oral contact by the perpetrator(s), ejaculation (if known by the patient) and penetration digitally or with foreign object(s). Analytical findings that corroborate the patient’s account will support the patient’s testimony in court. Drugs may have been used to subdue the patient or the patient may have been unconscious. This information is relevant to the analysis of the forensic evidence, because it can affect the interpretation of findings.

D. Actions of Patient since Sexual Assault

The quality of evidence is critically affected both physically and chemically by actions taken by the patient and by the passage of time.

It is important to know what, if any, activities were performed prior to the medical forensic examination, including bathing, urination, brushing teeth and/or changing clothes, any ofwhich could help explain the absence of secretions or foreign materials.

The presence of evidence such as foreign hairs, fibers, plant material or other microscopic debris deposited on the patient by the perpetrator(s) or transferred to the patient at the crime scene may also be affected by the length of time that elapses between the assault and the collection of evidence.

For example, douching would have an obvious chemical effect on the quantity and quality of semen remaining in the vagina. Failure to explain the circumstances under which semen could have been destroyed might jeopardize criminal prosecution, if apparent contradictions cannot be accounted for in court.

E. Last Consensual Sex

When analyzing semen specimens in sex-related crimes, forensic analysts sometimes find genetic markers that are inconsistent with the mixture from the patient and the suspect. A mixture of semen from a suspect and the patient's pre-assault or post-assault sexual partner could lead to DNA evidence which, if unexplained, could conflict with the patient's own account of the assault.

It is common practice to ask patients if they engaged in voluntary sexual intercourse within several days prior to or after the assault. If so, patients are then asked the date of the contact in order to help determine the possible significance of semen remaining from such activity.

The date of the last voluntary coitus is significant ***only*** to the extent that saliva and blood samples from the individual involved can be made available for comparison, if needed.

The actual identity of any consensual sexual partners should not be sought at the time of the initial examination.

In order to interpret the results correctly, to avoid falsely excluding the suspect as the donor of the semen or falsely including an innocent party, correct interpretation of analytical results requires knowing all the persons who could have contributed to the sample.

F. Contraceptive Preparations/Menstruation Information

Certain contraceptive preparations can interfere with accurate interpretation of the preliminary chemical test frequently used in the analysis of potential seminal stains. In addition, contraceptive foams, creams or sponges can destroy spermatozoa. Lubricant use should be noted.

Knowing whether or not a condom was used may be helpful in explaining the absence of semen or its components (e.g., sperm and seminal fluid).

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

G. Gynecological History Information

The patient's menstrual history, pregnancy history, including evaluation of possible current pregnancy, and contraceptive history should be evaluated and recorded. If the patient is at risk for pregnancy, a urine pregnancy test should be done to establish a baseline for possible pre-existing pregnancy.

IV. Sexual Assault Evidence Collection Kit (SAECK) Procedures

Many evidence collection procedures apply equally to adult, adolescent and child patients of sexual assault/sexual abuse and are discussed in this chapter. Specific instructions for the medical evaluation and treatment needs of children are discussed in Chapter 9 of this protocol.

A. Collecting Forensic Evidence

When a medical forensic examination is performed, it is vital that the medical and evidence collection procedures be integrated at all times. Remember, medical issues and treatment always takes priority over forensic evidence collection.

The medical provider or SANE must remember to do the following when collecting forensic evidence:

- Evidence is time sensitive. Collect as soon as possible.
- **In cases of reported oral assault, do this collection first.** ***(See Section N, Oral Swabs Collection.)***
- **Write legibly**. These items may be used in court to prosecute a sexual offense.
- Wear powder-free gloves when collecting and packaging evidence.
- Change gloves frequently when examining different body areas to avoid possible contamination of specimens.
- Allow all wet evidence to air dry completely prior to packaging.
- Swab any moist secretions with a dry swab to avoid dilution.
- Swab any dried secretion/stain with a lightly moistened swab.
- Allow swabs and smears to air dry completely before packaging.
- **Always label** the swabs and smear slides with the **site of collection**.
- **Label the swabs** used to prepare the smear slides.
- Specimens collected for medical purposes should be kept and processed at the health care facility, per facility policy.
- Specimens collected for forensic analysis should be transferred to the WVSP Forensic Laboratory.
- Seal paper bags with evidence tape, never use staples.
- Complete the information requested and affix a kit tracking label on all envelopes, forms, swab boxes and slide holders where indicated.

B. Packaging the Forensic Evidence

In order to prevent the loss of hairs, fibers or other trace evidence, clothing and other evidence specimens must be sealed in paper or cardboard containers. Do not use plastic containers.

Make sure all items are air dried before packaging. If the containers are plastic, moisture remaining in the evidence items will be sealed in, making it possible for bacteria to quickly destroy any unstable biological evidence. Unlike plastic, paper "breathes" and allows moisture to escape.

C. Preserving the Integrity of Evidence

Forensic evidence must be collected, preserved and documented in a manner that ensures its admissibility in court should it be needed for a criminal investigation. The custody of the evidence in the sexual assault evidence collection kit, as well as any clothing or other collected items, must be accounted for from the time it is initially collected until it is admitted into evidence at trial. This is necessary in order to maintain the "chain of custody".

"Chain of custody" chronologically documents each individual who handles a piece of evidence from the time it is collected. The unbroken chain of custody establishes the integrity of the evidence and any subsequent analysis of the evidence and is a prerequisite to admitting the evidence in court.

All evidence collected should be labeled with the name of the patient, the kit tracking number, the name of the examiner and the date of collection. To ensure the integrity of the forensic evidence and preclude tampering, medical personnel must seal the kit and any other items, with the evidence tape provided, and initial the seal(s). This also applies to any clothing or other items collected that are too large to be sealed inside the kit.

The kit should be stored in a secure locked area until it is picked up by law enforcement (if a report to law enforcement has been made) or shipped to MUFSC by FedEx (if it is a non-reported kit).

D. DNA Analysis

The method of choice for testing biological evidence is DNA analysis. The DNA analysis used in the WVSP Forensic Laboratory is based on the Polymerase Chain Reaction (PCR) technology.

Specific regions of DNA are cloned (amplified). The cloning generates billions of copies of a specified region of DNA. This cloning allows information to be obtained from very small amounts of the samples. The sensitivity of this type of DNA analysis allows a large variety of samples to be tested. Blood, tissue, semen, vaginal fluid, hair roots, saliva, or basically any cellular material can be used as a source of DNA.

In routine case work the techniques are so sensitive that DNA profiles have been obtained from blood stained clothing that had been washed, from gum that had been chewed, from envelopes that have been licked, from the mouth areas of bottles and cans, and from knives that have been handled.

With the increased sensitivity of DNA analysis, there is a greater chance that accidental contamination can be detected. Therefore every precaution should be taken to reduce possible sources of contamination when evidence is collected, including wearing a mask and lab coat.

E. Importance of Spermatozoa and Semen

Semen is composed of cellular and liquid components known as spermatozoa and seminal fluid, respectively. While one or the other may be present, both must be observed to identify semen. Semen *(spermatozoa and seminal fluid)*, and the role it plays in the analysis of sexual assault evidence is important.

The estimated survival time of spermatozoa in the vaginal, oral and anal orifices following ejaculation varies considerably in scientific studies. However, there is agreement that they can survive for up to 96 hours in the vagina (persisting longer in the cervical mucosa), and up to several hours or more in the anal cavity, particularly if the patient has not defecated since the assault.

In the absence of spermatozoa, seminal fluid components *(p30 and acid phosphatase)* can be used to identify semen.

- The presence of p30, an antigen known to exist in the semen of humans, is regarded as a conclusive indication of semen.
- Acid phosphatase, an enzyme, is present in high levels in seminal samples but is considered only a presumptive test for the presence of semen because it also appears in samples that are not seminal in origin, such as vaginal fluid.
- Spermatozoa and seminal fluid *(non-mixture)* can be used to positively identify donors, via DNA analysis.
- Seminal fluid is produced in all ejaculates, vasectomized or not.

Remember, lack of semen is not conclusive evidence that an assault did not occur. The perpetrator may have used a condom, have had a low sperm count (frequent with heavy drug or alcohol use), ejaculated somewhere other than in an orifice or on the patient's clothes or body, or failed to ejaculate during the assault.

The absence of semen may be explained by any of the reasons below, or by various other factors that may have contributed to the absence of detectable amounts of semen in the specimen.

Any of the following could explain the absence of semen when ejaculation occurred:

- A significant time delay between the assault and the collection of specimens;
- After ejaculation, the patient was penetrated by an object other than the penis;
- The patient could have inadvertently cleaned or washed away the semen; or
- The specimen was not collected in the examination process.

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

F. Clothing and Underwear Collection

Clothing frequently contains the most important evidence in cases of sexual assault.

Clothing provides a surface upon which traces of foreign material may be found, such as the suspect's semen, saliva, blood, hairs and fibers, as well as debris from the crime scene. While foreign matter can be washed off or worn off the body of the patient, the same substances often can be found intact on clothing for a considerable length of time following the assault. Damaged or torn clothing may be significant and provide evidence of force.

Prior to the full examination, the medical provider or SANE needs to determine if the patient is wearing the same clothing he or she wore during or immediately following the assault. If so, the clothing should be collected so that it may be examined for any foreign material, stains, or damage.

Important Reminders for Collecting Clothing

- ✓ Collect clothing items **worn during the assault based on the medical history** provided by the patient.
- ✓ **Most common items of clothing collected** from patients and submitted for analysis are underwear, hosiery, blouses, shirts and slacks/pants.
- ✓ An ultraviolet light source, which causes semen and other substances to become fluorescent when illuminated (Wood's lamp), can be used to detect stains on clothing.
- ✓ **Package clothing separately in paper bag(s)** to prevent cross-contamination.
- ✓ **Dry** any item of clothing that may have wet stains.
- ✓ Do **not** cut through existing rips, tears or stains.

Different garments may have contact with different surfaces and debris from both the crime scene and the suspect. Keeping garments separate from one another permits the forensic scientist to reach pertinent conclusions regarding reconstruction of criminal actions.

For example, if semen in the female patient's underpants is transferred accidentally to her bra or scarf during packaging, the finding of semen on those garments might appear to contradict the patient's testimony in court of exactly what events occurred in the assault.

If, after air drying as much as possible, moisture is still present on any item of clothing and could leak through the paper bag, the labeled and sealed clothing bag should be placed inside a larger plastic bag with the top of the plastic bag left open. A label would then need to be affixed to the outside of the plastic bag indicating to law enforcement that wet evidence is present. To avoid loss of evidence due to putrefaction, law enforcement could remove and dry the clothing item.

If it is determined that the patient is not wearing the same clothing, the medical provider or SANE should inquire as to the location of the original clothing. This information should be given to the investigating officer so that arrangements can be made to retrieve the clothing before any potential evidence is destroyed.

G. Debris Collection

Semen and blood are the most common body fluids deposited on a victim by a suspect. There are other fluids, such as saliva or sweat, which can also be analyzed to aid in the identification of the suspect.

Oral contact with the patient's breasts or genitalia is common. Be sure to ask the patient directly if and where the suspect put his/her mouth or where the suspect ejaculated.

It is important to examine the patient's body for evidence of foreign materials. A separate swab should be used for every sample area collected. An alternate light source should be used in this collection procedure.

If fluids, such as dried blood, seminal fluid, saliva, sweat, or other biological materials are observed on any part of the patient's body during the examination, or if the patient mentions this type of contact in her statement, the debris material(s) should be collected by using 2 swabs lightly moistened with sterile water. Allow the swabs to air dry, before packaging.

H. Debris Collection—Fingernail Swabbing(s) and/or Cutting(s)

Collect fingernail swabs if the patient broke a fingernail during the assault or scratched or dug at the body of the perpetrator. If yes, or if fibers or other materials are observed, collect fingernail swabbing(s) or cutting(s). Broken nails should be documented and photographed.

I. Debris Collection—Bite Marks

When a bite mark is observed, photograph and swab the affected area by slightly moistening two (2) swabs with sterile water. It is important that photographs of bite marks be taken **first** before the area is swabbed.

Bite mark impressions can be compared with the teeth of a perpetrator and can be, in some cases, as important, for identification purposes, as fingerprint evidence. Saliva, like, semen, may demonstrate the DNA profile of the individual from whom it originated.

Photograph the bite mark with a ruler placed adjacent to it, but not covering the bite mark to document its size. (Additional information on taking photographs can be found in Section S.)

In some bite mark cases it may be appropriate to have a three-dimensional cast made. When possible, a dentist or forensic odontologist should be called in to examine the bite mark, make the cast and further document the findings.

When needed, medical facilities may contact the West Virginia Chief Medical Examiner's Office *(304-558- 3920)* for a listing of qualified odontologists who can assist in this process.

J. Physical Examination

Document all details of trauma, such as bruises, abrasions, lacerations, bite marks, and blood, paying particular attention to the genital and anal areas of both male and female patients.

Common sites for trauma include: the breasts, the upper portion of the inner thighs, marks on the arms, wrists, or legs from being grabbed or restrained, injuries or soreness to the scalp area, back or buttocks, which may result from being thrown against an object or onto the ground and bruising behind the ears, if the patient was orally assaulted.

Sometimes saliva and semen stains are more easily visualized under ultraviolet light. The use of an alternate light source will assist in locating the presence of such stains on the body of the patient during the medical forensic examination.

For female patients, visual inspection is the most common and available examination technique to detect genital trauma. Findings may include tears, bruising, abrasions and abnormal redness. The areas where these types of injuries are often found include the posterior fourchette, fossa navicularis, labia minora and the hymen.

In the search for cross-transfer of evidence, it is essential to know the location and extent of the injuries sustained by the patient.

K. Hair Collection—Pubic Hair Combings

Loose hairs that may be identified on the patient are the only hairs that need to be collected. To lessen the chance that valuable trace evidence may be missed, combing of the pubic hair should be done thoroughly. A bindle (paper towel) is placed underneath the patient's pubic hair area. Using the comb provided, the pubic hair is combed in downward strokes, so that any loose hairs or debris will fall onto the bindle. The patient should always be given the option of combing. The bindle is carefully removed, and the comb is placed in the center of the paper. The towel is refolded in a manner to retain the comb and any evidence present. The bindle is returned to the envelope, labeled and sealed.

If the patient is prepubescent or has shaven her/his pubic hair, external genital swabs MUST be collected by swabbing the shaven area using a swab moistened with sterile water.

NOTE: Do NOT collect attached head or pubic hairs during the medical forensic examination.

Any evidence of semen or other matted material on pubic or head hair should be collect in the same manner as other dried fluids or debris materials. Any matted material may be collected by cutting. Patient consent is required prior to cutting any significant amount of hair.

L. Vaginal Swab and Smear Collection

Depending on the type of sexual assault, semen may be detected in the mouth, vagina and anus. The evidence samples collected from each of these areas generally will be both swabs and smears. The purpose of making smears is to allow the forensic analyst to microscopically identify spermatozoa. If no spermatozoa is present, the analyst will then use the swab(s) to identify the seminal fluid components to confirm the presence of seminal fluid.

When PCR-based DNA analysis is used, the smears alone often contain enough spermatozoa to identify the donor of the semen.

Important Reminders for Collecting Vaginal Swabs and Smear

- ✓ Collect swabs of female genitalia if there was vaginal/penile penetration, other genital-to-genital contact, or contact that could have left biological material including oral-to-genital.
- ✓ Vaginal swabs should only be obtained in the adolescent (pubertal) and adult population of female patients.
- ✓ Prepubescent patients should **ONLY** have external genital swabbing.
- ✓ Do not moisten swabs prior to sample collection.
- ✓ Two (2) to four (4) swabs should be collected from each body orifice examined.
- ✓ All swabs used in collection should be used to prepare the smear slide by placing the end of the collected swab(s) in the center of the frosted circles rolling the swabs forward and back twice.
- ✓ Label the swabs used to prepare the smear slide.
- ✓ Label the swabs and smear slide with the site of collection.
- ✓ Do not aspirate the vaginal orifice or dilute the secretions in any way when collecting vaginal swabs.

It is a routine practice in the court system to have evidence tested by more than one laboratory. Collecting duplicate swabs insures sufficient material for testing by multiple laboratories. Often, the number of tests performed on an item of evidence is limited by the quantity of material collected.

Embarrassment, trauma, or just a lack of recall about the assault may cause a patient to be vague or mistaken about the type of sexual contact that actually occurred. For these reasons, and because there may also be leakage of semen from the vagina or penis onto the anus, even without anal penetration, it is recommended that the patient be encouraged to allow examination of all three orifices so that specimens may be collected.

In cases where the patient insists that contact or penetration involved only one or two orifices *(or in some circumstances, no orifices at all),* it is important that the patient be allowed to decline collection of the non-contacted orifices. This "right to decline" serves to reinforce a primary therapeutic principle–-the return of control to the patient.

However, giving due consideration to the above principle, if during the course of the examination the medical provider or SANE believes that evidence may be present in areas disputed by the patient, it is recommended that the evidence be collected. Documentation that the patient declined the collection of those samples is necessary.

When collecting swabs, the medical provider or SANE should take special care not to contaminate the individual collections with secretions or material from other areas, such as vaginal to anal or penile to anal. Such inadvertent contamination may unnecessarily jeopardize future court proceedings.

Each of the collection envelopes (*Vaginal/Penile and Additional Swabs and Smears)* used for oral and anal samples, include the swabs and slides needed for collection. Care should be taken to be sure that the correct side of the slide is used to make the smear. Use the pencil provided to write the patient's last name on the frosted end of the smear slide.

The patient, who must use a bathroom facility *(pre-exam*), should be told that semen or other evidence may be present in the pubic, genital and anal areas and urged to take special care not to wash or wipe away those secretions until after evidence has been collected.

M. Penile Swab Collection

For the male patient, the presence of saliva on the penis could indicate that oral-genital contact was made. If bite mark(s) are present on the penis or scrotum, follow procedures for collecting saliva from bite marks.

For the male perpetrator, the presence of vaginal secretions from the victim's DNA could help corroborate that the penis was introduced into the vaginal orifice.

Collect swabs from the male's penile shaft and foreskin, glans and scrotum if there was penile/vaginal penetration, other genital-to-genital contact, oral contact, anal or rectal contact or foreign material disclosed or suspected (e.g., lubricant).

These swabs are not to be used for the medical diagnosis of sexually transmitted diseases; therefore, they should NOT be used to swab inside the penile opening.

N. Oral Swab Collection

In sexual assault cases when the patient was forced to perform oral sex, the oral swabs and smear can be as important as the vaginal or anal swabs and smears. The purpose of these swabs is to recover seminal fluid from the recesses in the oral cavity where traces of semen could survive.

In cases of suspected oral assaults, this collection should be done first. The longer this evidence is in the body cavity uncollected, the more likely it is to be lost. Doing this collection first allows the patient to rinse out her or his mouth. This will reduce a significant source of patient distress.

Important Reminders for Collecting Oral Swabs

- Collect oral swabs when there may have been genital/oral penetration with or without ejaculation.
- Use dry swabs to rub around teeth, checks, gums and under the tongue.
- **Collect oral swabs up to 24 hours post assault**. The longer this evidence is in the body cavity uncollected, the more likely it is to be lost.
- Collection allows the patient to rinse out her or his mouth as soon as possible and can reduce significant discomfort and distress.

NOTE: In the case of a suspected oral assault, it will be necessary to prepare the blood stain card for the known sample.

O. Anal Swab Collection

The medical provider or SANE should examine the buttocks, perianal skin and the anal folds for injury, foreign materials and other findings. Any dried and moist secretions, stains and debris/foreign materials should be collected.

Collect perianal and anal swabs when there has been anal/penile or rectal/penile penetration, oral/anal penetration or contact, digital/object penetration or contact by the perpetrator, foreign material or an object.

Important Reminders for Collecting Anal Swabs

- Swab the anal area using two (2) swabs simultaneously.
- Prepare the smear slide by rolling the swabs forward and back twice in the frosted circle on the slide.
- Allow the swabs and smear slide to dry.
- Package, label and seal.
- Label the swab box and slide holder with site of collection.

P. Known Saliva Collection

The patient should not smoke or have anything to eat or drink for at least 25 minutes prior to this procedure.

It is important that the saliva specimen not be contaminated by outside elements. The medical provider or SANE should collect the known saliva sample by collecting an adequate amount of DNA.

Important Reminder for Collection of Known Saliva

- Collect the known saliva sample by simultaneously swabbing around the inside of **each cheek for 10-15 seconds using three (3) swabs**. It is important to recover cells not just saliva.
- **Allow all six (6) swabs to air dry prior to labeling and packaging**. Be sure that nothing touches the tips of the swabs as they dry.

If there was an oral assault, the blood stain card should be used to collect the known sample.

Q. Known Blood Collection

The dry blood and saliva samples serve as reference samples for the patient's DNA profile. Both can be used to determine the DNA profile of the patient for comparison purposes. In many cases of sexual assault, biological materials may be found on the suspect, the suspect's clothes and/or at the crime scene. Materials may also be found on the patient or the patient's clothing.

In order to minimize patient discomfort, blood needed for the "Known Sample" should also be collected at the same time as the blood is collected for drug analysis.

If blood is being collected for medical or drug analysis purposes, a reference bloodstain should be made during the whole blood collection process.

If whole blood is not being collected for medical or drug analysis purposes, a medical lancet should be used to prick the patient's finger.

R. Body Diagrams

Document all findings using the body diagrams in the sexual assault information forms.

Findings include observable or palpable tissue injuries, physiological changes, or debris/ foreign material (*e.g., grass, sand, stains, dried or moist secretions or positive fluorescence materials.)* Be observant for erythema *(redness)*, abrasions, bruises, swelling, lacerations, fractures, bites, and burns. Note areas of tenderness or indurations.

Document injuries/findings on the body diagrams, describe the size, shape and the color and photograph.

S. Photography

Photographs can supplement the medical forensic history and physical findings. Photographs serve to visually document the actual physical appearance of an injury to preserve it for additional analysis and/or as evidence.[16]

If photographs are taken, it should be with the specific consent of the patient. Minimize patients' discomfort while they are being photographed and respect their need for modesty and privacy. Drape them appropriately when taking photographs.[17]

Photography should be limited to those instances where there is an opportunity to produce clear pictorial evidence of injury, such as bruises or lacerations. Photographs do not take the place of documentation of finding(s) on the body diagrams or written descriptions.

Because of the added trauma to the patient during the examination and in view of the probable and unnecessary embarrassment in court, photographs of the genital area should be taken after getting consent from the patient.

Once taken, photographs can be subpoenaed into evidence and may hurt the case if actual injuries appear minimal or cannot be seen.

Important Reminders for Taking Photographs[18]

- Photographs should be identified (labeled) with the patient's name, hospital/kit tracking number and date.
- Use an inch scale or ruler for size reference in photographs.
- Identify patients and anatomical locations being photographed by taking at least two photographs of each area, one with and one without scale.
- Take full-body images (anterior, posterior, and lateral) with the patient's face visible and clearly identifiable.
- Take medium-range photographs of each injury, including cuts, bruises, swelling, lacerations, and abrasions. Work from one side to the other and then top to bottom, or design a workable method.

- Take close up images of particular injuries, using the scale. When photographing a wound, show its relationship to another part of the body. Take at least three photographs involving a wound area. Be sure to shield uninvolved breast or genital areas when possible.
- Close up photographs of hands and fingernails may show traces of blood, skin, or hair.
- Photograph marks of restraint or bondage around wrists, ankles, or neck.
- Photographs or camera cards remain with the sexual assault information forms and should not be scanned or placed in medical records.

Photographs should NOT be sent to the WV State Police Forensic Laboratory in the kit.

T. Toxicology—Blood/Urine Screen—Drug Facilitated Sexual Assault

There has been an increase in sexual assaults involving the use of drugs and alcohol. Drugs and/or alcohol can result in a loss of consciousness and a loss of the ability to consent. Some of these drugs cause memory loss and incapacitation. The effects of all drugs are enhanced when taken with alcohol. Victims of alcohol and drug facilitated sexual assaults often cannot remember the assault itself and therefore may not immediately report the assault.

The most frequently used drugs are alcohol, marijuana, benzodiazepines, cocaine, methamphetamine and ketamine. These drugs are often mixed with alcohol or other beverages to incapacitate the victim because they can be difficult to detect when covertly slipped into a drink.

On October 12, 1996, a federal law entitled "The Drug-Induced Rape Prevention and Punishment Act of 1996" was enacted. The bill provides penalties of up to 20 years imprisonment for persons who intend to commit a crime of violence by distributing a controlled substance to another individual without that individual's knowledge.

Medical providers, SANEs, law enforcement and rape crisis center advocates should know what to look for in suspected drug-facilitated sexual assaults. If an adolescent/adult victim presents at a medical facility with a complaint of sexual assault and displays any of the following behaviors, it is strongly recommended that urine and/or blood specimens (depending on time frame) be taken and tested for drug facilitated sexual assault.

The victim of a drug-facilitated sexual assault may exhibit some of the following signs:

Lack of body control	Decreased blood pressure
Dizziness	Impaired motor skills
Confusion	Impaired judgment
Drowsiness	Reduced inhibition
Lack of body control	Decreased blood pressure
Severe intoxication	Slurred speech
Temporary paralysis	Memory loss or “Cameo Memories”

Once the victim recovers from the effects of the drug, anterograde amnesia, it may be difficult to recall the events following the ingestion of the drug. For this reason, if the patient presents to the Emergency Department and does not know if she/he has consumed a drug(s), and if the examining physician, nurse or SANE does not recognize the effects of the drug(s), the patient may appear to be intoxicated or “hung over.”

In a drug-facilitated sexual assault (DFSA) the likelihood of detecting drugs used to commit the sexual assault diminishes each time the patient urinates; therefore, it is imperative that immediate action is taken to preserve the first voided urine.

Toxicology screens should **not** be administered routinely to all patients of sexual assault. Blood and urine screens for the purpose of determining toxicology should be done in the following situations:

- If the patient or accompanying person *(such as a family member, friend or law enforcement)* reports that the patient was drugged by the perpetrator(s)
- If in the opinion of the medical provider or SANE patient’s medical condition appears to warrant toxicology screening.

Important Guidelines When Drug Facilitated Sexual Assault Is Suspected

- **If an alcohol or drug determination is made, always submit blood and urine when It Is less than 24 hours since the assault occurred.**
- **If the time since the assault is more than 24 hours but within 96 hours of the assault, collect ONLY urine from the patient. (96-Hour Rule-if the drug was ingested within the last 96 hours, collect a urine specimen.**
- If the kit's blood collection vials have expired, replace them with similar unexpired vials from hospital stock.
- Do not disinfect the skin with ethyl alcohol. Non-alcoholic antiseptics should be used.
- Sterile hypodermic needles and syringes should be used. Sterile disposable units are recommended.
- If the patient presents with a urine specimen, label the specimen, seal the specimen, and include the specimen in the toxicology collection kit with the urine sample collected by the hospital.
- Blood collection steps should be performed only by a physician, registered nurse or trained phlebotomist.

The WVSP Forensic Laboratory MUST be notified if a toxicology kit is present in the kit, so it can be refrigerated when received at the lab. Indicate that by placing a bio-hazard sticker on the outside of the kit.

U. Evaluation for Sexually Transmitted Diseases (STDs)

Contracting sexually transmitted diseases (STDs) from perpetrator(s) is typically a significant concern of patients who have been sexually assaulted. Because of these concerns, it should be addressed as part of the medical forensic examination.

According to STD Treatment Guidelines, 2015, from Centers for Disease Control and Prevention (CDC), trichomoniasis, bacterial vaginosis, gonorrhea and chlamydia are the most frequently diagnosed infections among women who have been sexually assaulted.[19]

Because the prevalence of these infections is high among sexually active women, their presence post-assault does not necessarily signify acquisition from the assault.[20]

CDC recommends the following prophylactic regimen as preventive therapy:[21]

- Post exposure hepatitis B vaccination, without HBIG; *(This vaccine should be administered to sexual assault patients at the time of the initial examination if they have not been previously vaccinated and if the hepatitis status of the suspect is unknown*).
- If the perpetrator is known to be HBsAg-positive, unvaccinated survivors should receive both hepatitis B vaccine and HBIG. *(The vaccine and HBIG, if indicated, should be administered to sexual assault survivors at the time of the initial examination, and follow-up doses of vaccine should be administered 1–2 and 4–6 months after the first dose. Survivors who were previously vaccinated but did not receive post vaccination testing should receive a single vaccine booster dose (see hepatitis B).)*
- HPV vaccination is recommended for female survivors aged 9–26 years and male survivors aged 9–21 years. For MSM who have not received HPV vaccine or who have been incompletely vaccinated, vaccine can be administered through age 26 years. The vaccine should be administered to sexual assault survivors at the time of the initial examination, and follow-up dose administered at 1–2 months and 6 months after the first dose.
- An empiric antimicrobial regimen for chlamydia, gonorrhea, and trichomonas; and
- Emergency contraception.

Recommended Regimens for Treating STDs:

Ceftriaxone 250 mg IM in a single dose

PLUS

Azithromycin 1 g orally in a single dose

PLUS

Metronidazole 2 g orally in a single dose

OR

Tinidazole 2g orally in a single dose

If alcohol has been recently ingested or emergency contraception is provided, metronidazole or tinidazole can be taken by the sexual assault survivor at home rather than as directly observed therapy to minimize potential side effects and drug interactions. Clinicians should counsel persons regarding the possible benefits and toxicities associated with these treatment regimens; gastrointestinal side effects can occur with this combination.

V. Follow-Up Care for STDs

After the initial post-assault examination, follow-up examinations provide an opportunity to do the following:

- Detect new infections acquired during or after the assault;
- Complete hepatitis B and HPV vaccinations, if indicated;
- Complete counseling and treatment for other STDs;
- Monitor side effects and adherence to post exposure prophylactic medication, if prescribed.

If treatment was provided, testing should be conducted only if the patient reports having symptoms. Clinicians should counsel patients regarding the possible benefits and toxicities associated with these treatment regimens; gastrointestinal side effects can occur with the combination of medications.

If treatment was not provided, a follow-up examination should be conducted within 1 week to ensure that results of positive tests can be discussed promptly and treatment provided.

Serologic tests for syphilis can be repeated six (6) weeks, three (3) months and six (6) months after the assault, if testing was done and results were negative.

At the initial examination and, if indicated, at follow-up examinations, patients should be counseled regarding the symptoms of STDs, the need for immediate examination (if symptoms occur) and abstinence from sexual intercourse until STD prophylactic treatment is completed.

It is recommended that the most recent Treatment Guidelines for STDs from Centers for Disease Control and Prevention be adhered to whenever possible.

W. Risk for Acquiring HIV Infection

The medical provider must address patients' concerns regarding the possibility of contracting HIV. Patients should be offered information about HIV risks, symptoms and the need for immediate examination, if the symptoms rise. HIV/AIDS testing must be discussed including the difference between anonymous and confidential testing.

Local referrals for testing and counseling are available at the AIDS/STD hotline: **1-800-642-8244**. The AIDS Hotline provides answers to questions regarding HIV and AIDS. The hotline is staffed with counselors trained to provide information about the symptoms of HIV disease, how the virus is transmitted, where to get tested, and how to contact support groups; STD staff perform confidential patient interviews and subsequent partner notification/referral for persons diagnosed with Syphilis, Gonorrhea, Chlamydia, and HIV infection.

X. HIV Post-Exposure Prophylaxis

The use of HIV Pot-Exposure Prophylaxis (PEP), after an acute sexual assault, is based on the efficacy in exposure should be made on an individual basis, and should be discussed with each patient.

These decisions should take into account not only the specifics of the individual incident *(e.g., the known facts about the suspect, the emotional state of the patient, the type of entry, whether ejaculation occurred, and the possible transfer of blood and other fluids)*, but should also be weighed with the usefulness of the tests in the given time frame. A patient may not test positive for 3 to 6 months or longer following exposure to HIV. Medical facilities are encouraged to develop policies and put procedures in place.

The decision to recommend post-exposure prophylaxis (PEP) must balance the risks and benefits of taking the medication. The risk is primarily an adverse drug reaction. The benefit would be not acquiring an HIV infection.

See Appendix I – Patient's Needs for HIV Medication to help evaluate a patient's need for HIV nPEP.[22]

Centers for Disease Control and Prevention make the following recommendations for adolescent/adults put at risk for acquiring AIDS infection through an isolated incident:[23]

a. Within seventy-two (72) hours of the exposure, refer patient to the local health department or to a primary care provider to obtain baseline HIV status where good pre-test counseling can be done. The possibility of contracting AIDS is outweighed by the probability that a single exposure will not transmit the infection.
b. Receive pre-test and post-test counseling if tested for HIV.

c. Take the following precautions until negative status at six (6) months:
    1. Abstain from sex, which includes penetration *(e.g., vaginal, anal and oral),* practice safe sex techniques with sexual partner(s) *(e.g., condoms, limit exchange of body fluids,)* and avoid high-risk sexual behavior;
    2. Do not donate blood or body fluids;
    3. Do not share intravenous needles;
    4. Do not share personal hygiene equipment *(i.e., razors, toothbrushes)*;
    5. Avoid pregnancy.
d. If tested for HIV consult with a specialist in HIV treatment, if nPEP is being considered
e. If the patient chooses to start nPEP, provide enough medication to last until the follow-up visit at 3–7 days after initial assessment and assess tolerance to medications.
f. If nPEP is started, perform CBC and serum chemistry at baseline.
g. Perform an HIV antibody test at original assessment; repeat at 6 weeks, 3 months, and 6 months.[25]

An important consideration before initiating HIV PEP should include the patient's ability to adhere to the medication regimen. Incomplete PEP treatment can present a theoretical risk of increased resistance and this makes HIV more difficult to treat should the patient become HIV positive. Follow up is needed after the starting of HIV PEP to monitor side effects and assess compliance. Additional information is available from CDC online at http://www.cdc.gov/std.

Y. Pregnancy Risk Evaluation and Care

The standard of emergency care established by the American Medical Association (AMA) requires that patients of a sexual assault be counseled about their risk of pregnancy and offered emergency contraception (EC).[24]

The sooner EC is taken the better it works to prevent pregnancy after sexual assault. EC is most effective when taken within the first 12 hours after sexual assault, but is effective up to 120 hours (5 days) after the assault.

Progestin-only pills like Plan B, Plan B One-Step and Next Choice are FDA-approved for use as EC. They are more effective and have fewer side effects than some other medications.

EC can be offered on site. Plan B is available for purchase without a prescription if the patient is 17 years of age or older. More information on Plan B can be obtained at www.go2planb.com.

Medical facilities should develop specific consent forms and provide written information about follow up care and how to call back should the patient have questions.

It is important to remember that patients of different ages, social, cultural and religious/spiritual backgrounds may have varying feelings regarding acceptable treatment of EC. Patients must be allowed to make their own decisions about using EC. EC medications do not end a pregnancy.

V. Procedures for Release of Evidence

A. Preliminary Procedures

All medical and forensic specimens collected during the medical forensic examination must be kept separate, both in terms of collection and processing.

- Specimens collected for medical purposes should be kept and processed at the examining medical facility.
- Specimens collected for forensic analysis should be packaged and placed in the sexual assault evidence collection kit.

B. Final Procedures

When all evidence specimens have been collected, return the envelopes to the kit, making sure that everything is properly labeled and sealed. All required written information should be completed on the forms and envelopes. The completed kit and clothing bags should be kept together and stored in a secured area with restricted access.

a. If the sexual assault is reported to law enforcement, only law enforcement or a duly authorized officer should transfer the kit from the medical facility to the WV State Police Forensic Laboratory.

If the patient has chosen to have a medical forensic examination and not involve law enforcement, the kit will be shipped by FedEx to Marshall University Forensic Science Center (MUFSC) where it will be stored for 24 months. *(Refer to Chapter 4 for detailed information on how "non-reports" to law enforcement MUST be handled by medical personnel to maintain chain of custody.)*

C. Release of Information and Evidence to Law Enforcement

Evidence collection items should not be released from a medical facility without the written authorization and consent of the informed adult patient, or an authorized third party acting on the patient's behalf if the patient is unable to understand or execute the release. An "Authorization for Release of Information and Evidence" should be completed.

In addition to obtaining the signature of the patient or authorized party on the form, signatures must be obtained from the medical provider or SANE turning over the evidence, as well as from law enforcement who picks up the evidence to ensure that the chain of custody is maintained.

The name of the physician completing the medical screening should be listed on page 10 of the sexual assault information form.

The signature of the physician is NOT required, unless he/she conducted the entire medical forensic examination. The name of the medical provider or SANE MUST be legible and printed on the label on the outside of the kit when transferred to maintain chain of custody.

VI. Post Examination

A. Patient Follow-Up

The discussion of follow-up services for both medical and counseling purposes is an important treatment aspect for a sexual assault patient. Before the patient leaves the medical facility, the patient should be given written discharge information. The type and dosage of any medication prescribed or administered should be recorded on the form. The original copy of the patient's discharge information should be given to the patient and the second copy retained for the medical facility's records.

The patient should be encouraged to obtain follow-up tests for possible pregnancy, sexually transmitted infections, or other infections. It is vital that both written and oral information be provided, including the locations of public health clinics or referrals to private physicians for medical follow-up.

It is important for the medical provider to be familiar with the local rape crisis center services. If the patient has not spoken to an advocate from the local rape crisis center at the hospital, information and resources should be provided about the services that are available.

B. Post Examination Care

The patient may want to wash after the examination and evidence collection process. The hospital should provide the basics required, such as mouth rinse, soap and a towel.

If garments have been collected for evidence purposes and no additional clothing is available, arrangements should be made to ensure that the patient does not leave the hospital in an examination gown.

In those instances when a law enforcement officer has transported a victim from home to the hospital, the victim should be advised to bring an additional set of clothing. The patient may wish to have a family member or friend contacted to bring clothing.

When the patient has no available personal clothing, necessary items could be supplied by hospital volunteer organizations and/or local victim assistance agencies.

VII. Checklist: Medical Forensic Examination

MEDICAL FACILITY - INTAKE

O Consider all patients reporting sexual assault as Acuity Level 2.

O Provide a private waiting area separate from the emergency department waiting area for the patient. Provide the necessary means to ensure the patient's privacy.

- O Respond to acute injury, trauma care and safety needs of patients before collecting evidence. Patients should not wash, change clothes, urinate, defecate, smoke, drink, or eat until an initial evaluation by the medical provider or SANE.
- O Provide expedited consultation and attention to the patient.
- O Explain the importance of obtaining support and resources from the victim advocate.

MEDICAL FORENSIC EXAMINATION

- O Establish procedures to obtain the patient's consent for each medical and evidentiary procedure. Consent for evidence collection can be withdrawn at any time.
- O Inform the patient that obtaining written consent for release of evidence means that the evidence collected becomes part of the criminal investigation.
- O Conduct the examination in accordance with the established sexual assault evidence collection protocol.
- O Minimize patient discomfort.
- O Adapt the exam process to address the unique needs and circumstances of each patient.
- O Explain each step of the medical forensic exam to the patient and the importance of the collection of forensic samples.
- O Ask only what is necessary to collect evidence and complete a thorough examination.
- O Inform the patient about possible pregnancy, sexually transmitted diseases (STDs), risk for acquiring HIV infection, and prophylactic steps to avoid pregnancy.
- O Set guidelines for making referrals for follow-up medical and mental health services.
- O Explain that the Forensic Medical Examination Fund will pay for the cost of the forensic portion of the examination, whether or not a report is made to law enforcement.
- O Coordinate the collection of forensic evidence to maintain the chain of custody.

NON-REPORTS TO LAW ENFORCEMENT

- O Inform the patient that when the medical forensic exam is completed and the decision has been made not to make a report to law enforcement, the kit will be shipped and stored to Marshall University Forensic Science Center (MUFSC), where it will l be stored for 24 months.
- O If liquid samples were collected as a part of the toxicology kit (blood and urine), the samples will degrade over time.
- O Samples collected as part of the medical forensic examination *(e.g., swabs and smears)* will have an unlimited lifespan, if collected and dried properly.
- O The kit tracking number will be needed for law enforcement to retrieve the sexual assault evidence collection kit from MUFSC.

- If an investigation has not been initiated within 24 months from the time of collection, the kit will be categorized as "non-active." After the 24 month time frame, the forensic samples collected as part of the forensic medical examination in "non-active" kits may be used for training purposes once all identifying information has been removed.
- After the 24 month time period, if the "non-active" sex crime evidence collection kit has not been used for training purposes, the victim can still request that an investigation be initiated. There is no statute of limitations on reporting sexual assault in West Virginia.

FINAL PROCEDURES

- Return all envelopes to the sexual assault evidence collection kit, making sure that everything is properly labeled, sealed and all information requested has been completed.
- Maintain chain of custody by dating and signing the sex crime evidence collection kit and bags of clothing.
- Transfer the completed sexual assault evidence collection kit to law enforcement, unless the victim has decided **not** to make a report to law enforcement.
- Prepare the sexual assault evidence collection kit to be shipped by FedEx to MUFSC, if it is a **"non-report"** to law enforcement.

Chapter 6

SUSPECT EXAMINATION PROTOCOL

I. Protocol for Sexual Assault Suspect Examination

The investigating officer must determine whether a forensic sexual assault examination should be obtained for the suspect. Factoring into that decisions are the following:

- Length of time since the assault occurred
- Nature of the assault
- Suspect was injured during the assault
- Transfer of cells, fluid or other biological/trace evidence was transferred from the victim to the suspect

A. The Suspect Examination

There are three ways a suspect examination may take place:

- Suspect consents
- Arrest has been made or a warrant issued
- Court order has been obtained

Medical personnel may gather limited samples at the request and direction of law enforcement (such as buccal or penile swabs) without obtaining medical history or conducting a physical examination.

The medical provider still needs to use the nursing process to complete the examination which would include assessment, diagnosis, planning, implementation and evaluation. Assault histories are not typically taken from the suspect by the medical provider conducting the examination. However, spontaneous statements, made by the suspect, may be recorded in the forensic record.

Before conducting a suspect exam, the medical provider must ensure law enforcement remains with the suspect throughout the process.

Precautions must be taken to avoid cross contamination, if the facility has also examined the victim (e.g., don't use the same room for both examinations and avoid any confrontation between the victim and the suspect, if both should appear in a common area at the same time.

It is **not** recommended that the medical provider do both the patient and suspect exam.

The physical examination of a suspect should be done, if the suspect is willing. All injuries or pertinent findings should be documented and photographed according to developed protocols.

An ano-genital examination may be useful in identifying indicators of STD's including penile lesions and discharge, as well as signs of friction and dried or crusted fluids.

B. Evidence Collection

Evidence collection may be guided by details of the assault, law enforcement, search warrant or per protocol.

To conduct a forensic evidentiary examination on a suspect the following would be needed:

1. Obtain history information from law enforcement, if needed, to conduct the examination
2. Obtain consent or review search warrant for guidance in collecting of evidence
3. Obtain medical history
    a. Medications
    b. Allergies
    c. Major medical conditions or recent surgeries
4. General physical examination
    a. Height, weight, vitals
    b. Note objective behavior and demeanor
    c. Observe any identifying marks such as tattoos, scars, birth marks or lesions
    d. Note need marks, if observed
5. Collection of forensic samples
    a. Oral swabs: Obtain as reference and in cases where there is suspected oral-genital contact by suspect.
    b. Finger nail swabs: Can obtain victim's epithelial cells. Consider swabbing hands, around rings and other jewelry when digital penetration is suspected.
    c. Hair samples or combings: Head, facial, chest and/or pubic hair.
    d. Genital swabs: Includes penis, scrotum and potentially perineum/perianus by history. Penile swabs include the shaft and scrotum. If suspect is uncircumcised, swab beneath the foreskin.
    e. Debris collection
    f. Dried fluid samples
    g. Urine samples: Reference sample or toxicology per protocol.
    h. Blood samples: Reference sample or toxicology per suspect consent or search warrant.

6. Collection of clothing
    a. Underwear or clothing worn next to genitalia from suspect as a component of the exam process: Should be collected regardless of whether the suspect is believed to have changed since committing the assault.
    b. Medical provider or SANE should note any stains, tears, or other alterations to collected garments.
    c. Consider the following when obtaining suspect's clothing:
        i. Avoid cutting through bullet or stab wounds in material.
        ii. Dry clothing when possible.
        iii. Package evidence per protocol
        iv. Maintain chain of custody as with any other components of evidentiary exams.

7. Use of condoms
    a. If there is suspicion or knowledge that the suspect used a condom during the assault, collect (at a minimum) three swabs: One for the defense and two for the exam process.

8. Follow basic treatment protocols
    a. Wound care, pain management and post discharge care.[25]

II. Checklist: Suspect Exam

O Collect clothing.
O Photograph any and all injuries, marks, scars, tattoos.
O Collect buccal swabs.
O Get hair samples.
O Collect penile swabs.
O Conduct examination for STD's.
O Collect other swabs depending upon the investigation information.
O Make sure consent is documented. If no consent is given, get a search warrant or court order.

CHAPTER 7

PROSECUTION RESPONSE

I. Victim Expectation and the Role of the Prosecutor

A sexual assault victim has been subjected to one of the most traumatic experiences possible. The common expectation is that the prosecutor will represent the victim's interests in what the victim perceives to be his/her case. Prosecutors, on the other hand, do not have a responsibility to represent the personal interests of each sexual assault victim. Their constitutional duty is to represent society in the state's cases. This dissonance between victim expectation and prosecutorial role can be a source of conflict and frustration.

This protocol does not advocate altering the level of discretion entrusted to the prosecutor; however it does endorse consideration of the victim's needs in exercising that prosecutorial discretion. A sexual assault victim deserves to be informed about the reasons that motivate decisions about the case, especially when those decisions might appear to be adverse to his/her interests.

Victim's should be made aware that it is possible that cases against perpetrators may move forward and evidence from their sexual assault examination may still be used in those cases where the Prosecutor has probable cause to believe a crime has been committed and evidence that the perpetrator committed it.

II. Recommendations for Prosecutors

The Final Report of the President's Task Force on Victims of Crime emphasizes the importance of victims' participation in the criminal justice process and makes the following recommendations:

- Prosecutors should assume ultimate responsibility for informing victims of the status of a case from the time of the initial charge to determination of parole.
- Prosecutors have an obligation to bring the views of victims of violent crime to the attention of the court on bail decisions, continuances, plea bargains, dismissals, sentencing, and restitution. They should establish procedures to ensure that such victims are given the opportunity to make their views on these matters known.
- Prosecutors should charge and pursue to the fullest extent of the law defendants who harass, threaten, injure, or otherwise attempt to intimidate or retaliate against victims or witnesses.
- Prosecutors should strongly discourage case continuances. When such delays are necessary, procedures should be established to ensure that cases are continued to

dates agreeable to victims and witnesses, that these dates are secured in advance whenever possible, and that the reasons for the continuances are adequately explained.

- Prosecutors' offices should establish and maintain direct liaison with victim/witnesses and rape crisis centers.
- Prosecutors must recognize the profound impact that crimes of sexual violence have on both child and adult victims and their families.

III. Neurobiology of Trauma

Understanding how trauma impacts behavior and memory is necessary when working with victims of sexual assault. Trauma can alter an individual's affect, memory, and ability to give detailed information about an experience. When confronted with a life-threatening event, the brain often enters the fight, flight, or freeze state and is flooded with chemicals that impact the victim's behavior and interfere with normal memory storage.

Dr. Rebecca Campbell[14] provides a helpful outline of chemicals that are often released in the brain when an individual experiences trauma. These may affect thoughts, actions and memory both during and after a traumatic event.

1. **Catecholamines**, such as adrenaline, are part of the traditional "fight or flight" response and can impact complex thinking processes.
2. **Cortisol** can increase available energy for the body in a stressful situation.
3. **Natural Opiates** can numb physical pain and make a victim appear emotionally flat.
4. **Oxytocin** can produce confusing responses like calm feelings or even laughter.

These counterintuitive responses are difficult for juries to understand without help. Jurors might ask themselves questions like, "If this person was really sexually assaulted, then why was she laughing when she reported to police?" Unless jurors understand that this behavior is normal, they might decide that the victim is not credible. This is an inaccurate assumption.

When it comes to other crimes, we understand this phenomenon intuitively. For example, if a mugging victim cannot remember the perpetrator's face because they were only focused on the gun the mugger was using, we do not conclude that this report was somehow less credible. Unfortunately, we have not always extended the same understanding to victims of sexual assault in the past.

In the end, it isn't necessary for all first responders to be experts on neurology, but it *is* necessary to explain normal victim behavior to juries. Prosecutors are encouraged to utilize expert testimony about victim behavior so juries will not mistake the symptoms of trauma for signs of deception. Prosecutors around the country have successfully used victim advocates from neighboring counties or SANEs to provide expert testimony about common victim behavior.

IV. Sexually Violent Predators

In West Virginia, offenders committing sexual offenses can be identified in three categories: sexual offenders, sexually violent offenders, and sexually violent predators. W.Va. Code §15- 12-2(k) defines “sexually violent predator” as any person who has been convicted or found not guilty by reason of mental illness, mental retardation or addiction of a sexually violent offense and who suffers from a mental abnormality or personality disorder that makes the person likely to engage in predatory sexually violent offenses. W.Va. Code §15-12-2(m) defines “predatory” as an act directed at a stranger or at a person with whom a relationship has been established or promoted for the primary purpose of victimization. Before a person can be deemed a “sexually violent predator”, he/she must undergo a specific review process outlined in W.Va. Code §15-12-2a, et seq”.

The formal process begins when a prosecutor files a written pleading with the Court detailing the record of judgment and a short and plain statement outlining that the offender suffers from a mental abnormality or personality disorder that makes him/her likely to engage in predatory sexually violent offenses. The Court may then order a psychiatric or other clinical examination.

Following the exam, the Court may order a period of observation in an appropriate facility within the State. The Court shall also refer the matter to the West Virginia Sex Offender Registration Advisory Board. After careful review, the Board will submit back to the Court for consideration written findings and a recommendation as to whether the person is a sexually violent predator.

The matter is then triable before the Court without a jury. The prosecutor bears the burden of proving by a preponderance of evidence that the offender is a sexually violent predator. The offender must be present for the hearing, has the right to be represented by counsel and has the right to introduce evidence and cross-examine witnesses. The offender shall also have access to a summary of the medical evidence to be presented by the prosecutor. He/she also has the right to an examination by an independent expert of his or her own choosing.

At the conclusion of the hearing, the Court will make a finding whether the offender is or is not a sexually violent predator. If the Court declares the offender a sexually violent predator, he/she is subject to stricter penalties under the law.

V: Checklist: Prosecution Response

GENERAL PROSECUTION PROTOCOL

- O Notify the victim of all hearings and changes in schedules.
- O Consider the needs of the victim when scheduling case-related activities (i.e., religious holidays, health requirements, family activities and occupational requirements).
- O Establish safe communication methods to avoid unnecessary trips to the courthouse,

(e.g., electronic pagers, an on-call system, or a voice mail system so victims may call in and receive current case status information).

- O Object to continuances unless they are tactically advantageous.
- O Establish and maintain direct liaison with victim/witnesses and rape crisis center advocates.
- O Recognize the impact that sexual assault has on child and adult victims.

INITIAL APPEARANCE, ARRAIGNMENT AND BAIL HEARING

- O Discuss conditions of release with the victim prior to bail hearing and allow the victim to express concerns about the accused.
- O Request that the accused's release on bail or release on his or her own recognizance include a no contact provision and an order of protection when applicable.
- O Inform the victim that upon being charged for sexual abuse, sexual assault, incest or sexual molestation, the perpetrator can be ordered to get an HIV test.
- O Inform the victim of the results of the testing for HIV, per procedural rule.
- O Inform the victim how to stay current on the detention status of the accused.

PLEA NEGOTIATIONS

- O Inform the victim of reasons to consider a negotiated plea.
- O Describe optional courses of action other than a negotiated plea.
- O Determine what courses of action the victim wants to take.
- O Consider the needs of the victim in determining whether to accept a plea *(e.g., restitution, protection, and emotional security).*

TRIAL

- O Provide separate waiting areas for the victim and defense witnesses.
- O Attempt to provide court accompaniment for the victim.
- O Keep the victim informed about court schedules: dates, times and places.

SENTENCING

- O Comply with WV Code §61-11A- et. sequiem (Victim Act of 1984).
- O Ensure an opportunity for the victim impact statement to be part of the sentencing considerations.
- O Include the victim's needs as part of the sentencing recommendations *(e.g., restitution, protection, and emotional security).*

POST SENTENCING

- O Notify the victim about changes in the status of the accused, if known.
- O Notify the victim of scheduled parole hearings, if known.
- O Provide priority prosecution for violations of release conditions.

CHAPTER 8

WEST VIRGINIA FORENSIC MEDICAL EXAMINATION FUND

The Violence Against Women Act provides that each state must have a method to pay the cost of forensic medical examinations for victims of sexual assault. In accordance with this mandate, the Forensic Medical Examination Fund was created by the 1996 West Virginia Legislature and is contained in WV Code Section §61-8B-1 and WV Code Section 61-8B-15 through18. Prior to the establishment of the Forensic Medical Examination Fund, West Virginia had no specific mechanism to pay for this type of examination.

WV Code §61-8B-16(5c)—States that a victim of sexual assault is NOT required to participate in the criminal justice system or cooperate with law enforcement in order to have a forensic medical exam.

In accordance with statutory provisions creating the West Virginia Forensic Medical Examination Fund, the WV Prosecuting Attorneys Institute (WVPAI) was charged with the responsibility of administering the Forensic Medical Examination Fund and providing reimbursement to licensed medical facilities performing forensic medical examinations.

The Forensic Medical Examination Fund is restricted to the payment of all reasonable and customary costs of a forensic medical examination, which must be conducted within a reasonable time of the alleged violation.

The legislation provides that following the forensic medical examination, the medical facility shall submit a statement of charges to the WV Prosecuting Attorneys Institute. Following the forensic medical examination, the medical facility shall submit an original invoice and completed certification form to the WV Prosecuting Attorneys Institute requesting reimbursement for the forensic medical examination.

Thereafter, the WV Prosecuting Attorneys Institute shall pay from the Forensic Medical Examination Fund all appropriate costs.

The major objective of the Forensic Medical Examination Fund is to provide payment for forensic medical examinations in sexual assault cases. However, additional benefits include providing a more effective prosecution of persons alleged to have committed a sexual assault, while protecting the rights and dignities of their victims.

§61-8B-15. Forensic Medical Examination Fund; Training of Sexual Assault Nurse Examiners (SANEs).

There is continued the "Forensic Medical Examination Fund", created as a special fund in the State Treasury, into which shall be deposited legislative appropriations to the fund. The West Virginia Prosecuting Attorneys Institute, created by the provisions of section six, article four, chapter seven of this code, shall make expenditures from the fund, where it is determined to be practical by the executive council and the executive director to pay the costs of forensic medical examinations as defined in section sixteen of this article, to train nurses to examine sexual assault victims and to reimburse the Institute for its expenses in administering payments from the fund.

§61-8B-16. Payment for Costs of the Forensic Medical Examination.

a. When any person alleges that he or she has been the victim of an offense proscribed by this article, the West Virginia Prosecuting Attorneys Institute shall pay to a licensed medical facility from the Forensic Medical Examination Fund the cost of the forensic medical examination for the alleged victim on the following conditions and in the following manner:

   1. The payment shall cover all reasonable, customary and usual costs of the forensic medical examination;
   2. The costs of additional non-forensic procedures performed by the licensed medical facility, including, but not limited to, prophylactic treatment, treatment of injuries, testing for pregnancy and testing for sexually transmitted diseases, may not be paid from the fund: Provided, That nothing in this section shall be construed to prohibit a licensed medical facility from seeking payment for services referred to in this subdivision from the alleged victim or his or her insurer, if any;
   3. The forensic medical examination must have been conducted within a reasonable time of the alleged violation.

The West Virginia State Police Forensic Laboratory has determined that ninety-six (96) hours is the "reasonable time" and outside limit for conducting the medical forensic examination.

   4. The licensed medical facility must apply for payment of the costs of a forensic medical examination from the fund within a reasonable time of the examination.

The West Virginia Prosecuting Attorneys Institute has determined that a reasonable time is "ninety days".

   5. The licensed medical facility shall certify that the forensic medical examination was performed and may submit a statement of charges to the West Virginia Prosecuting Attorneys Institute for payment from the fund.

To receive a reimbursement from the Forensic Medical Examination Fund, the licensed medical facility must complete the certification form and submit an original invoice of the charges to the WVPAI. ***See Appendix H – Certification Form.***

b. No licensed medical facility may collect the costs of a forensic medical examination from the victim of a violation of this article or from the victim's insurance coverage, if any.

c. Nothing in this section shall be construed to require an alleged victim of sexual assault to participate in the criminal justice system or to cooperate with law enforcement in order to be provided a forensic medical examination pursuant to the provisions of this section.

§61-8B-17. Study of Reimbursement; Recordkeeping; Disclosure; Confidentiality.

(a) The West Virginia Prosecuting Attorneys Institute is hereby directed to undertake a study of the viability of the state seeking reimbursement from private insurance companies for the cost of forensic medical examinations. The study shall be completed prior to the first day of the regular legislative session, one thousand nine hundred ninety-seven, and provided to the president of the Senate and the speaker of the House of Delegates.

(b) The West Virginia Prosecuting Attorneys Institute shall develop and maintain a database for use by law-enforcement personnel, prosecuting attorneys and persons engaged in lawful research of the information collected pursuant to its administration of the West Virginia Forensic Medical Examination Fund.

The database shall include the number of examinations performed, the facilities performing the examination and where feasible, other information considered to be of assistance to law- enforcement and the prosecution of sexual offenses. The database shall be maintained in a manner which assures the confidentiality of the information.

§61-8B-18. Rule-making Authority.

The executive council of the West Virginia Prosecuting Attorneys Institute (WVPAI), created by the provisions of section six Article four, chapter seven of this code, shall promulgate rules in accordance with article three, chapter twenty-nine-a of this code, for the administration of the Forensic Medical Examination Fund, establishing qualifications for medical personnel performing a forensic medical examination and any other rules necessary to the implementation of this program. The Institute shall also distribute to all licensed medical facilities forms necessary to receive payment from the fund.

From the effective date of this section until the date of the promulgation of these rules, the executive council of the West Virginia Prosecuting Attorneys Institute may file rules as emergency rules in accordance with the applicable provisions of this code in order to govern during this period of time the administration of the fund.

TITLE 168
PROCEDURAL RULE
PROSECUTING ATTORNEYS INSTITUTE

SERIES 1
PAYMENT FOR COSTS OF FORENSIC MEDICAL EXAMINATION

§168-1-1. General.

1.1. Scope. -- This rule outlines procedures for paying the costs of forensic medical examinations for victims of sexual offenses from the forensic medical examination fund administered by the West Virginia Prosecuting Attorneys Institute. This rule is not intended to set standards for the conduct of a criminal investigation or to affect in any manner the admissibility of evidence.

1.2. Authority. -- W. Va. Code §61-8b-18.

1.3. Filing Date. -- September 23, 2009.

1.4. Effective Date. -- November 1, 2009.

§168-1-2. Definitions.

2.1. Terms Defined by Statute -- Terms defined in W. Va. Code §61-8B have the same meanings when used in this rule unless the context or subject matter clearly requires a different interpretation.

2.2. Terms Defined -- As used in this rule, the following terms have the following meanings unless the context or subject matter clearly requires a different interpretation:

2.2.1. “Licensed health care professional” means a state-licensed health care professional licensed, registered or certified under Chapter 30 of the W. Va. Code.

2.2.2. “Licensed medical facility” or “hospital” means a hospital, critical access hospital or other health facility licensed under W. Va. Code §16-5B, a similarly licensed out-of-state hospital that accepts West Virginia medicaid patients in a county adjacent to the West Virginia county in which venue lies, or a facility authorized and operated under W. Va. Code §16-2.

2.2.3. “Physician” means a physician licensed under W. Va. Code §§30-3 or 30-14.

2.2.4. “Sexual assault nurse examiner” or “SANE” means a registered nurse who has received at least forty (40) hours of sexual assault nurse examiner classroom training in the area of sexual assault through an accredited school of nursing or a program approved for continuing education credit by the West Virginia Board of Examiners of Registered Professional Nurses, and who has completed the associated clinical experience requirement.

§168-1-3. Responsibilities of the Licensed Medical Facility.

3.1. In order to be eligible for and to receive reimbursement for conducting forensic medical examinations, a licensed medical facility must comply with the following procedures:

3.1.1. Each hospital performing medical examinations must use either the WV State Police Sexual Assault Kit or kits containing, at a minimum, the items contained in the WV State Police Sexual Assault Kit. Each hospital may order sexual assault kits free of charge from the WV State Police.

Kits can be ordered from the WVSP Forensic Laboratory, with no charge to the medical facility by email to laboratory.kits@wvsp.gov.

3.1.2. Where an alleged victim of an alleged violation of W. Va. Code §61-8b ET SEQ. chooses to participate in an investigation of said alleged violation and if an investigating officer is not present at the time the alleged victim arrives at the hospital, a law enforcement officer should be contacted immediately through appropriate emergency channels.

3.1.3. Prior to conducting a forensic medical examination, the examining physician or SANE will explain to the alleged victim what a sexual assault examination involves and determine whether the victim wishes to participate in an investigation regarding the alleged sex crimes violation and document said decision in writing. The obtaining of additional consents included in the sexual assault kit and any additional consents which may be required by law is the responsibility of the hospital.

If a victim **chooses to initiate or participate in an investigation** and release the records of the forensic medical exam to law enforcement, the victim or guardian MUST sign the “Waiver of Medical Privilege and Authorization for Release of Medical and Legal Information for a Victim of a Sex Crime,” included in the sexual assault information forms.

If the victims **chooses to have a forensic medical exam but <u>does not</u> want to initiate or participate in any investigation** relating to the sexual assault, the victim or guardian MUST sign the form for a “Non-Report” to law enforcement.
In a “Non-Report” to law enforcement, the medical provider/SANE must ensure that the sexual assault evidence collection kit tracking label is placed on all 3 copies of the non-report consent form. The pink copy of the form MUST be given to the victim at the end of the exam.

The kit tracking number will be needed by the victim should the decision be made to initiate an investigation with law enforcement at a later time.

3.1.4. If possible, the forensic medical examination should be conducted by a physician, a sexual assault nurse examiner (SANE), a physician assistant working under the direct supervision of a physician, or an advanced practice nurse. Recognizing, however, that sensitivity to the needs of a victim of sexual assault may preclude delays in conducting the examination, payment will not be refused based on qualifications of the medical personnel performing the examination when the forensic medical examination is conducted by a licensed health care professional acting within the scope of practice at a licensed medical facility.

3.1.5. Hospital personnel should take note of any physical evidence, such as statements made by the alleged victim, as well as articles of clothing, etc. It is strongly recommended that the hospital preserve documents concerning this evidence and record the methods of collection.

3.1.6. Where an alleged victim of an alleged violation of W. Va. Code §61-8b ET SEQ. chooses to participate in an investigation of said alleged violation, after gathering the forensic evidence, the sexual assault kit shall be sealed and turned over to the investigating officer or police agency. Any and all other evidence collected by hospital staff shall also be turned over to the investigating officer or police agency. Where an alleged victim of an alleged violation of W. Va. Code §61-8b ET SEQ. chooses not to participate in an investigation of said alleged violation hospital personnel will be responsible for preparing the forensic evidence to be transported in such a manner and to such a location as is designated in the instructions accompanying the WV State Police Sexual Assault Kits.

When a sexual assault evidence collection kit has been collected but is not released to law enforcement, the medical provider or SANE will be responsible for preparing the forensic evidence, while maintaining chain of custody, to be shipped by FedEx to Marshall University Forensic Science Center (MUFSC).

These steps must be followed:

- Seal the kit and secure it with evidence tape.
- Call MUFSU at 304-691-8959, Monday through Friday, 8:00a.m.–5:00p.m. to report that a kit is ready to be shipped.
- Complete the information requested on the Fed Ex shipping label. (If additional boxes are needed to package evidence, such as bags of clothing, the physician, SANE or other hospital personnel should be prepared to find additional boxes to use for shipping.)
- Place the sealed kit in the mailing box. (A plain expandable brown mailing box is provided to hospitals when the kits are shipped from the WV State Police Forensic Laboratory.)
- Attach the pre-printed shipping label to the FedEx mailing box making sure that all required information has been completed.
- Take the kit to the FedEx shipping/receiving area in the hospital once the kit has been boxed, sealed and labeled for shipment.
- Record the date/time and initials on the label. (If FedEx does not have a shipping/ receiving area in the hospital, the examiner must contact MUFSC [304-691-8959] for directions on how to proceed.)

A sexual assault evidence collection kit (SAECK) collected from a victim who chooses not to report the sexual assault to law enforcement will be sent to Marshall University Forensic Science Center, (MUFSC) where the forensic samples will be stored for 24 months. It is important to note that if liquid samples were collected as a part of the toxicology kit (blood and urine), the samples will have a limited life span and will degrade over time. All samples collected as part of the medical forensic examination (e.g., swabs, smears, etc.) will have an unlimited lifespan, if collected and dried properly.

If an investigation has not been initiated within 24 months from the time of collection, the kit will be catalogued as "non-active." Samples in "non-active" kits may be used for training purposes once all identifying information has been removed. After the 24 month time period, if the "non-active" kit has not been used for training purposes, the victim may still request that an investigation be initiated.

REMEMBER: There is no statute of limitations on reporting sexual assault in West Virginia.

Additional procedures and information for handling "Non-Report" kits can be found in Chapter IV, Section VIII - Adult Patient Forensic Medical Examination and Reporting Options.

3.1.7. Following the completion of a forensic medical examination, the hospital shall submit a certification that such an examination was performed and may submit, within a reasonable time of the date of examination, an original invoice for the forensic medical examination to the West Virginia Prosecuting Attorneys Institute at its regular business address, Attention: Forensic Medical Examination Fund. The invoice shall contain the name of the alleged victim and the date of the alleged offense.

The medical facility shall submit an original invoice along with a completed certification form. ***See Appendix H – Certification Form.***

3.1.8. Reimbursement from the Fund is limited to $350.00 for the cost of a forensic medical examination or, when that sum appears to be less than all reasonable, customary and usual costs of the forensic medical examination, a greater sum determined by resolution of the Executive Counsel of the West Virginia Prosecuting Attorneys Institute after consultation with providers and consideration of the limits of available funding. A licensed medical facility may not bill the alleged victim, or the alleged victim's insurance company, of an alleged violation for costs of a forensic medical examination.

§168-1-4. Responsibilities of Law Enforcement Agencies.

4.1. When contacted an investigating officer or law enforcement agency is responsible for the following duties:

4.1.1. The investigating officer should inform the victim upon arrival at the hospital that the Forensic Medical Examination Fund will pay for the cost of the forensic medical examination. The investigating officer may not require an alleged victim's agreement to pursue prosecution of the case as a condition precedent to of obtaining

the examination. Payment from the fund may not be refused for the reason that the victim later fails or refuses to cooperate in a criminal prosecution.

4.1.2. The investigating officer is responsible for contacting the prosecuting attorney or assistant prosecuting attorney in the county where the alleged offense occurred to alert said prosecuting attorney or assistant prosecuting attorney of the investigation.

4.1.3. Upon completion of the forensic medical exam, the investigating officer is responsible for promptly transferring all evidence to the WV State Police Crime Laboratory in South Charleston, West Virginia for evaluation.

If the victim originally completed the "Non-Report" form and now wishes to initiate an investigation, the victim would need to contact law enforcement and provide the kit tracking number. Law enforcement would request the kit from MUFSC by submitting a "Request to Transfer" form.

a. **If the victim does NOT have the kit tracking number, it will be necessary for the following to happen**:

1. The victim will need to contact the medical record department at the hospital where the medical forensic exam was completed to secure the kit tracking number for law enforcement.

OR

2. Law Enforcement will need to submit a written request for the sex crime evidence collection kit number on agency letterhead including the victim's name, the officer's name, agency, contact number and badge number to MUFSC explaining that a victim (ex. Jane Doe) wants to initiate an investigation but does not have the sex crime kit tracking number. The request should be addressed to:

MUFSC
Attn: Non-Report SA Kit Program
1401 Forensic Science Drive
Huntington, WV 25701

3. The contact at MUFSC will check to see if there is a sex crime kit catalogued for the identified victim. If so, MUFSC will be able to provide the sex crime kit tracking number to law enforcement. If law enforcement has additional questions about the kit, they can call MUFSC at 304-691-8959.

b. Once law enforcement has the kit tracking number for the sexual assault evidence collection kit that was collected as a "non-report", the following procedures MUST be followed by law enforcement to initiate the investigation:

1. **Download and print** the "Request to Transfer Sex Crime Evidence Collection Kit" form that can be found at http://forensics.marshall.edu/LabRequest/Form-TransferKitRequest.pdf.

2. **Complete the information** requested on the form to have a direct transfer of the Sexual Assault Evidence Collection Kit to the WV State Police Forensic Laboratory –

    i. A WVSP Case Submission Form 53 must be submitted to the WV State Police Forensic Laboratory prior to the transfer of the sexual assault evidence collection kit.

    ii. Law enforcement must notify the WV State Police Forensic Lab that Submission Form 53 is being submitted without the evidence. Once MUFSC is notified that Submission Form 53 for the non-reported kit has been received by the WV State Police Forensic Lab, the evidence will be directly transferred to them via FedEx by MUFSC. The request for transfer of evidence form MUST be received before any evidence can be transferred.

    iii. Mail the request to:

MUFSC
Attn: Non-Report SA Kit Program
1401 Forensic Science Drive
Huntington, WV 25701

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§168-1-5. Responsibilities of Prosecuting Attorneys Institute.

5.1. Upon receipt of certification that an examination was performed and an original invoice in proper form the Prosecuting Attorneys Institute shall promptly transmit, at intervals no less often than monthly, all necessary documentation, in a form acceptable to the Auditor, to the Department of Administration for computer entry and further payment processing.

§168-1-6. Limitations on Use of Fund.

6.1. A licensed medical facility performing a forensic medical examination must conduct the exam within a reasonable time of the alleged sexual assault in order to be eligible for reimbursement from the Fund. Generally, in order to obtain usable evidence, a reasonable time is as soon as possible and should not exceed ninety-six (96) hours after the time of the alleged assault. If, however, in the judgment of the physician, sexual assault nurse examiner (SANE), physician assistant working under the direct supervision of a physician or the advanced practice nurse, special circumstances exist and the forensic examination should be conducted even after the passage of ninety-six (96) hours such examination will be considered to be conducted within a reasonable time.

6.2. Medical exams are primarily restricted to the collection of forensic evidence.

6.3. The West Virginia Forensic Medical Examination Fund covers only the cost of forensic medical exams. The Fund does not cover the cost of any treatment of injuries, pregnancy prevention or additional testing for pregnancy or sexually transmitted diseases.

CHILD PROTOCOL
CHAPTER 9

Child Sexual Abuse and the Medical Evaluation

I. Child Sexual Abuse

In many cases of child sexual abuse, the disclosure of abuse is not recent and may have been happening for a long time before it was reported. For these reasons, the timing of the medical evaluation and the need for evidence collection in children is determined on a case-by-case basis by a trained medical provider who has experience in child sexual abuse.

Many children can be sexually abused over a period of years. In some instances, child sexual abuse may be restricted to fondling or genital touching; other instances may begin that way and escalate to penetration or intercourse after an extended period of time. Some children become adolescents before realizing that the sexual contact they have experienced is wrong and does not occur in most households.

For a child of any age, disclosing sexual abuse is especially difficult. Disclosures of abuse, for some children, may be a process that happens over a period of time—a delay in disclosure by a child is common.

II. System Response to Child Abuse Cases – Different from Adult/Adolescent Sexual Assault

There are many factors about child sexual abuse that make it uniquely different from the response to adult sexual assault cases; things like an automatic system engagement, delayed disclosure and the likelihood of non-diagnostic findings. Unlike adults in WV, there is no option for child sexual assault not to be reported—a system of professionals and processes are activated by a report.

All children deserve medical evaluation and treatment after a report of sexual abuse from a medical provider with specific training in this area of medicine. Due to the typical delay in disclosure, many children are brought in for a medical evaluation in a time frame where forensic evidence is unlikely to be recovered.

Child sexual abuse is rarely diagnosed solely on the basis of a physical examination or laboratory findings. Children's injuries heal quickly, and the majority of children with a history of sexual abuse have normal examinations.

III. Medical Evaluation of a Child Sexual Abuse Victim

The medical evaluation of a child sexual abuse victim, in this chapter, refers to an examination of a prepubescent child who has disclosed or is suspected of being sexually abused.

This kind of medical evaluation and collaboration with the system of professionals, meant to protect children and hold perpetrators accountable, requires a very specialized training and skill set. Child victims have different developmental, psychological and health needs compared to adults, and require age-appropriate accommodations.

This is why it is imperative for a child disclosing sexual abuse or suspected of being sexually abused to be seen by a child abuse medical provider who meets national training standards in the evaluation and treatment of child abuse. This ensures that the child will be provided holistic, trauma-sensitive and appropriate care.

For more information and resources on advanced education, supervised clinical practice, and certification for pediatric examiners go to Kidsta.org.

The National Protocol for Sexual Abuse Medical Forensic Examinations for Pediatrics is a guide for medical providers responding to child sexual abuse. It addresses the health care needs of prepubescent children who are victims of sexual assault, as well as children's safety, crisis intervention and advocacy. ***(See Appendix L – Initial Response Flowchart – National Pediatric Protocol.)***

The National Protocol for Sexual Abuse Medical Forensic Examinations for Pediatrics provides these guidelines for medical forensic evaluation of children:[26]

1. Provide children with timely access to examinations, trained examiners, and quality care.
2. Secure the physical and emotional safety of children.
3. Recognize each child has unique capacities and strengths to heal.
4. Offer comfort, encouragement, and support.
5. Provide information about the exam process and links to resources to further address needs.
6. Involve children in decision making, to the extent possible.
7. Ensure appropriate confidentiality.*

The National Protocol for Sexual Abuse Medical Forensic Examinations: Pediatrics, April 2016 can be found at www.kidsta.org.

IV. Role of Child Advocacy Centers in Child Sexual Abuse Medical Evaluations

Child Advocacy Centers (CACs) are child-focused, facility-based programs in which representatives of county Multidisciplinary Investigative Teams (MDITs)—law enforcement, Child Protective Services (CPS), prosecution, mental health providers, medical providers and victim advocacy work together to conduct interviews and make team decisions about the investigation, treatment, management and prosecution of child abuse cases.

In most WV counties, the MDIT works hand-in-hand with the local Child Advocacy Center (CAC). Both MDITs and CACs are defined in **WV State Code (§49-3-101 and §49-4-402).**

In the neutral setting of the CAC, team members can collaborate on strategies that will aid investigators and prosecutors without causing further harm to the child. This innovative, multidisciplinary approach significantly increases the likelihood of a successful outcome in court and long-term healing for the child.

CACs follow the national model established by The National Children's Alliance. The National Children's Alliance sets national accreditation standards for CACs based on research evidence and best practices proven to help children and families heal.

Local CACs provide an array of child-focused services including specialized forensic interviewing, medical evaluation and treatment, trauma-focused evidence-based mental health assessment and treatment, multidisciplinary case reviews, and comprehensive advocacy services.

Go to www.kidsta.org for links to resources for victim advocacy programs for working with child sexual abuse victims and their caregivers.

Per CACs' national accreditation standards, programs must be able to provide children with child abuse medical evaluations as a regular part of the team's community response to child abuse. Exams must be conducted by specialized medical providers under these standards:

- The medical provider must have a baseline level of training specific to the evaluation/treatment of child sexual abuse (such as, but not limited to, Pediatric Sexual Assault Nurse Examiner (P-SANE) training).
- The medical provider must obtain a minimum of 8 continuing education credit hours specific to the field of child abuse per every 2 year CEU cycle for that individual's level of practice.
- The CAC must facilitate the medical provider's access to expert medical review of child sexual abuse evaluations.
- The CAC must make these evaluations available on-site or through community linkages to all child victims, regardless of their ability to pay.
- The CAC and its MDIT(s) must have written protocols for how children are to be given access to appropriate medical evaluation and treatment and circumstances under which this care is recommended by the team.
- Medical findings must be recorded through writing and photo-documentation, with CAC and MDIT members having HIPAA-compliant access to findings to be discussed when making decisions about investigation and treatment.
- CAC staff and non-medical MDIT members must be trained regarding the purpose and nature of the medical evaluation for reported child sexual abuse.

Research has shown that medical providers without specialized training may be less capable of accurately identifying genital structures of children, correctly identifying abnormal findings, and may not know the evaluation techniques that ensure correct diagnoses and findings.

Child sexual abuse exams are often a much-needed opportunity to provide head-to-toe primary care to children. Specifically, the child abuse medical evaluation is a head-to-toe exam for the following purposes:

- Help ensure the health, safety, and well-being of the child
- Evaluate, document, diagnose, and address medical conditions resulting from abuse
- Differentiate medical findings that are indicative of abuse from those which may be explained by other medical conditions
- Document, diagnose, and address medical conditions unrelated to abuse
- Assess the child for any developmental, emotional, or behavioral problems needing further evaluation and treatment and make referrals as necessary
- Reassure and educate the child and family
- Refer for therapy to address the trauma related to the abuse/assault, if not provided by another member of the MDT/CAC

V. Components of the Medical Evaluation

All children/adolescents who are suspected victims of child sexual abuse are entitled to a medical evaluation. The medical evaluation for most children will include a medical history, a physical examination and an external inspection of the genitalia and the anus.

All healthcare professionals should understand the procedures to follow when presented with a child suspected of having been sexually abused. These procedures must be performed and documented by the medical provider who has appropriate knowledge and clinical experience. Otherwise, children, families, community agencies, courts and society may be harmed.[27]

If your county is served by a Child Advocacy Center (CAC), that organization will have a memorandum of understanding with a medical provider who meets national child abuse medical training standards.

The West Virginia Child Advocacy Network, in collaboration with FRIS and other stakeholders, has developed protocols for medical providers responding to child abuse that aid in screening and referrals to care. The protocol contains a visual reference that may be posted in your facility for quick reference. These have been endorsed by the WV Chapter of the American Academy of Pediatrics and the WV Chapter of the American College of Emergency Physicians. ***See Appendices J and K – West Virginia Medical Child Sexual Abuse Response Protocol and West Virginia Medical Child Physical Abuse Response Protocol.***

The initial medical provider needs information from the parent(s) and the child to determine safety concerns and the importance of a prompt examination. A medical evaluation must then be conducted; physical findings identified and documented, forensic materials preserved, and testing done for sexually transmitted diseases (STDs), if appropriate.

The medical evaluation also includes:

- Assessing for any health consequences and providing treatment as needed;
- Assessing the patient and parents' emotional status;
- Reassuring the child and family that the child is "OK" and that any injuries present will heal;
- Helping ensure the health, safety, and well-being of the child;
- Making referrals for counseling, if need is indicated; and
- Providing expert witness testimony, when necessary.

Timely evidence collection is critical to ensure the safety of the child, for medical intervention, for treatment of infections, for documentation and for treatment of injuries, and the recovery of any forensic evidence.

An **acute examination** is conducted when any of the following are present:

- Symptoms or history of recent traumatic sexual contact such as bleeding from the genital or anal area;
- Complaints of anogenital pain;
- Possible sexually transmitted diseases (STDs);
- Need for emergency contraception; or
- The time frame since the incident is within 96 hours of the sexual abuse.

The child should be seen as soon as possible to minimize the loss or deterioration of any evidence on the child's clothing or body.

A **non-acute examination** is conducted when the time frame is more than 96 hours after the incident. In many cases the reporting delay can be several days, weeks or months since the sexual abuse occurred. In non-acute cases, information can be obtained from the documentation of healed injuries or the presence of STDs.

Most medical evaluations of sexually abused children are non-acute. These medical evaluations may be scheduled at a local Child Advocacy Center (CAC) or other medical facility that specializes in the medical evaluation and treatment of the child who has been sexually abused.[28]

The date of the most recent contact should be taken into account when deciding when and where to schedule a medical evaluation.

Each case will need to be evaluated based on the medical history and potential for the collection and preservation of evidence.

See Appendix M – Care of Acute/Non-Acute Cases – National Pediatric Protocol.

VI. Presentation to a Medical Facility

Because of the inability of most children to secure medical treatment on their own, the majority of sexually abused children do not receive immediate medical attention. When medical attention is received, it is usually at the request of a third party.

This request is frequently made by a parent who notices genital soreness and/or discharge or urinary problems, by a teacher who sees a sudden change in the child's behavior, by a relative who suspects physical abuse or by a physician who discovers gonorrhea from a vaginal, urethra or throat culture.

Sometimes a request for a medical evaluation is made by a child protective service (cps) worker or law enforcement officer as part of an on-going investigation.

Collaboration is encouraged among organizations providing services to child sexual abuse victims, utilizing the expertise of professionals who are trained in the medical response and psychodynamics of child sexual abuse.

VII. Development of a Multidisciplinary Team

CACs work collaboratively with multidisciplinary teams to develop county-based protocols that address investigation and treatment in child abuse cases. These protocols include a component related to the medical evaluation and treatment of the child.

Ideally, each community should develop a multidisciplinary team of trained professionals to provide consistent, comprehensive care to children who have been sexually abused. The team may include a pediatrician, physician assistant, pediatric nurse practitioner, Pediatric Sexual Assault Nurse Examiner (SANE-P) for the physical examination; a victim advocate from the rape crisis center, and/or a social worker to provide patient support; law enforcement, a Child Protective Service (CPS) worker, staff from the Child Advocacy Center (CAC) and/or a mental health provider to coordinate the investigation, treatment and advocacy services for children and their families; and the prosecutor for the criminal justice process.

VIII. West Virginia's Protocol for Child Sexual Abuse Medical Evaluation

Recognizing the importance of this coordinated response, in addition to the challenges of finding a specially-trained medical provider, the West Virginia Child Advocacy Network (WVCAN) convened a group of partners and stakeholders to develop a Medical Child Sexual Abuse Response Protocol.

WVCAN, as the statewide alliance of CACs, promotes community awareness and advocacy, provides training and technical assistance to its centers, evaluates and

assess their efficacy, and acquires funding to ensure our CACs are well-equipped to help end the cycle of abuse.

This team built the **WV Medical Child Sexual Abuse Response Protocol *(see Appendix J)*** so that any medical provider or facility can appropriately respond to child sexual abuse victims when they present by alerting appropriate authorities, responding to any emergent medical or behavioral needs, and making appropriate referrals to the professionals specializing in this care.

A "sister" protocol for responding to child physical abuse, **Child Physical Abuse Medical Response Protocol *(see Appendix K)*,** should also be referenced in conjunction with the sexual abuse protocol, as these victimizations can occur hand-in-hand.

Both protocols, plus information about the partners involved in developing these protocols, can be found in the Appendix Section.

It is recommended that the flowcharts, **WV Medical Child Sexual Abuse Response Protocol *(Appendix J)* and the guidelines for Child Physical Abuse Medical Response Protocol *(Appendix K)*** be printed and posted in your medical facility.

A. Consent for the Medical Evaluation

Permission to provide a medical forensic exam must always be obtained. Medical providers must identify the parent/guardian who will be responsible for providing permission for the child's care. Policies and procedures to follow must be in place should the parent/guardian be suspected of the abuse, if a parent/guardian refuses to consent to an exam or if a parent/guardian is not available to provide consent.

Consent may be withdrawn at any time during the exam process. Children and parents/guardians should be informed of their options and their right to decline any of the exam procedures.

A medical provider would **NOT** proceed with an examination without the consent/cooperation of the child, even if the child's parent/guardian have given consent.

The medical provider would never restrain or otherwise force a child to comply with any part of the exam. An exception would be in cases of serious medical injury, pain, or trauma. If a child is not tolerating the examination, consider bringing the child back the next day for re-examination.*

The circuit court, in the county in which they live, may direct the appointment of a special guardian for the purposes of consenting to and providing authorization to provide medical treatment. The circuit court would not consider any petition without support documentation from a licensed physician.

In the event that a child presents to an Emergency Department without a parent or guardian, the attending medical personnel should consult the hospital's policies and procedures regarding conducting a forensic medical examination without a parent being available to provide consent.

B. Presence of Parent(s) or Guardian

As few persons as possible should be present during the medical history interview and medical evaluation. However, children should have the person of their choice available for support. Ideally, the parent or guardian should be supportive of the child/adolescent and help decrease anxiety. Those persons involved in the investigation, such as law enforcement or CPS, should not be in attendance during these procedures.

The pediatrician, physician assistant, pediatric nurse practitioner or Pediatric SANE (SANE-P) will determine if the presence of the parent(s) or guardian may be detrimental to the examination.

If the following situations occur, the parent(s) or guardian should **not** be present:

- When the parent is distraught or disbelieving and this behavior may have a negative effect on the child/adolescent;
- When a parent is acting to censor information the child/adolescent may provide;
- When a history of sexual abuse in the parent may trigger emotions in the parent that may affect the child/adolescent's behavior; or
- When the parent or guardian is the suspect.

The interview or examination should **NEVER** be done in the presence of a parent/guardian who is the suspected of being the abuser.

C. Medical History Interview

An appropriate medical history should be obtained in all cases before performing a medical evaluation. The medical provider (the pediatrician, physician assistant, pediatric nurse practitioner or SANE-P) obtaining the medical history from the child must be sure to use non-leading questions and techniques specific for the child's cultural background and age-appropriate language development.

Attempting to determine exactly what happened to the child and by whom, is the responsibility of the forensic interviewer. An exception to this protocol is if the child makes spontaneous statements about the reported event. If it is necessary to obtain information directly from the child, avoid leading questions. Many times children will respond "yes" to everything based on what they think you want them to answer. Children require more time to process questions and generate their answers. Avoid the use of medical terminology and use words that are easily understood by children. Document what the child says and put it in quotes using the child's exact words.

With children, to a much greater extent than with adults, the medical provider must be aware of the long-term ramifications of the questions that are asked. While the immediate goal is to elicit the clearest possible information from the child, medical personnel should try not to communicate any attitudes or personal feelings that might create or increase the child's trauma. This is especially important in cases of sexual abuse by a family member where, in the child's mind, the action may have been thought to be one of affection.

Physical injuries provide documentation to show the use of physical force and to determine treatment options. The findings, from the history and time frame provided, will help determine consistency with the signs and symptoms of sexual abuse. Throughout the medical evaluation and interviewing process, medical personnel should explain each step of the procedures along with the rationale for doing them.

An assessment of the child's emotional state is a vital part of the medical history interview. This is an age-dependent interpretation. It is also important to note the child's verbal skill level and for the examiner to use terms that are understandable to the child. This assessment may often be accomplished by asking typical questions about family, school, television, and every day events.

Sitting at eye-level with the child can help decrease fear and intimidation and says to the child that you, the medical provider, are genuinely interested.

Talking with children about abuse of any kind, physical or sexual, requires special skills. It can be difficult to get the child to talk or to understand what the child says. When children are asked about their sexual activities with adults or other children, many times their inability or reluctance to answer is due to embarrassment, shyness, a fear of being thought of as a "tattle-tale," disloyal or simply due to a lack of understanding of the question itself.[30]

D. Medical Evaluation

The medical evaluation should include the following:

- Medical history interview
- General physical examination
- Multi-method anal/ genital examination
- Use of photography
- Specialized exam techniques, when needed
- Collection of forensic evidence
- Documentation of findings
- Assessment of findings, treatment and referrals

Familiarity with the normal genital anatomy of infants and preadolescent children is a crucial skill for the medical provider asked to evaluate the child suspected of having been sexually abused.[31]

A normal examination is a common finding in cases of child sexual abuse. A substantial number of children are not physically injured because of the following:

- The abusive act often involves touching, fondling, or genital contact without vaginal or anal penetration;
- The vaginal opening is very elastic, even in prepubertal girls;
- The anal opening may dilate, therefore reducing the chance of injury; and
- The healing of the genital areas can be very rapid.

A normal genital examination can neither confirm nor negate sexual abuse incidents. In cases with obvious physical findings, medical personnel should document that the examination is consistent with the history of child sexual abuse.

The presence or absence of physical evidence does not prove whether a person has been sexually abused. Rather, the examination may provide supportive evidence that can be used to help in prosecution of the case. The ultimate diagnosis of child sexual abuse is made by an analysis of the child's medical history interview and subsequent investigation of the reported child abuse.

An immediate assessment of the child must be made to determine the presence of any significant vaginal, anal, penile or other sites of trauma or bleeding. If present, the control and stabilization of any trauma must be the priority.

The likelihood of finding visible physical evidence of child sexual abuse depends on the following factors:

- Whether force was used
- The size and age differences of the suspect and the child
- Whether a foreign object was placed/forced into the mouth, vulva, or anus
- How the child was positioned and the use of lubricants during the abuse
- Type of abuse and its frequency and chronicity, found that in children with genital injury from sexual assault, healing occurred rapidly and little scar formation resulted; irregular hymenal edges and narrow rims at the point of injury were the most persistent findings.[32]
- Whether the child resisted

For the **female** patient, non-diagnostic visual findings consistent with the history of child sexual abuse include the following:

- Vaginal discharge, urethral inflammation, lymph gland inflammation, pregnancy, recurrent atypical abdominal pain, blood stains on underwear or genital bleeding, genital pruritis, genital bruising
- Abrasions, chafing or bruising to medial thighs
- Bite marks to the thighs, breasts or other areas
- Scarring, tears or distortion to the hymen
- Injury to or scarring of the fossa navicularis or posterior fourchette
- Scars or tearing of the labia minora

For the **male** patient, findings consistent with the history of child sexual abuse include the following:

- Chafing or bruising to the genital region, anus, or back
- Penile discharge, painful urination, penile swelling
- Bite marks to the genital region, anus, or back
- Blood stains on underwear

For the **male and female** patients, the following are findings that can be consistent with the history of child sexual abuse:

- Presence of sexually transmitted diseases,
- Bruises, scars, or anal tears, or
- Tears to the labial frenulum or palatal petechiae.

An initial head-to-toe assessment, carefully looking for signs of injuries on the child's body, should be completed first. After the full examination, an alternate light source should be passed over the child to determine if seminal fluid is present on the body. If present, these areas should be swabbed.

A thorough physical examination should be carried out, with findings documented on the body diagrams. Photographic documentation should be requested if necessary.

The presence of any bruises, abrasions, lacerations, burns or other injuries should be documented, along with descriptions of the injuries, noting hematomas and the degree of healing of any abrasions. Fractures, loose or absent teeth, grab marks, suction or bite marks should also be documented.

Painful procedures, such as blood drawing, should be done nearer the end of the exam; and the genital/anal examination as the last part of the complete examination.

Each step in the examination process should be explained to the child prior to being performed. In some situations, if the child is not able to cooperate, the exam should be rescheduled for another time.[36]

Keys to minimizing trauma in an examination include:

- Adequate preparation of the child
- Skilled examiners who are familiar with various examination positions
- Approaching the child with confidence and sensitivity
- Communicating with the child in a developmentally appropriate way

1. Evidence Collection

Selective completion of the kit with a child patient may be most appropriate. The kit should be used to collect evidence in cases of child sexual abuse occurring within 96 hours (4 days) or when circumstances warrant evidence Collection past the 96 hour time frame. Detailed instructions for the collection of evidence for children can be found in the WV Child Sexual Abuse/Assault Medical Response Protocol *(Appendix J)* or refer to the National Pediatric Protocol Sexual Abuse Medical Forensic Examinations for Pediatrics at http://www.kidsta.org/?page=PediatricProtocol.

2. Child Genitalia Examination – Females

Medical personnel must also 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. However, a careful visual inspection should still be made.

Girls are examined in a frog-leg position or supine on the examining table so that genitalia can be fully viewed in a manner that is not painful or invasive.[33]

The presence of erythema, hematomas, excoriations, abrasions, old scars and bleeding, as well as the overall appearance of the introitus and the interlabial spread after traction, should be documented. The urethral meatus should be examined for any signs of trauma or abnormal dilation. Inspection of the vaginal area should also be directed to any discharge, odors, evidence of foreign bodies, tears, skin tags and tenderness.

Intentional trauma usually results in injury to structures such as the hymen, posterior fourchettte, fossa navicularis and the anus.

All females have a hymen.[34] The hymen is a membranous collar that surrounds the vaginal opening, rarely completely. There are anatomical variations in both the size and types of openings of the hymen. There are 3 basic kinds: fimbriated hymen, annular hymen and crescentic hymen.

The size of the hymenal opening is based on relaxation, position, technique used, and anatomic structure. The hymen is rarely affected in non-intentional trauma like straddle injury or falls. When a female lacks estrogen the hymen is sensitive to touch, appears thin, smooth and atrophic. When a female has high levels of estrogen, the hymen appears to be white and thick, quite redundant and is not sensitive to touch.

Internal speculum exams on children are administered in **ONLY** extreme cases, such as a life-threatening situation or when the removal of a foreign object would cause undue pain and trauma to the child. These exams would be done in the Operating Room with a recommendation that general anesthesia be used.

3. Child Genital Examination – Males

Both the glans and the scrotal area are targets of trauma in acute sexual assault. Evidence of erythema, bruises, suction marks, excoriations, burns or lacerations of the

glans and frenulum should be documented. The presence of testicular or prostatic tenderness or discharge from the urethra may reflect trauma or infection and may be a sign of abuse.

4. Child Anal and Perianal Examination – Both Males and Females

Medical personnel must decide on a case-by-case basis the extent to which anal examinations should be performed for children, both male and female, during the initial examination.

Recent anal trauma may manifest itself by perianal erythema, edema or contusions, skin tags and spasms of the anal sphincter. An examination of the sphincter tone for spasm or laxity is important. Any findings should be noted. Use of photography has been of value in detecting small scars and striations not previously visible to the eye.

If anal tears or bleeding are present, an anoscopy should be performed only by medical personnel trained to do the exam.

E. Children and STDs

It is important to recognize that the diagnosis of an STD in a prepubescent child may be evidence that the child has experienced sexual abuse. The CDC (2015e) noted the identification of sexually transmissible agents in children beyond the neonatal period strongly suggests sexual abuse (Jenny, Crawford-Jakubiak, & Committee on Child Abuse and Neglect, 2013).

Medical evaluation for children should include:

- Determining if an STD is present, then treatment would be essential
- Acquiring evidence for use in a criminal investigation, should that be necessary

In any case that a prepubescent child presents with an STD, an investigation should be conducted on an individual case-by-case basis, taking into account the risk factors and contacts, information obtained from the medical and social history and the medical evaluation conducted for sexual abuse. (*Black et al., 2009; CDC 2015e; Jenny, Crawford-Jakubiak, & Committee on child Abuse and Neglect, 2013; Girardet et al., 2011).*

STD presumptive treatment is NOT recommended until after initial tests are conducted and positive results are confirmed with follow up test (CDC, 2015e).[38]

Factors that indicate the need for STD testing for prepubescent children, regardless of whether the case is acute or non-acute include:[39]

- Child experienced penetration or there is evidence of recently healed penetrative injury to genitals, anus or oropharynx
- Child has been abused by a stranger

- Child has been abused by a perpetrator known to be infected with a STD or at high risk for STDs[37] (e.g., intravenous drug users, men who have sex with men, people with multiple sex partners, and those with histories of STDs)
- Child has a sibling or other relative or person in the household with an STD
- Child lives in an area with a high rate of STDs in the community
- Child has signs or symptoms of STDs (e.g., vaginal discharge or pain, genital itching or odor, urinary symptoms, and genial lesions or ulcers)
- Child has been diagnosed with one STD

If no infections were identified during the medial forensic evaluation and the exposure was recent, a repeat examination and testing should be done approximately 2 weeks after initial testing.

Medical providers should offer information about the risks of STDs for this population, symptoms, the necessity for testing, treatment options upon diagnosis and follow—up testing and care (adapted from the *National Protocol for Sexual Abuse Medical Forensic Examinations: Pediatric*).

For more information refer to *Appendix N – STD National Pediatric Protocol*.[40]

IX. POST-EXAMINATION INFORMATION

A. Referrals and Follow-Up

Document all information needed for any follow-up care. It is extremely important that children return for follow-up visits. A follow-up visit approximately 2 weeks after the most recent sexual exposure can include a repeat physical examination and collection of additional specimens. To allow sufficient time for antibodies to develop, another follow-up visit approximately 12 weeks after the most recent sexual exposure might be necessary.

CDC recommends repeat serologic testing for syphilis and HIV at six (6) weeks, three (3) months and six (6) months after the assault.[41]

A single examination might be sufficient if the child was abused for an extended period and if a substantial amount of time elapsed between the last suspected episode of abuse and the medical evaluation.

Refer the child for any follow-up tests or services. The provision of psychological and/or counseling services for children and their parent(s) or guardian(s) is important. This referral should be made to the rape crisis center, Child Advocacy Center (CAC), or other appropriate agency in the community.

B. Human Immunodeficiency Virus (HIV)

The risk of the child acquiring HIV as a result of sexual abuse must be considered during the medical evaluation. If there is a risk in an individual case, provision of HIV non-occupational post-exposure prophylaxis (nPEP) must be an option. The sooner nPEP is initiated after the exposure, the higher the likelihood that it will prevent HIV transmission, if HIV exposure did occur (Day & Pierce-Weeks, 2013). There is a short timeline to start nPep—no later than 72 hours post –exposure.[42]

Understand that the decision to recommend HIV serologic testing, as well as HIV nPEP, depends on local epidemiology, a case -by-case assessment of risk factors of the perpetrator, and details of the contact. The risk for an individual patient is extremely difficult to calculate, since details about the perpetrator's risk factors and HIV status are usually unknown.[43]

See Appendix O – HIV Testing nPEP – National Pediatric Protocol.

C. Discharge Information

Medical providers should check all forms for completeness of information and signatures. Procedures for handling any discharge paperwork should follow each hospital's policies and protocols.

Provide written documentation with "After Care Instructions and Resources."

ENDNOTES

[1] Paragraph adapted partially from Ohio Department of Health, *Ohio Protocol for Sexual Assault Forensic and Medical Examination* (Columbus, OH: Ohio Department of Health, Division of Prevention, Bureau of Health Promotion and Risk Reduction, Sexual Assault and Domestic Violence Prevention, 2012), .

[2] Paragraph drawn partially from American College of Emergency Physicians, *Evaluation and management of the sexually assaulted or sexually abused patient* (Dallas, TX, 1999. Updated 2013).

[3] E. Nugent-Borakove, P. Fanfli, D. Troutman, N. Johnson, A. Burgess, A. Lewis O'Conner, *Testing the efficacy of SANE/SART programs: Do they make a difference in sexual assault arrest & prosecution outcomes*? (2006), available at http://www.ncjrs.gov/pdffiles1/nij/grants/214252.pdf.

[4] West Virginia Bureau for Public Health, Health Statistics Center, *Behavioral risk factor surveillance system survey*. (Charleston, WV: Department of Health and Human Resources. 2008). See http://www.wvdhhr.org/bph/hsc/.

[5] D. Kilpatrick & J. McCauley, *Understanding national rape statistics*. (Harrisburg, PA: VAWnet: A project of the National Resource Center on Domestic Violence/Pennsylvania Coalition Against Domestic Violence, 2009).
Retrieved from http://www.vawnet.org.

[6] G. Abarbanel, Sexual assault background reading*, Consular Assistance to Victims of Crime* (Washington, DC: U.S. Department of State, 2004), available at www.state.gov/documents/organization/86842.pdf. As cited in training material from the Office for Victims of Crime's 2010 National Victim Assistance Academy [Track 1, foundation-level training, sexual assault]. This material was originally authored in 2007 by A. Seymour and reviewed by M. Gaboury and L. Ledray.

[7] Abarbanel.

[8] Abarbanel.

[9] Abarbanel.

[10] S. Gentlewarrior, *Culturally competent service provision to lesbian, gay, bisexual and transgender survivors of sexual violence* (Harrisburg, PA: VAWnet, a project of the National Resource Center on Domestic Violence/Pennsylvania Coalition Against Domestic Violence, 2009), available through http://www.vawnet.org.

[11] Taken from Prevent child abuse America fact sheet: *Sexual abuse of boys*. Retrieved March 17, 2011 from http://member.preventchildabuse.org/site/DocServer/sexual_abuse_of_boys.pdf?docID=127.

[12] Information from West Virginia Bureau for Public Health.

[13] Centers for Disease Control and Prevention, *Sexual violence facts at a glance* (Atlanta, GA: National Center for Injury Prevention and Control, 2008), available through http://www.cdc.gov/ViolencePrevention/.

[14] Paragraph was adapted from Understanding the Neurobiology of Trauma. Rebecca Campbell, Ph.D., Bracha, 2004; Southwick et al., 2005; Zoladz, 2014.

[15] Paragraph was adapted from Office on Violence Against Women, *A national protocol for sexual assault medical forensic examinations, adults/adolescents* (Washington, D.C.: U.S. Department of Justice, 2004), 57, available through http://www.ncjrs.gov/pdffiles1/ovw/206554.pdf.

[16] Drawn from California Governor's Office of Criminal Justice Planning, *California medical protocol for examination of sexual assault and child abuse victims* (Sacramento, CA: Governor's Office of Criminal Justice Planning, 2001), 56.

[17] Drawn from California Governor's Office of Criminal Justice Planning; and American College of Emergency Physicians, 113.

[18]Drawn from the California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims, 2001, p. 56, and the American College of Emergency Physicians' Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient 1999, p. 113.

[19]Centers for Disease Control and Prevention. *Sexually transmitted diseases treatment guidelines ((*Atlanta, GA:
National Center for Injury Prevention and Control, 2015. Available through http://www.cdc.gov/std/treatment/.

[20] Centers for Disease Control and Prevention, *Sexually transmitted diseases.*

[21] Centers for Disease Control and Prevention*, Sexually transmitted diseases*

[22] Centers for Disease Control and Prevention*, HIV, 2015).*

[23] Centers for Disease Control and Prevention, 2015).

[24] Adapted from L Ledray. Sexual Assault Nurse Examiner Development and Operation Guide. Office for Victims of Crime, Department of Justice, Washington, DC, 2016.

[25] Guidelines for the Suspect Examination were adapted from the Training Bulletin: - End Violence Against Women International and Palmetto Health Richland / Baptist SANE Program, 2013.

[26] Information was adapted from the National Protocol for Sexual Abuse Medical Forensic Examinations: Pediatrics, April 2016. This protocol benefited from guidance offered in *The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs* (Day & Pierce-Weeks, 2013), *Updated Guidelines for the Medical Assessment and Care of Children Who May Have Been Sexually Abused* (Adams et al., 2015), and *Medical Response to Child Sexual Abuse: A Resource for Professionals Working with Children and Families* (Kaplan et al., 2011). It also adapted recommendations, where applicable, from the U.S. Department of Justice's *National Protocol for Sexual Assault Medical Forensic Examinations—Adults/Adolescents* (2013). Available at www.kidsta.org.

[27] N. Kellog and the Committee on Child Abuse and Neglect. *The evaluation of sexual abuse in children*. (Pediatrics, 2005); 116; 506-512.

[28]G.. Horno, *A normal ano-genital exam: sexual abuse or not?* (J. Pediatric Health Care, 2010,) May-June, 24[3], Epub 2008, Dec.18); 145-51.

[29]K..L. Young, J.G. Jones, T. Worthington, P. Simpson and P. H. Casey. *Forensic laboratory, evidence in sexually abused children and adolescents. (Arch Pediatric Adolescent Medicine* 2006),150[6], 585-8.

[30] National Protocol for Sexual Abuse Medical Forensic Examinations for Pediatrics, 2016.

[31]K.L. Young, J.G. Jones, T. Worthington, P. Simpson and P. H. Casey. *Forensic laboratory, evidence in sexually abused children and adolescents. (Arch Pediatric Adolescent Medicine* 2006),150[6], 585-8.

[32]C. Jenny, J. Crawford- Jakubiak, & Committee on Child Abuse and Neglect. *The Evaluation of children in the primary care setting when sexual abuse Is suspected*. (2013).

[33]Centers for Disease Control and Prevention, *Sexually transmitted diseases.*

[34]C. Jenny, J. Crawford- Jakubiak, & Committee on Child Abuse and Neglect. (2013).

[35]National Protocol for Sexual Abuse Medical Forensic Examinations for Pediatrics. (2016).

[36] National Protocol for Sexual Abuse Medical Forensic Examinations for Pediatrics. (2016).

[37]Centers for Disease Control and Prevention. *Sexually transmitted diseases.*

[38]Non-Occupational Post-Exposure Prophylaxis for HIV: 10-Year Retrospective Analysis in WA., 2014.

[30]S. M. Lowe, N. Rahman, G. Forster. *Chain of evidence in sexual assault cases*. (Int. J. STD/AIDS, 2009; Epub 2009, Oct. 15), 799-800.

[31]Spencer. *Criteria for the use of speculum in children.* (Topics of Emergency Medicine, 2005).

[32]C. Boyle, J. McCann, S. Miyamoto, K. Rogers. *Comparison of examination methods used in the evaluation of pre-pubertal and pubertal female genitalia: a descriptive study.* (2008).

[33]There is no documented case of an infant girl born without a hymen. As cited in 3 studies Jenny, et.al. (1987), Mor & Merlob, (1988), Berenson, (1992) over 29, 199 newborn girls were examined: all had hymens.

[34]Section taken from Centers for Disease Control and Prevention. *Sexually transmitted diseases.*

[35]Spencer. *Criteria for the use of speculum in children.* (Topics of Emergency Medicine, 2005).

[36]K.L. Young, J.G. Jones, T. Worthington, P. Simpson and P. H. Casey. *Forensic laboratory, evidence in sexually abused children and adolescents. (Arch Pediatric Adolescent Medicine* 2006),150[6], 585-8.

[37]C. Jenny, J. Crawford- Jakubiak, & Committee on Child Abuse and Neglect. *The Evaluation of children in the primary care setting when sexual abuse Is suspected*. (2013).

[38]Centers for Disease Control and Prevention, *Sexually transmitted diseases.*

[39]C. Jenny, J. Crawford- Jakubiak, & Committee on Child Abuse and Neglect. (2013).

[40]National Protocol for Sexual Abuse Medical Forensic Examinations for Pediatrics. (2016).

[41]National Protocol for Sexual Abuse Medical Forensic Examinations for Pediatrics. (2016).

[42]Centers for Disease Control and Prevention. *Sexually transmitted diseases.*

[43]Non-Occupational Post-Exposure Prophylaxis for HIV: 10-Year Retrospective Analysis in WA. (2014).

REFERENCES

1. *CALIFORNIA MEDICAL PROTOCOL FOR EXAMINATION OF SEXUAL ASSAULT,* Office of Criminal Justice Planning, State of California, Sacramento, CA: January 2001.
2. *EVALUATION AND MANAGEMENT OF THE SEXUALLY ASSAULTED OR SEXUALLY ABUSED PATIENT,* American College of Emergency Physicians, Dallas, Texas, June 1999.
3. *First Response to Victims of Crime,* US Department of Justice, Office of Justice Programs, 2008.
4. *Health Care—Women & The Law: A Legal Rights Handbook,* West Virginia Women's Commission and the Women Lawyer's Committee, West Virginia State Bar, Charleston, West Virginia, 2009 On-line Edition
5. *Investigating Sexual Assault Model Policy,* International Association of Chiefs of Police, National Law Enforcement Policy Center, Arlington, Virginia, 2005. http://www.ncdsv.org/images/IACP_InvestigatingSAConceptsIssuesPaper_7-2005.pdf.
6. *NATIONAL PROTOCOL FOR SEXUAL ASSAULT MEDICAL FORENSIC EXAMINATIONS: ADULTS/ ADOLESCENTS,* Office on Violence Against Women of the U.S. Department of Justice, Washington, DC: September 2013.
7. *NEW HAMPSHIRE SEXUAL ASSAULT: AN ACUTE CARE PROTOCOL, FOR MEDICAL / FORENSIC EVALUATION—FOURTH EDITION,* Office of the Attorney General, State of New Hampshire, 2012.
8. *OHIO PROTOCOL FOR SEXUAL ASSAULT FORENSIC AND MEDICAL EXAMS,* Ohio Department of Health, Columbus, OH: Revised 2012.
9. *Pediatric Sexual Assault Nurse Examiner's Training Manual,* D. Faugno, 2010.
10. Rennison, C. A. (2002). Rape and sexual assault: Reporting to police and medical attention, 1992-2000 NCJ 194530]. Retrieved from the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics: http://bjs.ojp.usdoj.gov/content/pub/pdf/rsarp00.pdf.
11. *Sexual Assault Nurse Examiner Development and Operation Guide,* Linda E. Ledray, Office for Victims of Crime of the U.S. Department of Justice, Washington, DC: 2016. The Technical Assistance Source for Pediatric Sexual Assault Forensic Examinations. International Association of Forensic Nurses. Made possible by the Office on Violence Against Women, U.S. Department of Justice. 2015.
12. *Victims with Disabilities: Collaborative, Multidisciplinary First Response,* The Office for Victims of Crime, US Department of Justice, Office of Justice Programs, 2009. http://www.ovc.gov/publications/infores/pdftxt/VwD_FirstResponse.pdf
13. *West Virginia Medical Child Sexual Abuse Response Protocol and West Virginia Medical Child Physical Abuse Response Protocol. A* project of the West Virginia Child Advocacy Network (WVCAN) funded by the Claude Worthington Benedum Foundation and the Bernard McDonough Foundation. Endorsed by the West Virginia Chapter of the American Academy of Pediatrics and the West Virginia Chapter of the American College of Emergency Physicians.
14. *WV S.A.F.E. Training and Collaboration Toolkit: Serving sexual violence victims with disabilities* (West Foundation for Rape Information Services, Northern West Virginia Center for Independent Living, & West Virginia Department of Health and Human Resources, 2010), B8. Emotional trauma.

APPENDICES

Advocacy
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Appendix B – Protection Orders

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Appendix K – West Virginia Child Physical Abuse Medical Response Protocol
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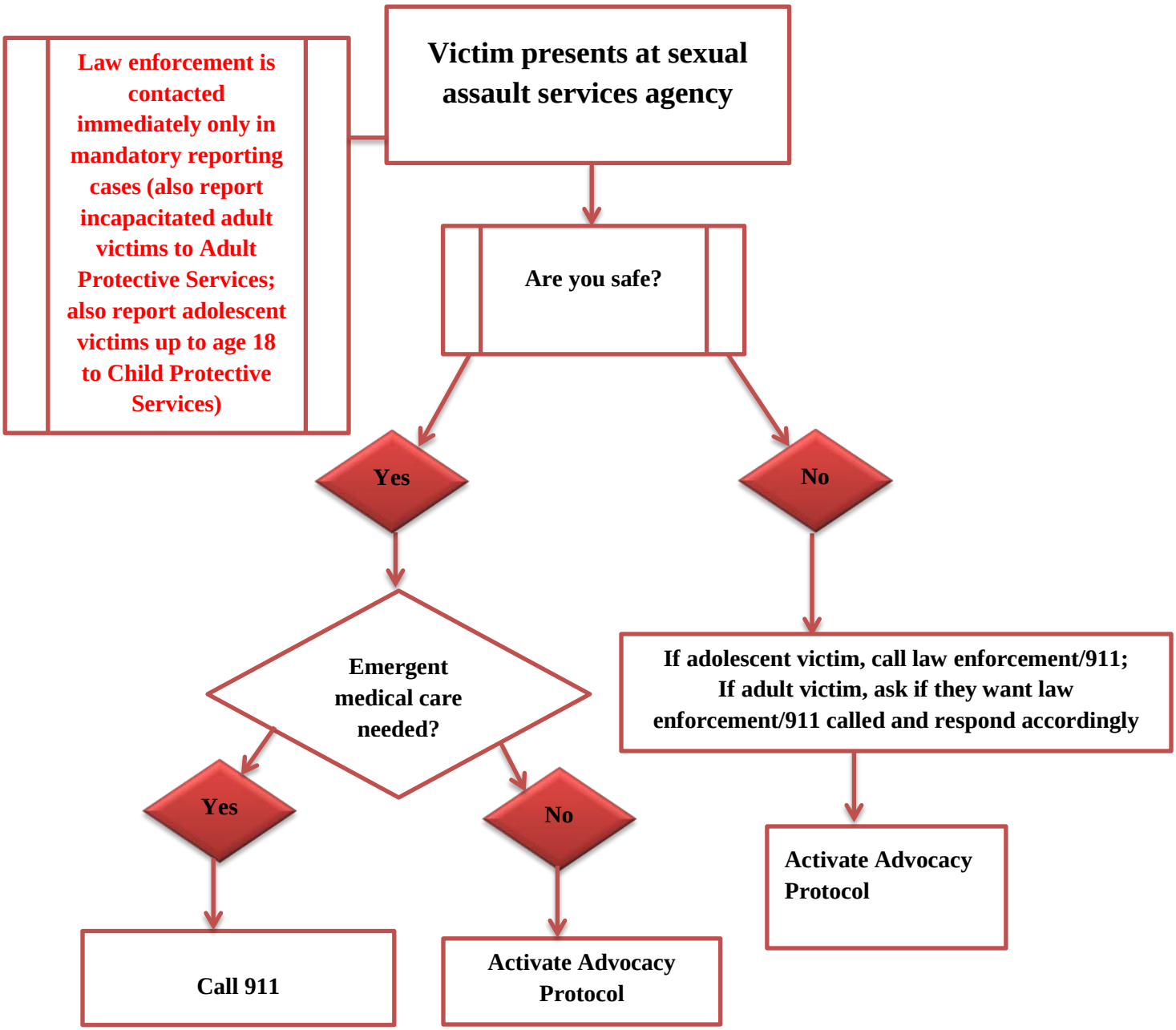
Appendix M – Care of Acute/Non Acute Cases – National Pediatric Protocol
Appendix N – STD National Pediatric Protocol
Appendix O – HIV National Pediatric Protocol

Adult/Adolescent Sexual Assault Victim Presents for Sexual Assault Advocacy Services



WEST VIRGINIA PROTECTIVE ORDERS

Note: The West Virginia statute regarding protective orders can change during any legislative session. The information below was current as of January 2017. The section of the WV Code relating to protective orders **§53-8-4** and can be found at http://www.legis.state.wv.us/WVCODE/Code.cfm?chap=53&art=8#08.

West Virginia Code provides protection for victims of:

1. sexual assault/abuse, stalking, and repeated credible threats of bodily injury through the Personal Safety Order (PSO), and
2. domestic violence, stalking and harassment through the Domestic Violence Protective Order (DVPO).

Eligibility for the orders is determined by state code based on the relationship of the victim to the offender and by the type of crime committed. A victim abused/stalked by a family or household member is eligible only for a DVPO. A victim of a sex offense or stalking in non-domestic situations is eligible only for a PSO. Both initial orders are granted through magistrate court and filing fees may be waived. If the magistrate grants the temporary PSO, a final hearing on the PSO will be scheduled and heard by the magistrate. If magistrate grants a DVPO, then a final hearing on the DVPO will be scheduled and held by the family court. These are civil remedies, and there is no obligation to file a criminal report to obtain a PSO or DVPO.

A PSO can be requested by a parent, guardian or custodian on the behalf of a minor child or an incapacitated adult. A DVPO can be requested by an adult family or household member for the protection of the victim or for any family or household member who is a minor child or physically or mentally incapacitated to the extent that he or she cannot file on his or her own behalf.

Filing a PSO and a DVPO consists of completing a 'fill in the blank' form/petition. For a PSO, there will be a space to describe the most recent incident with the offender, and can include any previous harm or injury. For a DVPO there will be a space to describe the abuse or threats of abuse that led to filing the petition.

For a PSO, *an address may be omitted from the form at the discretion of the court.* This can be requested by explaining to the court any safety concerns. For a DVPO, an address may be omitted from the form by checking a box on the first page of the DVPO Petition.

Protective orders can be temporary (up to 10 days) or long term. The victim must attend all court proceedings for a petition to be considered. Upon filing a petition for an order, if a magistrate finds reasonable cause to believe the alleged offender committed the offense, then a temporary order can be issued.

⇒ Under a DVPO, remedies may include ordering the offender to 'stay away' (e.g., refrain from direct or indirect contract), temporary child custody, possession of the residence and/or support.

⇒ A PSO may include:

a. An order to stop making threats or acting on threats;
b. An order to not contact or try to contact the victim directly or through friends and family;
c. An order to stay away from the victim's home, work, and/or school. If the parties work together, the court cannot order an offender to stay away from their own work;
d. An order to not visit, molest, or interfere with the victim's life. If the victim is a minor, this protection can extend to brothers and sisters.
e. An order to prohibit possession of a firearm if the victim was threatened with a gun, or if the offender has violated previous orders or been convicted of an offense involving a gun.

The magistrate court may extend the order or hold a final PSO hearing. At the final hearing, the PSO order may be issued for up to two years. A DVPO is usually granted for ninety or one hundred eighty days and may be automatically extended for an additional ninety days if the petitioner files a written request prior to the expiration of the original order. In certain limited circumstances, a DVPO can be issued for a period of one year and in some divorce cases, a DVPO may be issued for longer than one year.

PSOs and DVPOs are both confidential orders that are sealed from the general public. Hearings for PSOs and DVPOs cannot be attended by the general public. Victims may take someone with them to a hearing for support, but the support person/advocate may not speak during the hearing.

Rape crisis centers advocates are available to support victims while filing protective orders. Legal Aid of West Virginia is in partnership with the rape crisis centers and domestic violence programs in the state and provides free consultation/representation at protective order hearings in several counties when legal counsel is available and eligibility guidelines are met. This service through Legal Aid is accessed through the rape crisis services and domestic violence programs.

The two types of protective orders differ in several areas, as the following chart describes.

PERSONAL SAFETY ORDER (PSO)	DOMESTIC VIOLENCE PROTECTIVE ORDER (DVPO)
WHO CAN FILE? • Victim of sexual offense (completed or attempted) or stalking[1] in non-domestic situation • Victim repeated credible threats of bodily injury causing to fear for safety • Victims who are not eligible for DVPO • Parent, guardian or custodian on behalf of a child or incapacitated adult **WHAT IS INVOLVED?** • Content of petition narrative must give nature and extent of the underlying act (completed or attempted sexual offense, stalking); any previous or pending actions between the parties • Parties cannot live with, be related to, or otherwise have a current or past intimate relationship with each other (but victim in this situation could file a DVPO) • If petition is denied, court costs may apply unless prohibited by law[2] but waiver options may be available[3] • No criminal charges need filed to be eligible for a PSO • Firearms prohibition is discretionary • PSO not put on DVPO registry **WHERE DOES THIS TAKE PLACE?** • Petition is filed in Magistrate Court in county where either part is living or the act occurred • Temporary and final hearings are in Magistrate Court • Appeals of issuance or denials are re-heard in Circuit Court (*de novo*) **HOW LONG DOES THE ORDER LAST?** • As stated in the order; can't exceed 2 yrs.	**WHO CAN FILE?** • Victim of stalking/ harassment or domestic violence by a family/household member • Adult family or household member on behalf of a child or an incapacitated adult • Someone who saw or reported domestic violence and, as a result has been abused, threatened or intimidated **WHAT IS INVOLVED?** • Content of petition must show that the respondent committed domestic violence or abuse • The petitioner and the respondent must be family or household members, which include persons with (a) current or past partner relationships (married, dating, living together, parents of a child, roommates, etc.); (b) close family relationships (parents, grandparents, siblings, aunts, uncles, etc.); or (c) a combination of family and partner relationships • Firearms prohibition • DVPO put on statewide electronic registry **WHERE DOES THIS TAKE PLACE?** • Petition is filed in Magistrate Court • Ex parte hearing for Emergency Protective Order (EPO) is in Magistrate Court • DVPO final hearing is in Family Court • If the EPO is denied, the petitioner may appeal to Family Court **HOW LONG DOES THE ORDER LAST?** • As stated in the order; 90, 180 or 365 days

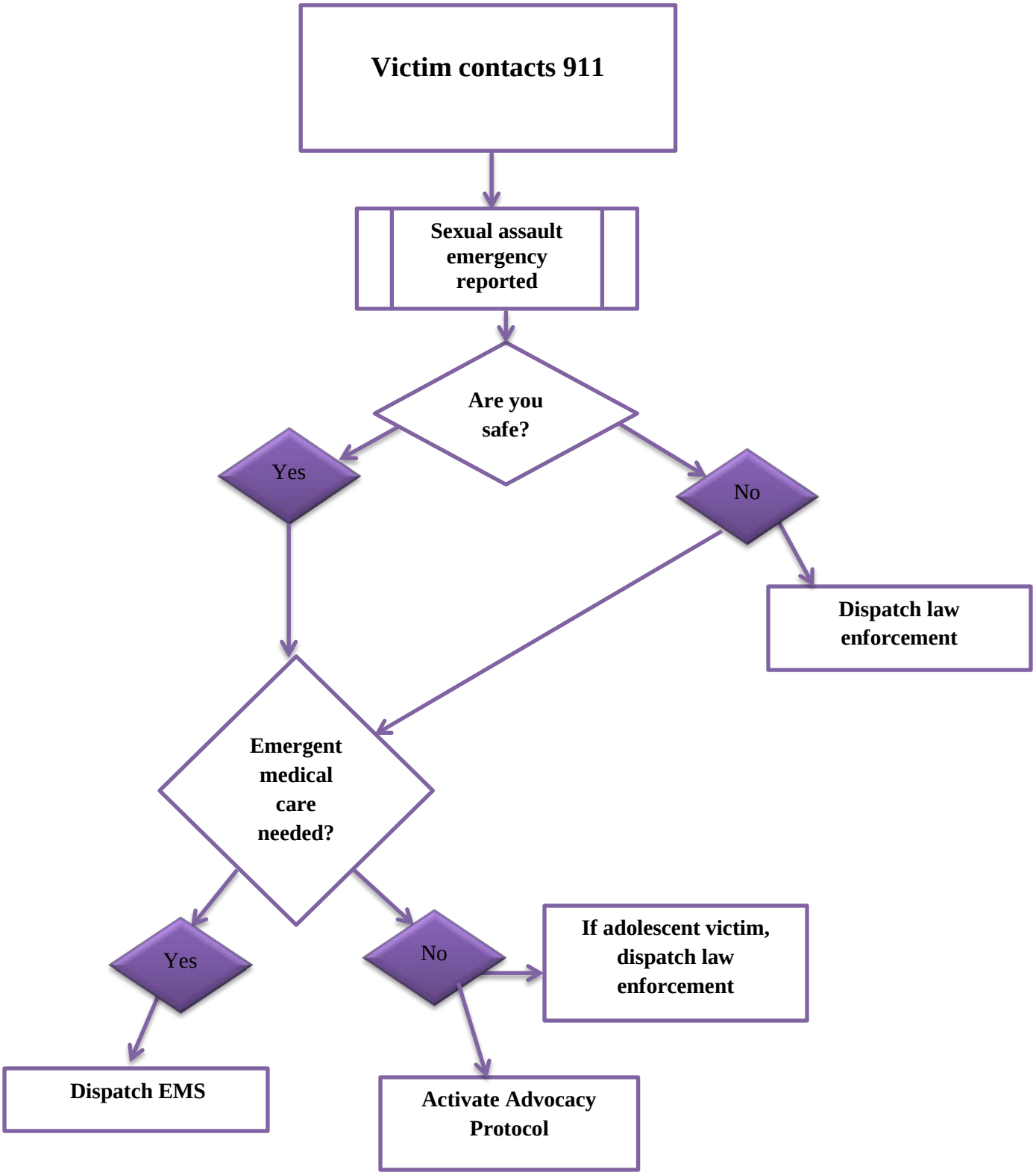
[1] §61-2-9a. Stalking; harassment; penalties; definitions.

(a) Any person who **repeatedly follows** another knowing or having reason to know that the conduct causes the person followed to reasonably fear for his or her safety or suffer significant emotional distress, is guilty of a misdemeanor and, upon conviction thereof, shall be incarcerated in the county or regional jail for not more than six months or fined not more than one thousand dollars, or both.

[2] VAWA prohibits assessing fees against victims of sexual assault and stalking.

[3] Petitioner can file a fee waiver if unable to pay.

Adult/Adolescent Sexual Assault Victim Contacts 911



APPENDIX D - TRANSFER FORM FOR NON-REPORTS

Request to Transfer a Non-Report Sex Crime Evidence Collection Kit

As a result of a report of a crime of sexual assault, forensic evidence was collected as a non-report to law enforcement. A request to open an investigation has been made by the victim and that requires that the sex crime evidence collection kit that was stored at Marshall University Forensic Science Center (MUFSC) as a non-report be transferred to the WVSP Forensic Laboratory.

A WVSP Case Submission Form 53 must be submitted to the WV State Police Forensic Laboratory prior to the transfer of the sex crime evidence collection kit.

You ***must*** notify the WV State Police Forensic Lab, at 304-746-2473, that you are submitting the Case Submission Form 53 without the sex crime evidence collection kit.

Once MUFSC is notified that the Submission Form 53 has been received by the WV State Police Forensic Lab, the sex crime evidence collection kit will be directly transferred to the lab via a secure carrier.

The transfer of the sex crime evidence collection kit requires the following information be submitted.

Date of Request:

Sex Crime Kit Tracking Number:

Agency Case Number:

Agency Name:

Agency Address:

Investigator Name and Title:

Investigator Telephone:

Investigator Email:

Print Form

Press the Print Form button above.

Sign and date the printed request.

Forward a hardcopy to:

Attn: Non-Report SA Kit Program
Marshall University
Forensic Science Center
1401 Forensic Science Drive
Huntington, WV 25701

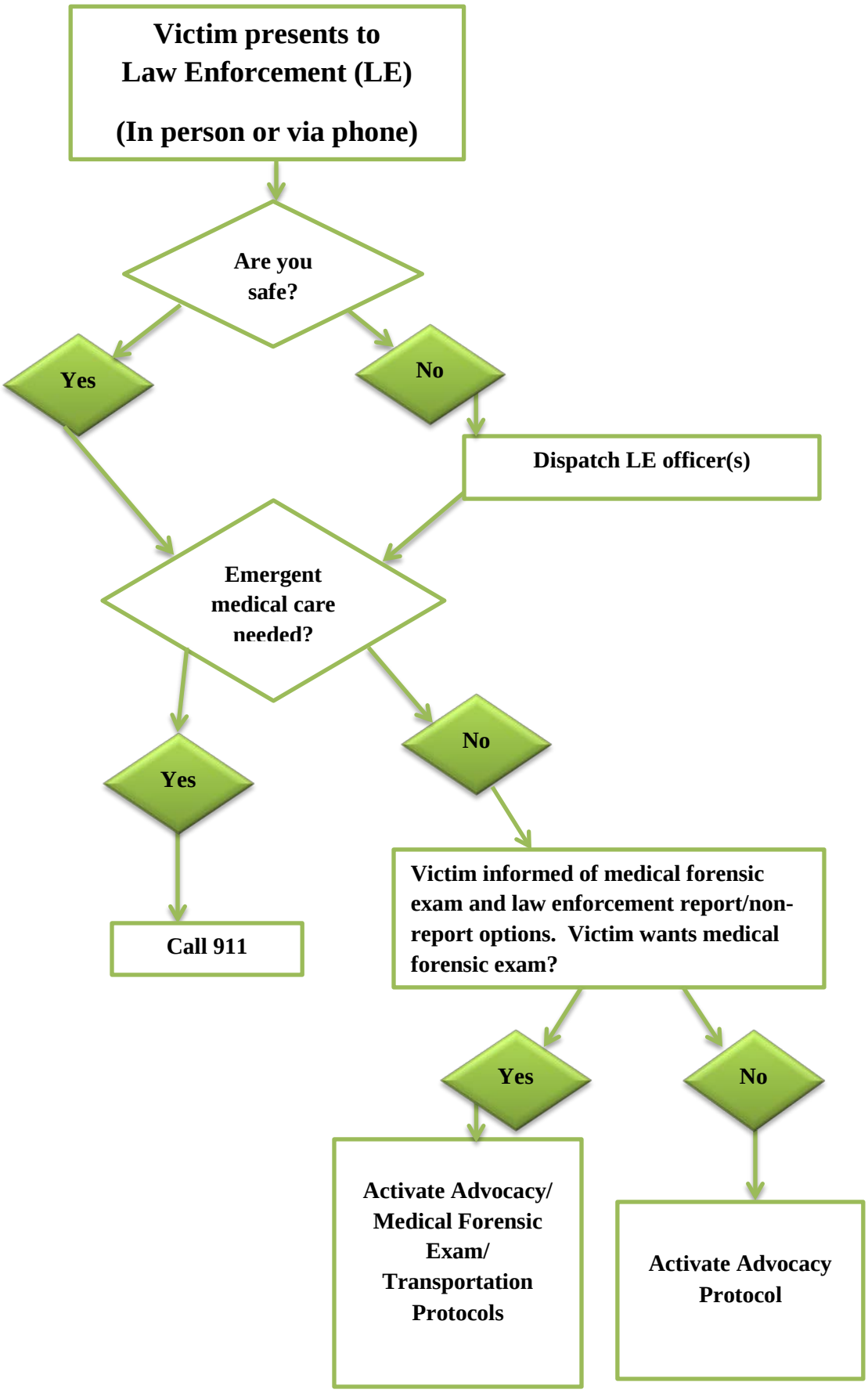
Signature: _____

Print Name: _____

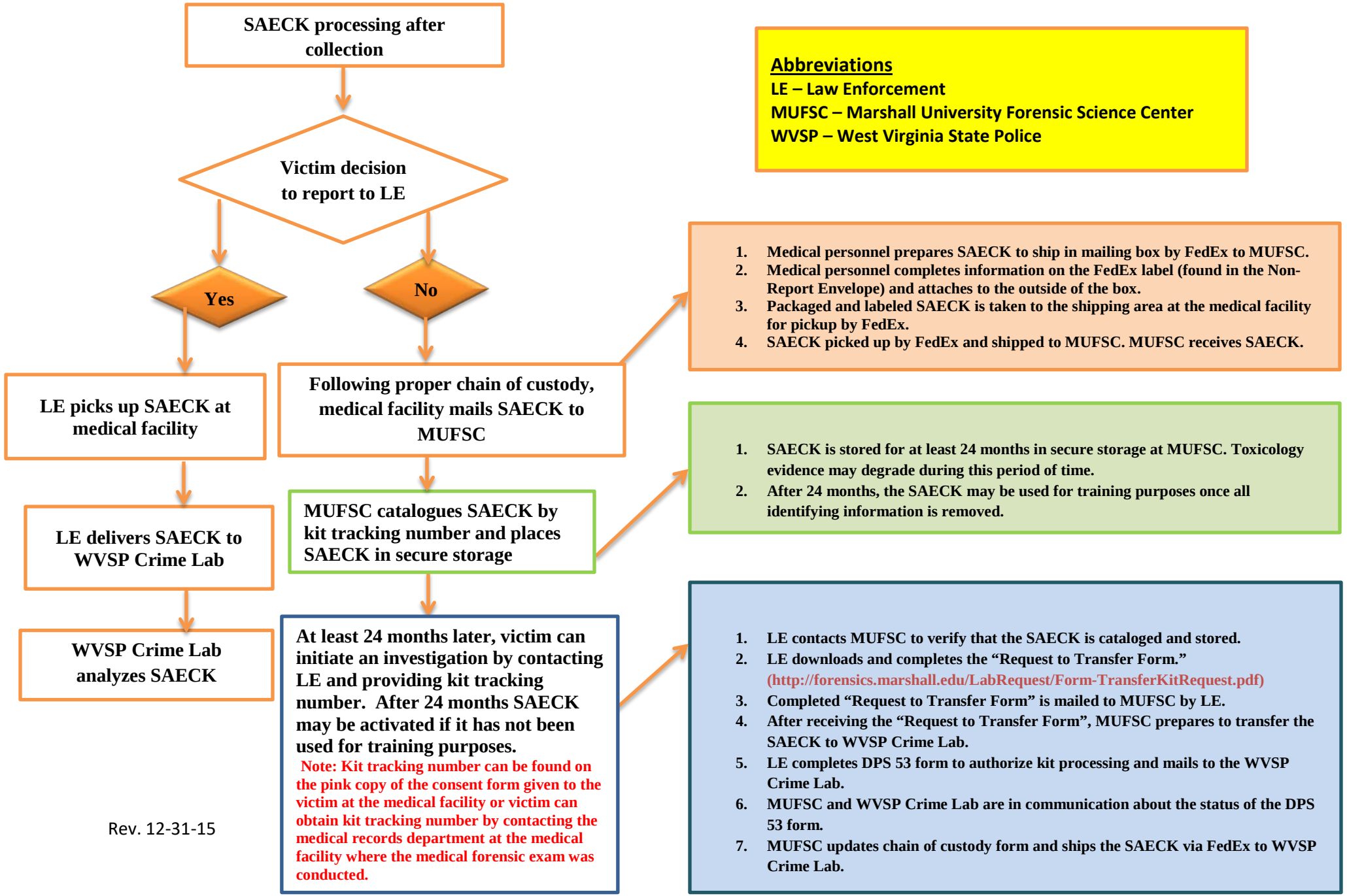
Date: _____

Your request will not be fulfilled if all the required information is not provided. Please double check the information you have entered before submitting your request.

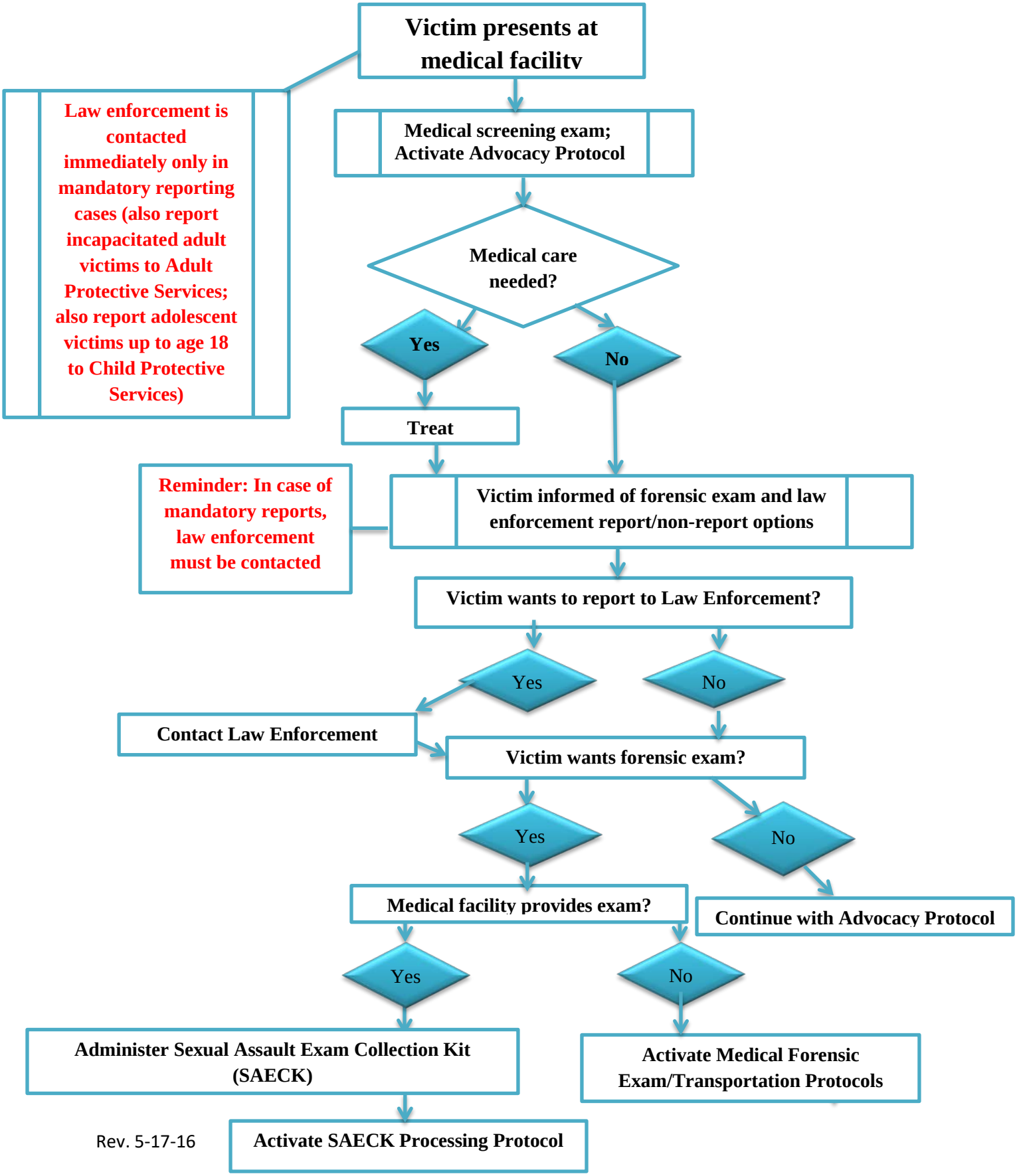
Adult/Adolescent Sexual Assault Victim Presents to Law Enforcement



Processing of the Sexual Assault Evidence Collection Kit (SAECK) After Collection



Adult/Adolescent Sexual Assault Victim Presents at Medical Facility



APPENDIX H – CERTIFICATION FORM

West Virginia Forensic Medical Examination Fund
Certification Form

To receive the reimbursement for the medical forensic exam, the medical facility must submit and mail an original invoice and a completed copy of the certification form.

Sexual Assault Evidence Collection Kit Tracking # _____

Name of Victim _____	**Date of Examination** _____	**Reimbursement Fee** **$350.00**
Pediatric Exam ☐ **OR** **Adolescent/Adult** Exam ☐	**Hospital Invoice #** _____	

Please attach the hospital invoice with an itemized list of costs.

West Virginia Code §61-8B-16(a) (5) requires that licensed medical facilities, when submitting a statement of charges to the Forensic Medical Examination Fund for payment, certify that the sexual assault examination was performed.

Certification *(please print)*:

I,_____, on behalf of _____, *(licensed medical facility)* do hereby certify that the charges listed above were for the purpose of performing a forensic medical examination of an alleged sexual assault in accord with **West Virginia Code section §61-8B-16(a) (5)**.

Signed:_____Date:_____

REMIT PAYMENT TO: *(Provide licensed medical facility's name and billing address):*

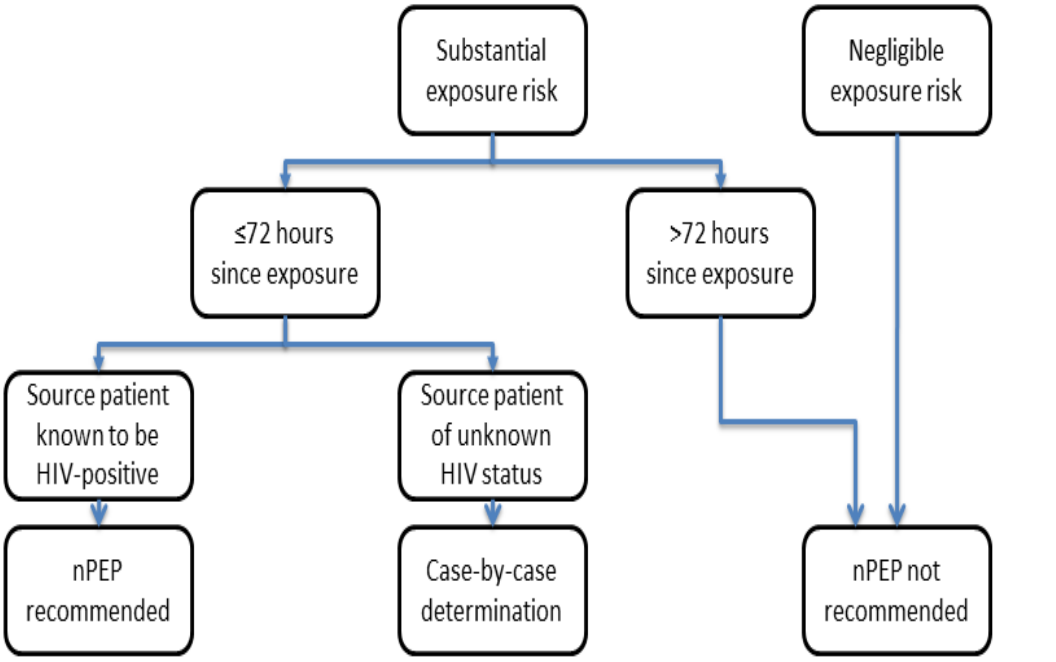
_____
_____
_____

Please attach an original hospital invoice to this form and mail to:

West Virginia Prosecuting Attorneys Institute
Attention: Forensic Medical Examination Fund
1124 Smith Street
4th Floor
Charleston, WV 25301

APPENDIX I - PATIENT'S NEEDS FOR HIV MEDICATION

Algorithm from CDC to Evaluate Patient Need for HIV nPEP



Substantial Risk for HIV Acquisition

Exposure of
vagina, rectum, eye, mouth,
or other mucous membrane,
nonintact skin, or percutaneous contact

With
blood, semen, vaginal secretions, rectal secretions, breast milk, or any body fluid that is visibly contaminated with blood

When
the source is known to be HIV-positive

Negligible Risk for HIV Acquisition

Exposure of
vagina, rectum, eye, mouth,
or other mucous membrane,
intact or nonintact skin,
or percutaneous contact

With
urine, nasal secretions, saliva, sweat, or tears if not visibly contaminated with blood

Regardless
of the known or suspected HIV status of the source

Child Sexual Abuse/Assault Medical Response Protocol[1]

All children who are suspected victims of child sexual abuse should be offered a timely medical evaluation by a provider skilled in performing such evaluations. The primary purpose of the medical evaluation is to identify, document, diagnose, prevent, and treat medical conditions and/or trauma (resulting from abuse and unrelated to abuse), as well as to assess issues related to patient safety and wellbeing. An additional purpose of the medical evaluation is to determine the appropriateness of trace evidence collection and, if indicated, to ensure that biologic trace materials are properly collected and preserved.

A medically-based screening process can guide medical professionals and community partners in determining whether a child requires an immediate medical examination by an emergency medical provider, mental health provider, or social worker. A child who does not require emergency services will be more effectively served by contacting the nearest Children's Advocacy Center (CAC) so that the child may be referred to a medical provider skilled in addressing non-acute child sexual abuse.

While most child abuse victims of sexual abuse/assault do not require emergency medical evaluations, reasons for emergency medical examinations include, but are not limited to:

- The alleged assault may have resulted in the transfer of trace biological material and occurred within the previous 3 days (or other locally determined interval up to 5 days).
- The reported assault may have placed the child at risk for pregnancy and occurred in the previous 5 days.
- The child complains of pain in the genital or anal area.
- There is evidence or complaint of anogenital bleeding or injury.

Reasons for emergency medical health or social interventions include, but are not limited to:

- Intervention is needed emergently to assure the safety of the child.
- The child is experiencing significant behavioral or emotional problems that could make the child a danger to themselves or others.

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The flowchart on the next page is meant to support medical professionals and facilities in their decision-making when a child presents to them with allegations, suspicions, or signs of child sexual abuse. The place where you, your institution, or community refers a child for acute sexual assault exams may vary depending on when the child presents to you. There is a place on the flowchart to fill in your local business-hours contact and the after-hours/weekend contact to whom you may refer a child for an acute sexual assault exam. For non-acute sexual abuse exams, your local Children's Advocacy Center will be able to point you to the nearest provider or facility with specially-trained medical professionals and support specific to these children's needs.

[1] **This protocol has been a project of the West Virginia Child Advocacy Network (WVCAN) funded by the Claude Worthington Benedum Foundation and the Bernard McDonough Foundation. It has been endorsed by the West Virginia Chapter of the American Academy of Pediatrics and the West Virginia Chapter of the American College of Emergency Physicians.**

Child Sexual Abuse/Assault Screening Protocol Flowchart

*** Refer to Additional Information**

CPS: Hotline 800-352-6513
State Police Detachment: _____
Local CAC: _____

A child has disclosed sexual abuse, abuse was witnessed, or there is other credible concern that a child was sexually abused. **1***

↓

MANDATED REPORTING—Make a child abuse/neglect report to CPS and law enforcement. **2***

↓

Could the contact have resulted in transfer of biologic evidence? **3**

YES → Is it possible that the contact occurred in the last 3 days (or other locally agreed time interval up to 5 days)? Refer to additional info on trace evidence collection. **4***

YES → Emergency medical care, to include possible trace evidence collection and possible prophylactic medications, should be provided in the nearest appropriate facility. Contact your local Children's Advocacy Center (CAC) to determine appropriate follow-up care. **5***

NO ↓

Is the child at risk of pregnancy?
- Female with signs of pubertal development (such as breast development) AND
- Penile-vaginal contact is suspected **6***

YES → Is it possible that the contact leading to that pregnancy risk occurred in the last 5 days? **7**

YES → Emergency medical care, to include possible offer of pregnancy prophylaxis, should be provided in the nearest appropriate facility. Then contact your local Children's Advocacy Center (CAC) to determine appropriate follow-up care. **8***

NO ↓

Is the child experiencing symptoms of pain or bleeding? **9***

YES → Emergency medical care should be provided in the nearest appropriate facility. Contact your local Children's Advocacy Center (CAC) to determine appropriate follow-up care. **10***

NO ↓

Is the child displaying behavioral or emotional problems that put themselves or others in danger? **11***

YES → Emergency mental health care should be provided in the nearest appropriate facility. Then contact your local Children's Advocacy Center (CAC) to determine appropriate follow-up care. **12***

NO ↓

Is an emergent intervention needed to assure the safety of the child? **13***

YES → Emergency social intervention should be provided in the nearest appropriate facility, which may be a medical facility. Then contact your local Children's Advocacy Center (CAC) to schedule a comprehensive sexual abuse medical evaluation. **14***

NO ↓

Contact your local CAC to determine if and/or when a scheduled comprehensive sexual abuse medical evaluation is recommended. **15***

Additional Information

Figure 1: A child has disclosed sexual abuse, abuse was witnessed, or there is other credible concern that a child was sexually abused.

Victims of child sexual abuse present for medical care in many different ways. Some children will tell someone they trust about the abuse. A child does not have to repeat the disclosure to a medical provider to be offered appropriate medical care. A provider must remember that children frequently do not disclose all aspects of the abuse immediately. Some children do not disclose sexual abuse but other credible evidence is obtained or found, such as a witness disclosure or photographs of abuse are found. Providers should use the best and most complete information available in determining the need for emergency medical services.

Frequently, a concerned adult will request a medical evaluation for sexual abuse because of non-specific indications (such as a behavior change) or a strong distrust of a specific person or people in the child's life. These medically-based screening guidelines will still apply for this patient population, but decisions to perform acute medical interventions should be based on more specific indications that an abusive event has occurred.

Figure 2: Make a Child Abuse/Neglect Report.

All medical providers are mandated reporters (West Virginia Code §49-6A-2). Any mandated reporter "who has reasonable cause to suspect that a child is neglected or abused or observes the child being subjected to conditions that are likely to result in abuse or neglect shall immediately, and not more than forty-eight hours after suspecting this abuse or neglect, report the circumstances or cause a report to be made to the Department of Health and Human Resources: Provided, That in any case where the reporter believes that the child suffered serious physical abuse or sexual abuse or sexual assault, the reporter shall also immediately report, or cause a report to be made, to the State Police and any law-enforcement agency having jurisdiction to investigate the complaint."

It is the responsibility of the medical provider(s) evaluating the child to follow the mandated reporting statute. It is not the reporter's responsibility to prove that abuse has occurred prior to making a report. In fact, delaying a mandated report to perform an independent investigation may result in criminal charges and civil liability. Use the chart below to fill in your local information. **There is space on the flowchart above to document this information for quick access.**

Figure 4: Could the contact have resulted in transfer of biologic evidence? Is it possible that the contact occurred in the last 3 days (or other locally agreed time interval)?

Indications that trace evidence collection may provide forensically valuable information include:

1. Debris or body fluid is visible on child's body or clothing, -or-
2. The contact included possible body fluid (semen, blood, saliva) or debris transfer,
    a. This includes (but is not limited to) a perpetrator licking, biting, or using genitals to touch a child anywhere on their body.

b. Remember that a child may not disclose or have knowledge of all details of an abusive act; therefore, do not use an assumption of "no ejaculation" or "no penetration" as a reason to defer trace evidence collection –or-

3. Acute genital injury indicating an abusive event is detected during physical examination, regardless of history provided.

Local Child Abuse multidisciplinary investigative teams (MDITs) composed of local representatives from law enforcement, Child Protective Services (CPS), Children's Advocacy Centers (CACs), prosecutors, mental health providers, and medical providers will determine how long after a reported sexual abuse event trace evidence collection will be recommended. MDITs will use information from the West Virginia State Police Forensic Laboratory to assist in determining how likely it is that trace evidence collection may lead to a forensically relevant positive result.

When determining how long after a reported abusive act trace evidence should be collected, use your local MDIT agreed upon interval, which may range from 1-5 days, depending on the age of the child and the nature of the contact.

1. After 24 hours, the likelihood of obtaining trace evidence from a young child's body is low.
2. It is well established that trace evidence collection from anywhere on or in a child is never indicated past 7 days.
3. Clothing and bedding from a scene may yield positive results even years after the crime has occurred. Encourage law enforcement investigators to collect evidence from the scene or clothing as soon as possible.

Figure 5: **See pg. 5**

Figure 6: Is the child at risk of pregnancy? Is it possible that the contact leading to that pregnancy risk occurred in the last 5 days?

Pregnancy prophylaxis is available and should be offered to females who meet the following criteria:

1. History of menarche or has a Sexual Maturity rating (breast or pubic hair) of 3 or greater; and
2. Suspected penile-vaginal contact, with or without a history of penetration, condom use, or ejaculation; and
3. Contact occurred in the previous 5 days.

Figure 8: **See pg. 5**

Figure 9: Is the child experiencing symptoms of pain or bleeding?

Current anogenital pain or bleeding may represent a traumatic injury from sexual abuse/assault or other medical condition which requires emergency medical intervention. A history of distant anogenital pain or bleeding, now resolved, typically does not require emergency medical care, but that historical

information should be communicated to the medical provider responsible for the scheduled comprehensive medical evaluation.

Figure 10: **See pg. 5**

Figure 11: Is the child displaying behavioral or emotional problems that put themselves or others in danger?

An appropriate medical or mental health provider should evaluate any concern that a child's behavior or emotional state represents a danger to themselves or others (including but not limited to suicidal/homicidal thoughts). Emergency care may include crisis counseling, mental health evaluation, and/or treatment plan.

Figure 13: Is an emergent intervention needed to assure the safety of the child?

A child victim of sexual abuse should be protected from possible perpetrators during the investigation. If a child remains at risk for sexual abuse, Child Protective Services and your state police attachment should be notified to evaluate the circumstances and establish a safety plan.

Figures 5, 8, 10, 12, 14, 15: Locating a medical provider with specialized training in identifying and treating child abuse.

NOTE*: Always make sure to make a mandated report to CPS and law enforcement as soon as a child presents.*

Normal Business Hours (Monday-Friday, 9am-5pm): Your local Children's Advocacy Center (CAC) can assist you in referring to a medical provider with specialized training in identifying and treating child abuse in emergency and non-emergency situations. If your county falls outside of an official CAC service area, a child may still be able to receive courtesy services. Please call the CAC in your nearest neighboring county. If you need additional assistance in locating a provider, please call the West Virginia Child Advocacy Network at 304-414-4455 during normal business hours.

After Business Hours: Follow your facility's protocols, make a mandated report to CPS and law enforcement, and follow up with your local CAC as soon as possible.

Background

The West Virginia Child Advocacy Network (WVCAN) and a multidisciplinary committee it has convened have adapted these guidelines from "A Medically-Based Screening Preotocol for the Medical Response to Child Abuse/Assault" with permission from Missouri's Sexual Assault Forensic Exam-Child Abuse Resource and Education (SAFE-CARE) Network. http://health.mo.gov/living/families/injuries/safecare/

The SAFE-CARE Advisory Council provides guidance regarding services, education, networking, quality assurance, and consultation. Advisory Council members include professionals from nursing, medicine, social work, and child advocacy centers.

The SAFE-CARE Advisory Council developed these recommendations to comply with Missouri Revised Statutes Section 334.950.4: "The SAFE CARE network shall develop recommendations concerning medically based screening processes and forensic evidence collection for children who may be in need of an emergency examination following an alleged sexual assault. Such recommendations shall be provided to the SAFE CARE providers, child advocacy centers, hospitals and licensed practitioners that provide emergency examinations for children suspected of being victims of abuse."

References

Adams JA, et al. Guidelines for Medical Care of Children Who May Have Been Sexually Abused. Journal of Pediatric and Adolescent Gynecology. (2001) 20:163-172.

Floyed RL, Hirsh DA, Greenbaum VJ, Simon HK. Development of a Screening Tool for Pediatric Sexual Assault May Reduce Emergency-Department Visits. Pediatrics. (2011) 128:221-226

Girardet R, et al. Collection of Forensic Evidence From Pediatric Victims of Sexual Assault. Pediatrics. (2011) 128:233-238.

Mollen CJ, Goyal MK, Frioux SM. Acute Sexual Assault: A Review. Pediatric Emergency Care. (2012) Vol 28(6):584-590.

Thacheray JD, Hornor G, Benzinger EA, Scribano PV. Forensic Evid

Child Physical Abuse Medical Response Protocol[1]

This protocol is intended to help health care providers identify children who may be victims of physical abuse and provides information on how to report suspected abuse, how to refer cases to a medical provider with specialized training in the identification and treatment of child physical abuse, and what steps to take in addition to serving that child's basic medical needs. The guidelines below provide only general characteristics of accidental and non-accidental pediatric injury; the clinician must be guided by his or her professional assessment of individual case circumstances.

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THE AMERICAN ACADEMY OF PEDIATRICS

[1] **This protocol has been a project of the West Virginia Child Advocacy Network (WVCAN) funded by the Claude Worthington Benedum Foundation and the Bernard McDonough Foundation. It has been endorsed by the West Virginia Chapter of the American Academy of Pediatrics and the West Virginia Chapter of the American College of Emergency Physicians.**

Suggestive of Accidental Pediatric Injury

INJURY STORY

Clear/Unchanging story of injury circumstances that is:

- Consistent with injury type
- Consistent with injury severity
- Consistent with injury location & distribution
- Consistent with time & date of injury event
- Consistent with the expected behavioral repertoire of the child, both before and after injury event.

CARETAKER BEHAVIOR

- Early/Timely presentation to medical care

EXAM FINDINGS

Accidental–type soft tissue injuries for children who are able to "cruise":

- Bruising/laceration to knees, shins, elbows, single bruise to face or head in a cruising/walking child
  - Generally to the front of the body
  - Restricted to single body planes
- Non-patterned injury: burns / bruises
- Hot liquid burns: pour type, to frontal body surfaces
- Presents with single soft tissue injury type: bruising with laceration or abrasion, or burns; not both.

Bone fractures non-specific for abuse:

- Long bone shaft fractures
- Midshaft clavicle fracture
- Linear skull fracture without diastasis (cerebral edema) or intracranial injury

Accidental poisoning characteristics:

- Early presentation to medical care
- Caretaker identification of involved/suspected household material and clear reported circumstances of ingestion/exposure
- No evidence of chronic exposure; no pharmaceutical involvement
- Age ≥ 8 months to 5 years

All medical providers are mandated reporters (West Virginia Code §49-6A-2), meaning suspected cases of child abuse must be reported to Child Protective Services (CPS) and law enforcement. It is not the reporter's responsibility to prove that abuse has occurred prior to making a report.

If you need to make a referral for medical care, Children's Advocacy Centers (CACs) can help you identify medical providers with specialized training in identifying and treating child abuse during normal business hours. If it is after business hours, follow your facility's protocols, make a mandated report to CPS and law enforcement, and follow up with your local CAC as soon as possible. If you need additional assistance in locating a provider, please call the West Virginia Child Advocacy Network at 304-414-4455 during normal business hours.

Suggestive of Non-Accidental Pediatric Injury

MANDATED REPORTING Child Protective Services: 800-352-6513 (Hotline) Local State Police Detachment: _____	To locate a medical provider with specialized training in identifying and treating child abuse, call your local CAC: _____

INJURY STORY

Story of injury circumstances presents persistent ambiguities, conflicts, contradictions:

- Different stories from household members/incident witnesses
- Caretaker story changes significantly over time
- Story inconsistent with: injury type, injury severity, child's expected post-injury behaviors, or expected injury location and distribution on the body
- Story circumstances inconsistent with age-appropriate child behaviors/capabilities

CARETAKER BEHAVIOR

If you check any of these, proceed to the corresponding box in the next column.

☐ Unusual caretaker behaviors manifest—violent or impaired behaviors / unexplained; inappropriate during patient presentation / hospitalization ☐ Unexplained / inappropriately late presentation of child by caretaker to medical attention, or presents with injury complications such as infection	**Document thoroughly in chart, especially excited utterance, in quotes**

EXAM FINDINGS

If you check any of these, proceed to the corresponding box in the next column.

For <u>non-mobile child</u> presenting with SOFT TISSUE INJURY or FRACTURE: ☐ Any soft tissue injury on a child that can't cruise ☐ All fractures, fresh or healing, without a clear accidental explanation (e.g., car crash)	**<u>For children <1:</u>** • **CT scan of the head without contrast** **<u>For Children 0-2 years:</u>** • **Skeletal survey, repeat limited skeletal survey 2 weeks later** • **Other workup as indicated (ophthalmologic evaluation as indicated)** **<u>All Children:</u>** • **Entire body surface and each soft tissue injury (note swelling) photographed with and without scale and labeled with child's name, date/ time/ photographer** • **Contact child abuse pediatrician for additional information 304-388-2391**
Soft tissue inflicted injury characteristics <u>in a cruising/walking child</u>: ☐ Multiple grouped injuries anywhere and/or distributed over more than one body plane ☐ Injury involving primarily posterior body surfaces, or the torso, neck, frenula (oral cavity), or ears ☐ Bruising to body areas not directly overlying boney prominences ☐ Bruising associated with localized petechial hemorrhages ☐ Any injury that forms a pattern or shape ☐ Soft tissue injuries involving more than one cause (e.g., burns and bruises together) ☐ All immersion burns	
<u>Infants and children</u> with any of the following fractures: ☐ Displaced fracture, classic metaphyseal lesions ☐ Presentation of fracture with healing changes (periosteal/callus formation) or malunion ☐ Skull fracture that is complex, diastatic, or associated with neurologic signs ☐ Fractures of ribs, scapula, vertebral processes, orbital fractures, multiple fractures of differing ages	
Suspected intentional poisoning in infancy or early childhood: ☐ UDS positive for <u>non-prescribed</u> pharmaceuticals such as narcotics or benzodiazepines, or inappropriate over the counter medicine such as Benadryl, etc. ☐ Presentation of unexplained altered sensorium without anatomic findings ☐ Prior admission for drug toxicity	• **Save admit blood and all other <u>first day</u> bio samples**

References

Chadwick DL, Giardino AP, Alexander R, Eserino-Jenssen D, Thackeray J. Chadwick's Child Maltreatment, Fourth Edition. St. Louis, MO: STM Learning, Inc.; 2014.

Flaherty EG, Perez-Rossello JM, Levine MA, Hennrikus WL, American Academy of Pediatrics Committee on Child Abuse and Neglect. Evaluating Children With Fracture for Child Physical Abuse. Pediatrics. 2014; 133(2): e447-e489. doi: 10.1542/peds.2013-3793.

Frasier L, Rauth-Farley K, Alexander R, Parrish R. Abusive Head Trauma in Infants and Children: A Medical, Legal and Forensic Reference. St. Louis, MO: GW Medical Publishing; 2006.

Jenny, C. Child Abuse and Neglect Diagnosis, Treatment and Evidence. St. Louis, MO: Saunders; 2011.

Kemp AM, Dunstan F, Harrison S, Morris S, Mann M, Rolfe K, et al. Patterns of skeletal fractures in child abuse: systematic review. BMJ 2008; 337:a1518. doi: 10.1136/bmj.a1518.

Leventhal JM, Martin KD, Asnes AG. Incidence of fractures attributable to abuse in young hospitalized children: results from analysis of a United States database. Pediatrics. 2008; 122(3): 599–604. doi: 10.1542/peds.2007-1959.

Peters ML, Starling SP, Barnes-Eley ML, Heisler KW. (2008).The presence of bruising associated with fractures. Arch Pediatr Adolesc Med. 2008; 162(9): 877–881. doi: 10.1001/archpedi.162.9.877.

Pierce, et. al. Bruising Characteristics Discriminating Physical Child Abuse from Accidental Trauma. Pediatrics. 2010; 125(1): 67-74. doi: 10.1542/peds.2008-3632.

Reece RM, Christian C. Child Abuse: Medical Diagnosis & Management, 3rd Edition. American Academy of Pediatrics: 2009.

Sheets LK, Leach ME, Koszewski IJ, Lessmeier AM, Nugent M, Simpson P. Sentinel Injuries in Infants Evaluated for Child Physical Abuse. Pediatrics. 2013; 131(4): 701-707. doi: 10.1542/peds.2012-2780.

APPENDIX L – INITIAL RESPONSE FLOWCHART – NATIONAL PEDIATRIC PROTOCOL

Taken from the National Protocol for Sexual Abuse Medical Forensic Examinations - Pediatric. For the full Pediatric SAFE Protocol, see www.KIDSta.org.

This project was supported by Grant No. 2015-TA-AX-K079 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this Web Site are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

This algorithm, based on B2. Initial Response, is meant to illustrate the general flow of and procedures involved in initial response in prepubescent child sexual abuse cases. However, flow and procedures are subject to jurisdictional and agency/facility policies.

Disclosure or Suspicion of Child Sexual Abuse is Made: Child's disclosure to first responder or person in community; or suspicion of sexual abuse by caregiver, first responder, or other person

Multidisciplinary response team and/or children's advocacy center, if existing, may play role in coordinating response across agencies

If disclosure or suspicion is first reported to child protective services (CPS) or law enforcement

Initial CPS, Law Enforcement, 911 Response

- Safety of child and family
- Emergency medical care
- Information to child and caregiver
- Limited fact finding
- Arrange initial health care assessment of child to determine urgency of care needed
  - Transport to health care facility
  - Alert facility of pending arrival
  - Preserve forensic evidence on child's body, clothing, and other related items until arrival at facility (recent abuse)
- Investigative/forensic interview either before or after medical forensic examination
- Activate advocate

If disclosure or suspicion is first made to/by advocacy/victim services, report as per agency policy (if mandatory reporter) to trigger CPS/law enforcement action

Advocacy/Victim Services may offer during initial response-

- Crisis intervention
- Emotional support
- Information
- Advocacy
- Medical & legal accompaniment

Child/caregiver may seek these services directly. CPS, law enforcement, or health care provider can also trigger advocate involvement

If disclosure or suspicion is first made to/by health care provider who does not have specialty care training for child sexual abuse

Initial Health Care Assessment/Triage of Child by Health Care Provider

- Prioritize child sexual abuse patient
- Gather minimal history
- Mandatory report and communicate immediate safety concerns
- Medical screening exam: Evaluate for acute injury, pain, bleeding and stabilize
  - If acute presentation, preserve forensic evidence on child's body, clothing, and other related items
  - Emergent treatment supersedes forensic evidence preservation
- **Determine urgency of care needed- acute or nonacute** (see *Care Algorithm*)
  - **Arrange medical forensic care/involve pediatric examiner preservation**
- Activate advocate

NOTE: WV'S TIMEFRAME IS 96 HOURS NOT 72

Acute or nonacute medical forensic care

< 72 hours; If initial assessment is not at exam site, transport to designated acute exam facility

>72 hours; transport to designated nonacute facility

APPENDIX M – CARE OF ACUTE/NON-ACUTE CASES – NATIONAL PEDIATRIC PROTOCOL

Taken from the National Protocol for Sexual Abuse Medical Forensic Examinations - Pediatric. For the full Pediatric SAFE Protocol, see www.KIDSta.org.

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The algorithm, adapted in part from Day and Pierce-Weeks (2013), illustrates the general flow of and procedures involved in medical forensic care in prepubescent child sexual abuse cases. However, flow and procedures are subject to jurisdictional and agency/facility policies.

NOTE: WV'S TIMEFRAME IS 96 HOURS NOT 72

Sexual Abuse <72 hours? Unknown time frame? Chance of biological or trace evidence?

Sexual Abuse >72hours

Contact victim advocate from community based sexual assault program, child advocacy center, or other entity to offer child and caregiver support

Acute Exam with Collection of Forensic Samples

- Consent
- Mandatory report
- Medical history
- Physical and anogenital examination
- Injury/disease treatment
- Documentation
- Collection of forensic samples
- Consider testing for STDs, including HIV as appropriate
- Offer HIV nPeP when appropriate
- Discharge and follow-up care planning: medical, safety, counseling. and support

Acute Exam >72 hours if-

- *Current symptoms of injury (pain, bleeding, STD)*
- *History of abduction*
- *Need for evaluation for possible suicidal or homicidal ideation*
- *Child or caregiver has fears and pressing concerns that acute exam can address*
- *Risk of imminent danger to child and/or not clear where the child will be residing in near future*
- *Concern that family will not return child for nonacute exam on another day*

Nonacute Exam

- Consent
- Mandatory report
- Medical history
- Physical and anogenital examination
- Injury/disease treatment
- Documentation
- Consider testing for STDs, including HIV as appropriate
- Discharge and follow-up care planning: medical, safety, counseling, and support

All Patients

- Trained pediatric examiner provides above medical forensic care
- Immediate and appropriate referral to mental health services for suicidal/homicidal ideation
- Access to victim advocacy services during/after exam, if available
- Psychosocial counseling referrals
- Other community resource linkages

APPENDIX N – STD NATIONAL PEDIATRIC PROTOCOL

Taken from the National Protocol for Sexual Abuse Medical Forensic Examinations - Pediatric. For the full Pediatric SAFE Protocol, see www.KIDSta.org.

Kidsta.org
The Technical Assistance Source for Pediatric Sexual Assault Forensic Examinations

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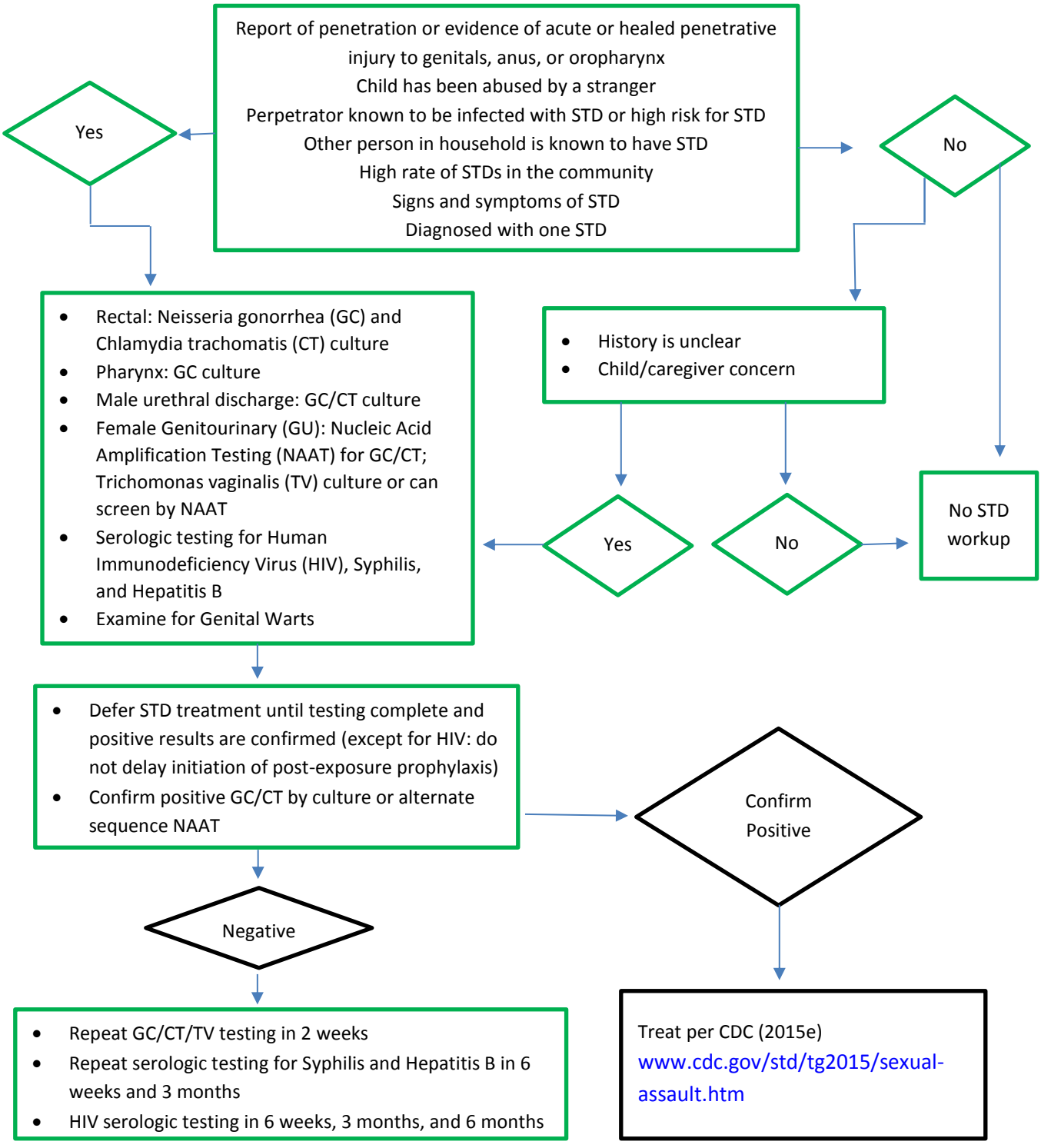
This algorithm is based on B10. Sexually Transmitted Disease Evaluation and Care, and adapted from/supported by sources including the CDC (2015e), Esernio-Jenssen and Barnes (2011), Farst (2011), Jenny, Crawford-Jakubiak, and Committee on Child Abuse and Neglect (2013), and Hammerschlag and Gaydos (2012). It is meant to illustrate the general flow of and procedures involved in STD testing in prepubescent child sexual abuse cases. However, flow and procedures are subject to jurisdictional and agency/facility policies.



APPENDIX O – HIV TESTING nPEP – NATIONAL PEDIATRIC PROTOCOL

Taken from the National Protocol for Sexual Abuse Medical Forensic Examinations - Pediatric. For the full Pediatric SAFE Protocol, see www.KIDSta.org.

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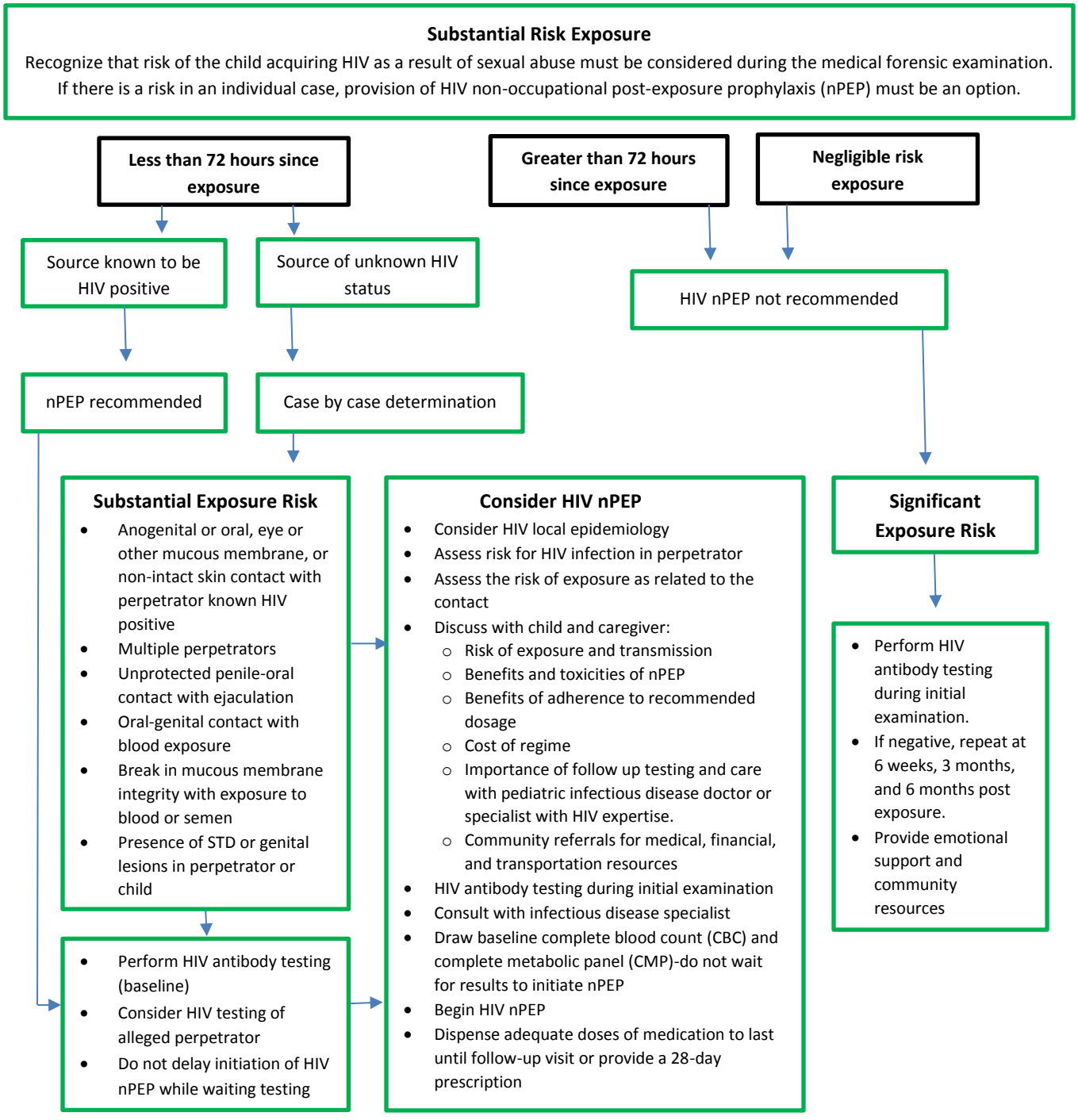
The algorithm, based on information provided in B10. Sexually Transmitted Disease Evaluation and Care, illustrates the general flow of and procedures involved in post-exposure HIV risk assessment in prepubescent child sexual abuse cases. However, flow and procedures are subject to jurisdictional and agency/facility policies.



[260] The algorithm was drawn from information from the CDC (2015e), Jenny et al. (2013); the Ohio Chapter of the AAP Committee on Child Abuse and Neglect (2009); and the State of New Hampshire (2015).