

THE

SEXUAL
ASSAULT
FORENSIC
EXAMINER

**COORDINATOR'S
HANDBOOK:**
Lessons Learned in Queens

by Rebecca W. Carman, LCSW

A Project of the New York State Coalition Against Sexual Assault

This manual was made possible in part by the Joyful Heart Foundation.



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Published by the
New York State Coalition Against Sexual Assault
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(518) 482-4222 phone
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www.nyscasa.org

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Printed in the United States of America.

ISBN 978-0-9823192-0-8

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For additional copies of this handbook, or to submit feedback, corrections or updates on any of its contents, please contact NYSCASA at (518) 482-4222.

For additional projects by Rebecca Carman, please see: www.RebeccaWCarman.com

PREFACE

Dear Healer,

Thank you for the work you do on behalf of sexual assault survivors. Your compassion and dedication often represent the first step on a survivor's journey of recovery. Through you, they have their first encounter with the possibility of healing from their trauma.

I am honored to be able to stand among you as you work to combat this violence and shine the light of hope and recovery.

The manual you hold is designed to complement the film, *A Body of Evidence*, a rape-kit training film Joyful Heart created with the NYS Division of Criminal Justice Services. Our goal is to provide a comprehensive tool that complements your work and enables you to be as knowledgeable and informed as possible in your mission to serve survivors better.

I am humbled by your dedication and emboldened by your courage.

Joyfully, and with much gratitude,

A handwritten signature in black ink that reads "Mariska". The signature is fluid and cursive, with a long, sweeping tail on the letter 'a'.

Mariska Hargitay
Founder & President, Joyful Heart Foundation

ACKNOWLEDGEMENTS

This handbook contains a synthesis of facts and opinions from numerous people over a period of many years. Using my own words, I have represented prevailing views as clearly and concisely as possible. To the extent that this Q&A guide proves useful and accurate, I am grateful to the people and organizations acknowledged. While I am eager to thank all those who have advanced my knowledge in the field of sexual assault, my doing so does not imply these parties' endorsement of *The SAFE Coordinator's Handbook: Lessons Learned in Queens* either in its entirety or any parts within.

—Rebecca Carman

Scenarios and responses have been adapted from the day-to-day operations of Elmhurst's Sexual Assault Response Team (SART) Program, 2004-2008: Glenda Guzman, PA-C, M.P.A., Coordinator; Sheree Givre, M.D., Medical Director.

This project came into existence because of two people:

Eric Rosenbaum, Chief, DNA Prosecutions Unit, Special Victims Bureau, District Attorney Queens County, who presented at Elmhurst Hospital Center in May, 2005, and

Tamara Pollak, previously Forensic Healthcare Program Director, New York City Alliance Against Sexual Assault, who—among a myriad of profoundly helpful activities—tape recorded and transcribed the extended Q & A session that took place that day.

I am also grateful to Jean Fei, Project Co-Director of the DNA Training Initiative at NYSCASA, for championing *The SAFE Coordinator's Handbook: Lessons Learned in Queens* through publication and distribution.

And to Kim Oppelt, Administrator, Violence Against Women Unit, NYS Division of Criminal Justice Services, for recruiting subject matter experts and coordinating an extensive review of this document.

The New York City Alliance Against Sexual Assault has been an invaluable clearinghouse for information regarding all aspects of care for survivors.

This project would not have been possible without my supervisors, Victor Snyder and Barbara Carey, who provided unqualified support at every step.

And Hans Broek—I owe you a world of appreciation.

SPECIAL THANKS TO:

Glenda Guzman, for her tireless efforts on behalf of the SART Program in Queens, and for contributing the knowledge, experience, and perspectives that make her such an exemplary SAFE

Marjory Fisher, Bureau Chief, Special Victims Bureau, District Attorney Queens County

Lorraine Giordano, MD, Medical Director, SAFE Program, St. Luke's Roosevelt Hospital and Beth Israel Medical Center

Kenneth Appelbaum, Deputy Bureau Chief, District Attorney Queens County

Lt. Arthur Hall, Commanding Officer, Queens Special Victims Squad

Sgt. Grace-Marie O'Donnell, Commanding Officer, Special Victims Liaison Unit

Karen Carroll, Janice Ceccucci, and Erin Ptak: SAFE examiners and expert consultants

Ami Sanghvi and the New York Civil Liberties Union, for feedback on the legal discussions regarding minors' consent and confidentiality

Fiona Thompson, for her consummate editing and production skills

Donna Gaffney, for her early input in this project's development

Also the SAVI program, Project Shield, Lydia de Castro, Kerry Stout, Amy Weinstein, Karyn Brownson, and many others

NYS Division of Criminal Justice Services Program Representatives Colleen Farnan, Ed Guider, and Laura Gardinier, for their ongoing support of EHC SAFE programming

Finally, the success of EHC's efforts begins and ends with our examiners. It has been a privilege to work with all of you.

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INTRODUCTION

In the spring of 2004, I became the Coordinator of Elmhurst Hospital Center's Sexual Assault Forensic Examiner (SAFE)¹ program. Through this 24-hour on-call system, SAFE examiners provide evidence collection and medical care to patients of sexual assault. A large city hospital serving a diverse area of the Borough of Queens in New York City, Elmhurst sees a high volume of sexual assault cases, typically over one hundred per year.

For me, this position involved a steep learning curve. Among their responsibilities, SAFE coordinators serve as in-house consultants when questions and issues relating to sexual assault arise. At times, I needed guidance and turned to colleagues at Elmhurst and other hospitals, our District Attorney (DA)'s office, the New York City Alliance Against Sexual Assault, and specialists at the New York City Health and Hospitals Corporation (HHC)'s Office of Clinical Affairs. A generous and committed community, they provided me with technical and moral support on countless occasions.

I found myself keeping a running list of situations, responses, and guiding principles and practices, hoping to save others from arduously reinventing the wheel. Four years later, *The SAFE Coordinator's Handbook: Lessons Learned in Queens* is the result of this effort. Designed for SAFE coordinators, examiners, and Emergency Department (ED) personnel such as nurses, social workers, and attendings, this Q & A handbook is a user-friendly, hands-on manual for all aspects of SAFE program operations.

The SAFE Coordinator's Handbook: Lessons Learned in Queens is not meant to be a definitive guide or a substitute for formal SAFE training; it is merely a chronicle of learning in a field that seems to continually evolve. My hope is that this handbook can be a starting point for other SAFE professionals, as they confront similar issues or seek to refine their own guidelines and policies. The "A's" to follow are not the only responses possible but ideally will be food for thought for practitioners of all levels of experience. Informed judgment, nuanced decision-making, and case by case response will always be hallmarks of optimum SAFE care.

This booklet includes sections on evidence collection, issues of consent and confidentiality, documenta-

1. SAFE is used as the generic term throughout; however, at Elmhurst and all the HHC hospitals we use the term SART (Sexual Assault Response Team).

tion, and the interface with the criminal justice system. The heart of the Q & A is its case scenarios. I have chosen a blend of those recurring again and again as well as “stumpers”—unusual situations that proved hard to address. Since this field encompasses disparate cultures (medical, social work, legal-forensic, patient ethics, and risk management), I tried to present a useful synthesis whenever possible.

References used are at times specific to Elmhurst Hospital, the HHC system or the Borough of Queens. For example, the names of consent forms, the use of social workers and other departments for consultation, and the setting in which case outcomes are determined may differ from SAFE program to SAFE program. Please feel free to adapt terminology, procedures, and recommendations according to your own program design and locale, and consult your own Risk Management department when thorny issues arise.

The three or four hours patients spend in the ED are crucially important. For the patient, a skilled practitioner can be the difference between leaving the hospital feeling calm and in control vs. experiencing still more distress. The SAFE team's words and actions can impact whether a sexual assault case succeeds or fails in court, and whether perpetrators go free or are brought to justice. Each discipline has an opportunity to earn trust, to extend compassion, and to empower patients during a crisis some consider the worst of their lives.

It is a heartening time to be part of the SAFE program movement, as advocates for sexual assault patients gain momentum city-wide and throughout the state. Here at Elmhurst Hospital, veteran staff well remember when SAFE programming was virtually non-existent; a decade later, through the concerted efforts of many individuals, we are proud to maintain Center of Excellence status and to provide SAFE exams without fail whenever they are called for. We are grateful to all those who have contributed to our collective goal: the day when each and every sexual assault patient receives the utmost in state-of-the art SAFE care.

SAFE CARE: TIPS FOR EXAMINERS²

WHAT ARE SOME GENERAL THINGS THE HEALTH CARE TEAM SHOULD KEEP IN MIND WHEN WORKING ON SEXUAL ASSAULT CASES?

Strive for these to be model charts documenting “state of the art” exams; SAFE exams should represent your best work in every respect. Be sure to:

- a) Write legibly. If a case goes to court, it will help everyone if the documentation is clear.
 - Actual documentation may be enlarged and presented to jurors.
 - If prosecutors can read the medical record, they may have less need to talk to you.
 - Legibility can reduce the amount of time health care personnel must spend in court. You may not have to testify in a grand jury if your record is well documented.
- b) Put the chief complaint in quotes: “I was raped.”
- c) Document the examination comprehensively. Years and many SAFE exams later, you likely won’t remember the case as clearly but it’s the vivid details that can be pivotal when testifying in court. Do not leave sections of the medical record blank.

SAFE EXAMINERS ARE INSTRUCTED TO BE “SENSITIVE” AS THEY CONDUCT EXAMS. WHAT EXACTLY DOES THIS ENTAIL?

2. Please note this guide is an adjunct to formal SAFE training and not a substitute. It does not contain comprehensive instructions on conducting SAFE exams.

Ideally, the sexual assault patient will leave the ED feeling truly cared for, listened to, and understood. Skilled examiners keep in mind that patients have been through a traumatic event, and that performing the exam may trigger memories of this event. Examiners should remain attuned to their patients' emotional states, and actively help them manage acute anxiety and distress. When possible, statements and actions should be geared towards helping patients regain a sense of power and control.

Many medical professionals have a matter-of-fact information gathering style. If patients share charged material (for example, "I was held at knifepoint while my four year old screamed hysterically and clung to my legs"), it is rarely appropriate to simply proceed to the next item on the assessment checklist. Statements such as "I'm so sorry you went through that" and "that must have been terrible" or even pausing to make compassionate eye contact can go a long way.

Therapeutic statements potentially of benefit to patients:

"I'm sorry about what happened."

"You're safe here with us; the assault is over."

"I'm glad to be the one helping you."

"You are not responsible for what happened."

"The rape was not your fault."

"Your feelings are normal."

"It's normal to have many types of feelings after such a traumatic incident."

"There's nothing to feel ashamed of." (if the patient is expressing feelings of shame)

"You did what you needed to do to survive."

"Talking about it can help."

"Counseling services are available free of charge."

"You are not alone."

Strive to be as knowledgeable and respectful as possible regarding patients' ethnic, cultural, and religious backgrounds.

WHAT ARE TIPS IN TERMS OF LANGUAGE TO USE?

- Medical professionals should use the word "patient" instead of "victim."
- Stay away from language like the patient "claims" or "alleges" she³ was raped, or "supposedly" was raped, because this suggests that medical staff doubt her story.
- Use quotes as much as possible when providing the history. For example, write: "Patient states, 'I was forced to have sex.'"
- Avoid seemingly judgmental statements like "patient passed out," or "patient was drunk." Alternatives might include "difficult to arouse" or "alcohol on breath." Look for factual ways to say things rather than ways that could be construed as value-laden.
- Using colloquialisms may impact your credibility. So, for example, describe "hickeys" using medical language or put these words in quotes, such as "patient states, 'he gave me a hickey.'" Similarly, use the patient's words for oral sex with quotation marks around them.
- Be wary of the phrases "no distress noted" or "no trauma." You may be referring to a lack of medical trauma, but a jury might conclude that the patient wasn't traumatized in the emotional sense. It is acceptable to use the phrase "no physical injury noted."
- The terms "WNL" (within normal limits) and "normal exam" are to be avoided. It is best to avoid use of abbreviations in general.
- For every visible injury, it is important to use all methods of documentation available: exact written documentation of the injury, photography, and use of a traumagram or body map to illustrate the injury. Forgoing any one of these methods could potentially impact the Assistant District Attorney (ADA)'s ability to prosecute the case.

3. Throughout, this document will primarily refer to patients as "she" or "her." This choice, made for ease of readability and because females comprise the majority of sexual assault victims, is not meant to obscure the fact that males can also be victims of sexual assault.

WHEN DOCUMENTING THE PATIENT'S ACCOUNT OF THE RAPE, WHAT ARE THE IMPORTANT ELEMENTS TO CAPTURE? HOW SHOULD WE GAUGE THE PROPER LEVEL OF DETAIL?

It's important to include the basics of the narrative, including the "who, what, when, where, and how." What the perpetrator said to the patient, descriptions of threats, degree of fear, use of force, the patient's statements in terms of trying to resist, the mechanism behind presenting injuries, expressions of emotional trauma—all of these are good to cover during the history-taking or interview.

Try to find simple ways to convey elements of the patient's narrative. Refrain from exhaustive detail. If the case makes its way to trial, the defense will search for inconsistencies, and small details are generally more difficult for the patient to remember. So writing "the patient was dragged from the car" would be preferable to "the patient was dragged by her right arm three feet away from the Buick." Extended histories and pages of details unrelated to treatment are potentially problematic in court. ED team members other than the examiner should aim to limit documentation to that directly related to the provision of medical care, rather than to details of the assault.

SAFE examiners should have working familiarity with New York State law regarding sexual assault, as this provides important context for the history and forensic examination.

SHOULD WE DOCUMENT WHAT WE THINK WILL HELP A PATIENT AT TRIAL OR WHAT WE ACTUALLY OBSERVE?

Regardless of your discipline, document objectively, based on what you hear and see in the course of rendering care. Any elaboration or omission of relevant information would be unethical and could create inconsistencies harmful to the patient's case.

Social work standards and SAFE examiner documentation are different. Typically, the social worker conducts a full psycho-social assessment and information may emerge that could be considered "damaging"—this is to help the entire team deliver appropriate, informed care. In recognition of this, the social work note is often not part of the "discoverable" portion of the medical chart.

In comparison, the SAFE examiner is there solely to collect information relevant to medical diagnosis and treatment, and to collect forensic evidence related to the assault. SAFE examiners must be objective and must not appear to be seeking to aid the investigation.

ARE NOTATIONS OF TIMES AND DATES IMPORTANT?

Include the time that the evidence was gathered and the time the kit was sealed. This is important to the legal process because it reinforces the integrity of the evidence and the chain of custody. In addition, the ADA may use this information to establish the significant amount of time dedicated by the patient in an effort to obtain a forensic exam.

For designated Centers of Excellence where patients must be seen within an hour, noting the time the exam started also ensures that standards of care are being met. If the patient is in the midst of being interviewed by a social worker or law enforcement officer, document the time of your arrival, the nature of the interview in progress, and any other factors preventing you from beginning the evaluation right away.

ARE THERE ANY OTHER IMPORTANT TIPS?

- Document aspects of the patient's presentation that are consistent with emotional trauma. For example, if the patient is crying, shaking, or making poor eye contact, document those observations.
- Document any pain or tenderness on examination; these may be the only findings that corroborate the patient's history of assault. For example, if the patient says it feels painful to walk, document this complaint.
- If there are physical findings, record as much detail as possible. For example, "hymen torn" is informative, but "nonbleeding tear to hymen at 4 o'clock" is more helpful. Documentation for every injury must include size, type, location, and color, as well as whether an injury is actively bleeding.
- Refrain from giving the patient mouthwash or drinking water until the "oral swabbing" portion of the exam has been completed.
- When collecting dried secretions, label their origin (i.e., what part of the body was swabbed) and whether they might be saliva, semen, blood, etc.
- If you do not collect certain specimens because of the case history or patient preference, be sure to mark "not collected as per patient's history" or "patient declines collection at this time" on those specific envelopes. Return to the box all envelopes for all steps of the evidence collection, both collected and not collected, before you seal the kit.

- Collect clothes worn at the time of assault as well, especially if they are torn or stained. Clothing items (other than underwear, which goes into the evidence kit) should go into separate brown paper bags, which are then sealed with tape, labeled, and initialed to maintain chain of custody. Plastic bags should not be used, as they are conducive to mildew, which leads to degradation of evidence. Assuming patient consent, all clothing should be handed over, along with the remainder of the evidence, to the police officer or detective present at the hospital. (Unless the patient has consented, there is no reason to give medical information, patient belongings, or other potential evidence to the police.)
- Change gloves between every step to avoid cross-contamination of evidence.
- Patients who are unsure of whether or not they want to make a police report may have evidence collected; the hospital must hold the kit for at least thirty days.

WHAT ARE ALL THE FORMS FOUND INSIDE THE KIT?

There are currently three types of paperwork inside the kit: a form to document the exam, NYS Office of Victim Services (OVS) forms, and a Release of Evidence form for police. In addition to the forms, you will find brochures, instruction sheets, and a Drug Facilitated Sexual Assault (DFSA) alert sheet.

Many hospitals provide their own documentation paperwork; for example, Elmhurst Hospital Center uses HHC's Comprehensive Sexual Assault Assessment Form (CSAAF). The exam form in the kit is rudimentary; use that one only if your hospital has not developed a more comprehensive form.

OVS forms are provided inside the kit. Give these forms to the patient in the ED, but be sure to communicate that help is available from a designated counselor to complete and submit them. OVS forms allow patients to apply for reimbursement of costs not covered through the hospital SAFE program. Also available from OVS is the Medical Provider Rape Examination Direct Reimbursement Claim Form, a form that allows the hospital to be reimbursed for costs of doing the forensic exam.

Finally, you will find Consent to Release Evidence forms for use with law enforcement. You may use these to authorize release of evidence.

WE ARE MEDICAL PROFESSIONALS, BUT TRAINED AS FORENSIC EXAMINERS. WHICH ROLE TAKES PRIORITY WHEN CARING FOR SEXUAL ASSAULT PATIENTS?

The medical needs of the patient are always the first priority. If the patient has a concurrent medical

emergency, that issue must be addressed by the ED staff before the forensic portion of the evaluation can take place. For example, if a woman comes in with head trauma, she should be stabilized and capable of consenting before a SAFE exam is performed. In fact, all the suggestions in the following pages should be incorporated into your procedures only if they don't impede a person's medical care. Strive for best practice medical care (like pain management) and resist any temptation to focus exclusively on the demands of forensics.⁴

4. In the cases discussed in the remainder of this handbook, it is assumed that patients would be offered all medical care appropriate to their history, even when not noted explicitly.

ISSUES OF CONSENT

HOW DO WE DETERMINE IF SOMEONE HAS THE CAPACITY TO CONSENT TO TREATMENT?

Informed consent is required prior to the administration of any medical treatment, except in emergency situations.⁵ Capacity to consent to treatment is, by definition, understanding the nature and purpose of proposed and alternative treatments, as well as possible risks and benefits associated with each approach, including those of not receiving treatment.

Determinations are made on a case-by-case basis. The examiner must decide if the individual in question has sufficient understanding of the medical/forensic exam at this specific moment. "Capacity" should be thought of as decision- and/or situation-specific, not something that a person either "has" or "doesn't have." A patient may be able to make basic health care decisions, but lack capacity to consent in situations involving greater complexity.

Minors are potentially capable of providing informed consent for post-sexual assault care. New York State law does not create a minimum age of consent; rather, each patient, regardless of age, should be assessed for their capacity to provide informed consent. Parental wishes cannot overrule decisions made by minors capable of providing informed consent.

If lack of capacity is potentially an issue, a consultation with Psychiatry (or whoever is designated within your program model) may be appropriate. SAFE examiners should be aware that the person providing treatment (i.e., the examiner) is ultimately responsible for obtaining meaningful consent.

Carefully document how determinations regarding capacity have been reached.

WHAT IS MEANT BY CONSENTING TO A SAFE EXAM?

Consent for a SAFE exam is an ongoing process. Ideally, the examiner will explain each step of the exam to

5. New York (NY) Public Health Law (PBH) § 2805-d; NY Mental Hygiene Law (MHY) § 80.03

the patient, and continually assess the patient's understanding of and comfort level with the proceedings. The patient should be aware that she can decline any step of the process at any time, without compromising her access to other care. For more information about the informed consent process, please consult hospital administrative policies and procedures.

Post-sexual assault care includes elements of both medical care and non-medical care such as forensic evidence collection. Therefore, a SAFE examiner's ability to proceed depends on the type of care in question and any reasons for incapacity to consent.

IN CASES OF SEXUAL ASSAULT, DO MINORS HAVE THE RIGHT TO REFUSE SAFE EXAMS, DECLINE REPORTING TO POLICE, AND KEEP ALL INFORMATION ABOUT THE HOSPITAL VISIT CONFIDENTIAL? DO THEY HAVE THE RIGHT TO PREVENT MEDICAL STAFF FROM INFORMING THEIR PARENTS?

Yes. A minor who can provide informed consent can refuse both medical care and forensic evidence collection after a sexual assault without involving a parent or the police. This is because minors may consent to all of the confidential reproductive and other health services that comprise sexual assault treatment, as well as rape crisis counseling⁶ and forensic evidence collection. When young people feel secure in the knowledge that hospital staff will respect their confidentiality, they may be more likely to seek care, especially after a sexual assault.

Elmhurst Hospital's SAFE program serves adolescents aged 13 to 17 in addition to adults; this group is afforded the same choices and rights as their older counterparts. Other programs have different age parameters for the minors they serve.

IS THERE AN AGE CUT-OFF FOR PATIENTS IN TERMS OF THEIR RIGHTS TO REFUSE FORENSIC EXAMS, DECLINE REPORTING THE INCIDENT TO THE POLICE AND/OR DECIDE NOT TO TELL THEIR PARENTS? WHAT ABOUT 12 YEAR OLDS, OR 9 OR 8 YEAR OLDS?

As noted previously, in New York State there is no minimum age established as a cut-off when determining whether or not a minor has the capacity to provide informed consent. This is a case-by-case evaluation based on the minor's ability to understand various treatment options and weigh the risks and benefits of each. While it is much less likely that very young children would meet the criteria for possessing capacity to

6. NY Civil Practice Law & Rules (CPLR) § 4510(a)(3)

consent, there is no law that establishes a minimum age to do so. In cases calling for mandatory reporting of child abuse or maltreatment, please refer to the section on disclosure on page 37.

IS A GENERIC FORM GIVING CONSENT FOR MEDICAL TREATMENT (SUCH AS THOSE PROVIDED FOR PATIENTS WITH DEVELOPMENTAL DISABILITIES) SUFFICIENT TO PROCEED WITH A FORENSIC EXAM?

No, this would not be sufficient for the forensic elements of post-sexual assault care.

WHEN PATIENTS PRESENT FOR MEDICAL CARE AND LACK CAPACITY TO CONSENT, HOSPITALS HAVE TIERED PROCEDURES INVOLVING ATTENDING, THE PATIENT'S "BEST INTEREST," ETC. DO THESE PROCEDURES APPLY IN CASES OF SEXUAL ASSAULT?

In general, emergency medical care may be provided in the absence of consent by an incapacitated patient, but the patient or someone legally authorized to consent on behalf of the patient must consent for the non-emergency medical or *forensic* aspects of care.⁷ If the patient is not able to provide informed consent, the health care team must wait until the authorized person becomes available to provide consent before proceeding. If no such person exists then the forensic aspects of the exam cannot take place.

In the case of a patient who is temporarily incapacitated, attempt to wait for the patient to regain capacity. If the incapacity to consent is a long-term condition, different rules may apply depending on whether a patient is a minor or adult. Family members, or even the hospital, may be able to petition the court for guardianship.

IF THE PATIENT IS UNCONSCIOUS AND INJURIES SUGGEST THAT SHE'S BEEN RAPED, CAN YOU ASSUME CONSENT TO PROCEED WITH THE KIT?

No. As controversial as this may be, if the patient is unconscious, she is unable to provide consent for the forensic exam.⁸ One rationale guiding this rule is that doing the exam under these circumstances could be experienced as a second violation. When the patient is conscious and able to think clearly, explore what

7. 10 NY Codes Rules and Regulations (NYCRR) § 405.9(c)

8. *Id.*

happened and whether or not she would like an evidence collection kit done. Until this time, nothing invasive should be performed (such as an internal exam) for evidence collection purposes. This practice is in line with patient agency and self-determination, which is particularly important for survivors of sexual assault.⁹

In the meantime, prevent evidence from being lost by collecting and storing clothing and maintaining chain of custody. Keep the patient in a secure setting, without washing or bathing. It is also acceptable to collect and store evidence that is yielded passively (for example, vaginal secretions on a sheet or absorbent pad) or during medical procedures (for example, from use of a foley catheter). Proper authorization/consent for release of such evidence can then be obtained at some future time.¹⁰

IN THIS SAME INSTANCE, WHAT IF THE PATIENT HAS LITTLE PROSPECT OF REGAINING CONSCIOUSNESS?

The answer is the same. If the patient is unable to provide consent, a forensic examination cannot be done. With respect to adult incapacitated patients, the normal rules governing provision of medical care to incapacitated patients (e.g., healthcare proxy) would apply to the medical elements of the sexual assault examination. However, there is no clear authority (other than a broad power of attorney or a court order) permitting administrative or healthcare proxy consent for performance of the forensic elements of the exam.

In the case of a minor incapacitated patient (with little or no prospect of regaining capacity), parents or guardians would typically have the authority to consent to both provision of post-sexual assault medical care as well as the collection of forensic evidence.

If a patient dies following an assault that also included a sexual assault, an evidence collection kit would be performed at the Medical Examiner (ME)'s office as part of the autopsy, either based on information received from an investigator or based on the condition of the patient's body during the external examination.

A PATIENT PRESENTS TO THE ED AFTER BEING SEXUALLY ASSAULTED, AND SHE IS INTOXICATED. CAN SHE CONSENT TO THE EXAM?

Medical providers should again be guided by the issue of capacity to give informed consent despite this patient's alcohol intake. Is she able to understand the procedure, its risks and benefits, and so on? If the

9. American Medical Association Code of Ethics, Informed Consent (E.8.08) (March 1981, updated November 2006): <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion808.shtml>

10. See Patricia M. Lee, British Columbia Centre of Excellence for Women's Health, *In the Absence of Consent: Sexual Assault, Unconsciousness and Forensic Evidence 7* (2001): <http://www.bcccewh.bc.ca/publications-resources/documents/absencereport.pdf>

patient is intoxicated to the point of lacking capacity, the provider should refrain from performing the evidence collection kit. Place the patient in a secure location so as to preserve evidence, document the situation including the patient's state and the reported time frame, and reconvene once the patient regains capacity. This is important not only to gain proper consent but to obtain the most complete narrative possible regarding the assault.

The procedure outlined above should also be followed in the case of a minor temporarily incapacitated due to drug or alcohol consumption. A parent is typically not able to give consent for a forensic examination in these circumstances because the minor would (most likely) be able to consent if he or she were not intoxicated. Therefore the best practice would be to wait until the minor regains the capacity to provide consent.

A PERSON WITH A DEVELOPMENTAL DISABILITY PRESENTS TO THE ED FOR A FORENSIC EXAM. IS SHE ABLE TO CONSENT?

Establish whether the patient is able to describe what transpired using words, drawings, or other methods such as picture boards or sign language. As with all patients, assess her level of understanding regarding the forensic exam and thus her ability to provide informed consent.

If the patient lacks capacity to consent, discuss issues of guardianship with the parents or staff accompanying the patient to the ED. Inquire about whether the patient has been deemed to have capacity to make medical decisions, and if not, who has been designated to do so. (If the patient is over 18 years of age, her parent is not automatically the legal guardian.) Ask to see legal documentation attesting to the designation, and document this in the patient's chart.

Either the patient or a person *legally designated* to make medical decisions for the patient must provide consent. (Again, forensic evidence collection does not constitute medical treatment; depending on the scope of the guardianship, this aspect may not be covered.)

If the patient cannot provide consent and is alone, or the guardian with appropriate authority declines the forensic exam or is unable to be located, the exam should not be performed. In addition, physical resistance should be interpreted as lack of consent. Exams should not be performed if the patient is struggling against the procedure.

WHAT SHOULD SAFE EXAMINERS KEEP IN MIND WHEN COLLABORATING WITH PSYCHIATRY REGARDING FORENSIC EXAMS?

Psychiatry should be consulted in many cases where the patient has underlying psychiatric issues. Suicidal or homicidal ideation indicates the need for psychiatric consultation.

Psychiatry should be able to generally describe the medical and forensic exam to the patient, including the risks and benefits involved, in order to determine capacity to provide informed consent. Once the procedure and the rationale for doing the exam have been explained, the patient should be invited to verbally repeat what she has just heard. Consent for the exam must be expressed coherently (though it may be expressed through diverse methods, as per the question on developmental disabilities).

If the patient is unable to convey consent, the exam should not be done. If the patient is impaired in terms of reality testing, capacity to consent to an exam must be considered with particular care. However, even patients with significant mental illness, if they concretely understand this particular decision, may possess capacity to consent to the SAFE exam.

IF A PATIENT MAKES "POOR" JUDGMENTS CAN WE INFER LACK OF CAPACITY TO PROVIDE CONSENT? FOR EXAMPLE, WHAT ABOUT A PATIENT WHO IS REFUSING HIV PROPHYLAXIS DESPITE NUMEROUS RISK FACTORS?

This is a difficult area that highlights tensions between personal autonomy vs. providers "knowing what's best" for patients. The onus is on the provider to ensure that the patient understands the risks and benefits of a particular course of treatment. If it appears that a patient doesn't completely understand the risks in question (for example, the gravity of acquiring HIV) but does seem to have capacity to provide consent generally, take some extra time to explain things clearly. If she continues to decline the HIV medication with apparent full understanding of potential consequences, then that decision must be respected.

If the time window permits, the provider might revisit the question the next day once the patient has had more time to reflect on the situation.

ARE THERE ANY INSTANCES IN WHICH THE HOSPITAL COULD GET IN TROUBLE FOR PROVIDING A FORENSIC EXAM?

Hospitals must obtain proper consent before proceeding with a forensic exam. Thus far, there are no precedents of a court holding a hospital, acting in good faith, liable for providing such care.¹¹

11. There are, however, cases that have been brought against hospitals for not meeting standards of care for sexual assault patients: <http://www.health.state.ny.us/press/releases/2000/coney.htm>.

WHEN TO COLLECT EVIDENCE

IN CASES OF STATUTORY RAPE,¹² WHERE THE SEXUAL CONTACT WAS CONSENSUAL AND THE PERPETRATOR KNOWN, IS IT IMPORTANT TO USE THE EVIDENCE COLLECTION KIT?

Yes, providing the minor consents to evidence collection. DNA from the perpetrator found in an evidence collection kit will prevent him from later arguing the victim made up the allegations, including the fact that sexual contact occurred. It puts the case into a different category: now, the ADA does not have to prove that sexual activity took place or the identity of the perpetrator. If victims choose to proceed with evidence collection, all their options remain open to them.

Minors can refuse post-sexual assault care, including evidence collection¹³ in cases of statutory rape.

IF THE PATIENT REPORTS ONLY DIGITAL PENETRATION, SHOULD AN EVIDENCE COLLECTION KIT BE DONE?

If the patient is the slightest bit unsure about what happened, err on the side of completing an evidence collection kit. A crucial issue to consider is whether the patient is able to remember the entire sequence of their assault. You must also be confident that the patient feels comfortable enough to disclose key aspects of what happened; for example, is he or she too embarrassed to disclose forced anal sex? Cases abound in

12. *Statutory Rape* is defined as non-forcible sexual intercourse with a person who is younger than the statutory age of consent; in New York, the age of consent is 17 years old. In general, the greater the age difference between victim and perpetrator, the more serious the offense.

13. From this point forward, in all instances that a kit is recommended it is with the assumption that the patient is providing informed consent.

which victims deny certain kinds of contact out of shame.

According to the New York City Medical Examiner's (ME's) office, it is very rare for digital contact alone to yield DNA results. Exceptions might include if the perpetrator licked his finger beforehand or had ejaculated into his hand.

When caring for patients who report exclusively digital penetration, use a colposcope to look for minute injuries. As with all sexual assault cases, document on the comprehensive assessment form, offer mental health counseling, etc. Perform components of the forensic exam appropriate to the history provided, such as collecting debris or scraping under the patient's fingernails. Treatment/prophylaxis for STDs probably would not be indicated (again, provided you have confidence in the patient's account).

Advances in DNA Science: Low Template DNA Testing

Low Template DNA testing (LT-DNA)* is a relatively new technology that enables testing of very low amounts of DNA. It is currently in use at the Forensic Biology Laboratory at the New York City Office of Chief Medical Examiner and just a few other labs across the country.

LT-DNA testing is best suited for clean surfaces (for example, a gun or a knife handle) handled extensively by only one individual.

This testing would be unlikely to detect the DNA of an attacker if he made only fleeting skin-to-skin contact (for example, rubbing his hand on a victim's arm). This is because DNA from the victim's own skin cells would overwhelm the scant cells the perpetrator left behind.

* Also known as Low Copy Number (LCN) or High Sensitivity DNA testing, and colloquially referred to as "Touch DNA."

IF A PATIENT REPORTS FORCED PERFORMANCE OF ORAL SEX, SHOULD EVIDENCE BE COLLECTED?

Oral swabs should be collected from the patient's mouth, in addition to other swabs/steps appropriate to the complaint. Be sure to swab between the lips and the gums, in back of the molars, etc. Examiners can also look for physical findings such as injuries to the lips and roof of the mouth.

In addition, collecting a dried secretion swab from the external genitalia of a patient who had oral sex performed on her may yield DNA from the perpetrator's saliva. Anywhere a bodily fluid may be recovered, it is best to collect a specimen.

IF THE PATIENT REPORTS AN ATTEMPTED RAPE OR SODOMY, SHOULD AN EVIDENCE COLLECTION KIT BE PREPARED?

In most cases, yes. What patients call an "attempt" will many times leave forensic evidence. Often patients are unaware of the degree of penetration that occurred or whether seminal fluid or saliva was left on them. In addition, patients sometimes report "attempted rape" out of embarrassment. Of course, if the patient describes momentary contact over a layer of clothing, then common sense should prevail, and a decision to forego the evidence collection kit made accordingly.

The legal definition of rape is specific, and different from what most people outside of law enforcement assume. While a patient might say, "He tried to rape me" because partial insertion occurred, the criminal definition of rape requires simply "penetration, however slight." Similarly, other terms describing sex acts may have specific meanings under the law and differ from common usage. If a patient says "tried to rape," put her words in quotes but in the chart also write factually what happened. In your descriptions, any penetration reported, *however slight, or any contact* between body parts should be noted.

These patients should be considered victims of sexual assault. Clinicians may be inclined to write "attempted rape" as the diagnosis; they should write "sexual assault" instead.

IS FORCIBLE KISSING OR LICKING OF NON-GENITAL REGIONS A SEX CRIME? SHOULD SWABS BE COLLECTED?

Any contact for sexual gratification may be prosecutable as the crime of sexual abuse¹⁴ if it occurs as the result of force or without the patient's consent. For example, a stranger licking a woman's neck on the subway or grabbing and kissing a child on the street could be a crime, as could contact involving an "intimate part," broadly defined (in one case, a toe). Swabs of these areas may yield forensic evidence.

14. NY Penal Code § 130

A PATIENT REPORTS BEING RAPED SEVERAL WEEKS AGO AND IS SEEKING MEDICAL ATTENTION FOR THE FIRST TIME. WHAT SHOULD ED STAFF OFFER THE PATIENT?

Cases like this can often be prosecuted. In fact, many patients wait days, months and even years before telling anyone what happened. As long as there is an understandable reason for the delay (for example, shame or fear) this does not necessarily pose a problem for the DA's office.

Even though DNA evidence generally would not be available beyond 96 hours past the assault, there is much that can still be done. Complete documentation of the assault is still important. Be alert for injuries that might not have completely healed. For child and adolescent patients who are not sexually active, it is especially important to conduct this aspect of the exam even if significant time has passed.

Whenever possible, use SAFE-trained examiners to care for patients reporting sexual assault, regardless of the timing of their hospital visit.

WHAT CARE IS APPROPRIATE FOR A PATIENT WHO, BECAUSE OF BEING INTOXICATED OR OTHERWISE IMPAIRED, CANNOT RECALL WHETHER OR NOT SHE CONSENTED TO SEX WITH SOMEONE?

The first step is to wait for the effects of the substance to wear off so the patient is able to think more clearly. Then, assess the patient carefully, listening for the point in the narrative at which the patient is not able to recall events. Since she has presented to the ED, she evidently feels distressed or violated in some way; fully explore the basis of these feelings. If there is any indication that the patient may not have consented to sex, an evidence collection kit would be indicated with the patient's permission. In these cases, the DFSA kit might also be in order.

The evidence collection kit is designed for use when non-consensual sex is reported. This is information valuable for the patient to consider. Prosecutors need to be able to prove lack of consent beyond a reasonable doubt. If the patient states she cannot remember whether or not she provided consent, proving that a sex crime occurred may be difficult.

When the facts of the case are not clear and the patient consents to evidence collection, evidence can always be collected and saved.

IF A PATIENT REPORTS CONSUMING ALCOHOL AND HAS MEMORY LAPSES AS A RESULT, SHOULD A DFSA KIT BE DONE?

DFSA scenarios often include a drink left unattended for some period of time, the drink being prepared out of sight of the patient, strange qualities (unusually salty, foamy, or with residue on the surface), and a more intense physiological reaction than usual with drinking alcohol. Typically, the patient will report having had one drink, and then no memory or “snapshot memories” from that point on. To learn more about the effects of “date rape” drugs, consult the information sheet within the DFSA evidence collection kit.

Make an informed decision leaning toward use of the DFSA evidence collection kit if there is the slightest suspicion that a drug was used to subdue the patient or that the patient was intoxicated to the point of being unconscious. There is no harm in collecting this evidence, especially if it appears that the patient's ability to consent was compromised.

IF A PATIENT REPORTS BEING DRUGGED BUT NOT SEXUALLY ASSAULTED, SHOULD A DFSA KIT BE USED?

Where outside facts suggest sexual activity took place notwithstanding the patient's contrary belief (for example, underwear is missing, a condom wrapper is found, or a witness saw the patient being fondled), the patient should be encouraged to consider a forensic exam. In many locales, a DFSA kit cannot be submitted without a sexual offense evidence collection kit as well.

A PATIENT PRESENTS TO THE ED AND STATES THAT PHOTOS OF HER INJURIES WERE TAKEN BEFORE SHE CAME TO THE HOSPITAL. SHOULD THE EXAMINER FOREGO TAKING PHOTOGRAPHS?

The examiner is an expert in forensic documentation and should endeavor to take photographs of injuries even if the patient, parents, and/or staff state that this has already been done. In Queens, photographs taken by police can be downloaded by the ADA and used at arraignment, so collaboration with law enforcement can be advantageous.

From a legal standpoint, it is irrelevant who takes the picture. Pictures need only fairly and accurately depict what is shown in them. Photographs should be labeled with the examiner's signature, date, patient name, and MR number, and stored according to hospital protocol.

Always be predisposed to take photographs. The importance of doing so can't be overstated. If a patient's injuries and bruises become more visible over time, they can be re-photographed.

ISSUES OF CREDIBILITY

HOW SHOULD AN EXAMINER HANDLE A SITUATION IN WHICH A PATIENT GIVES AN IMPLAUSIBLE RENDITION OF EVENTS?

The forensic examiner's role is to provide care and collect potential evidence, and not to judge the ultimate accuracy of a patient's account. It is important to remember that it is not the job of the medical team to decide if events did or did not occur.

Usually, the best course of action is to accept the history that is given and to provide the indicated treatment. There is therapeutic value to the patient in being taken seriously and believed. Furthermore, it is central to the SAFE program ethos to give choices and control to the patient rather than peremptorily making decisions on her behalf.

However, there will be times when examiners find themselves having misgivings. Why allow a patient to endure a grueling exam when it seems entirely superfluous? In such a case, emphasize that the most meaningful treatment inevitably depends on the patient providing accurate information. Inquire about what the patient feels she might gain from the forensic examination and/or briefly explain the seriousness of the criminal investigation following an allegation of sexual assault.

Create a safe environment for the patient to fully disclose what occurred. Exploring the patient's concerns may be helpful. For example, an adolescent may be apprehensive about parental reactions to a consensual sexual relationship, becoming pregnant, or a missed curfew; an adult may be seeking medical care she fears she couldn't otherwise afford. With a general statement, an examiner might mention that people sometimes find themselves in such situations. Assure the patient that social work support will be provided to help with her concerns. At no time should examiners, or any hospital personnel, depart from a judgment-free treatment environment.

WHAT IF AN EXAMINER DISCOVERS UPON ARRIVAL THAT DETECTIVES ARE NOT PLANNING TO TAKE A GIVEN CASE?

Hospital protocol requires an assessment, treatment, and evidence collection if the patient reports sexual assault and consents to the forensic exam. In most instances it should be the social worker, advocate or examiner who provides the initial care. However, if an examiner arrives and detectives have already concluded that they will not pursue the case, the reasons for their decision can be discussed with the patient, and support provided. If the patient still wants to proceed with the forensic exam, evidence can be collected and maintained at the hospital.

HOW SHOULD WE THINK ABOUT CASES WE HAVE SEEN WHERE IT IS LATER DETERMINED THAT THE ALLEGATION WAS FALSE?

As a matter of course, a small percentage of patients cared for by examiners will be providing reports that the examiner suspects or that are later proven to be untrue. (This is true in all crimes, not just sexual assaults.)

There can be many reasons why a person reports in a way that is untruthful. For example, a person may be angry at the accused perpetrator, or she may be using the story of sexual assault to seek nurturing and attention. In some cases, patients might have experienced sexual assault or abuse in the past and genuinely believe it is reoccurring through flashbacks or delusions. A sense of desperation may drive these reports; the patient is trying to cope with distress that otherwise would feel unmanageable. Viewed in this light, a false report should be seen as a cry for help. Patients should be provided with support and resources to help them make more adaptive choices in the future. Examiners should simply provide care for the stated complaint, considering it part of the job that some of the complaints will prove to be unfounded.

DOCUMENTATION

AN ADOLESCENT PATIENT IS WAITING FOR DETECTIVES TO ARRIVE. DURING THIS TIME, SHE IS TALKING AND LAUGHING INTO HER CELL PHONE. WHAT SHOULD BE WRITTEN IN THE "EMOTIONAL PRESENTATION" CATEGORY?

The examiner doesn't need to write anything. This is especially true if the behavior takes place before the exam/history begins. Some reactions (such as giggling during the history-taking) can be a normal response to a stressful or uncomfortable situation.

A TEEN HAS AN EXTENSIVE RECORD OF RUNNING AWAY, PINS PETITIONS, AND ALCOHOL AND DRUG USE. HOW MUCH OF THIS INFORMATION SHOULD BE INCLUDED IN THE SAFE EXAMINER'S DOCUMENTATION?

SAFE documentation should be based on the assessment of the patient and focus exclusively on the circumstances of the sexual assault and what is necessary for medical diagnosis and treatment. To the extent that the "who, what, when, where and how" of the sexual assault incorporates this information, it may be included where appropriate.

IN A SIMILAR CASE, AN ADOLESCENT PRESENTS AFTER BEING RAPED. HER MOTHER IS WITH HER AND IS ANGRILY PROVIDING SENSITIVE INFORMATION (HER DAUGHTER BRINGING MEN HOME FOR SEX, TRUANCY, ETC.). WHAT, IF ANY, OF THIS INFORMATION SHOULD BE INCLUDED IN THE SOCIAL WORK NOTE?

Social workers conduct collateral interviews with family members and must judge what portions of a parent's statements are valuable in creating psycho-social assessments. Inclusion of sensitive information should be geared toward patient treatment needs. (As noted previously, social work notes are typically not

discoverable, though there are circumstances in which they must be turned over to the counsel for the defense.)

The daughter's acting out behavior and the mother's anger in the face of a traumatic event warrant a mental health referral. In addition, both the mother and patient would likely benefit from education regarding the blaming of victims of sexual assault. Regardless of a victim's actions, the burden of responsibility rests with the perpetrator.

A CHILD VICTIM OF A STRANGER RAPE CAME TO THE PEDIATRIC ED. THE ATTENDING WROTE AS THE DISCHARGE DIAGNOSIS "SEXUAL ABUSE" INSTEAD OF "SEXUAL ASSAULT." WHICH TERM IS PREFERABLE, AND WHY?

Sexual offenses have legal definitions as well as common usage connotations. As a general rule, "assault" implies the use of force regardless of whether the patient is a child or adult. "Abuse" may be used in cases involving relatives or people known to a child; "abuse" also may be used in hand-to-body touching, regardless of age. Many health care providers automatically use the word "abuse" to describe sexual contact with children. However, if force was used "assault" is typically a better choice. To some, including potential jurors, the term "abuse" sounds less serious than the term "assault."

A PATIENT PROVIDED ONE RENDITION OF THE EVENTS OF THE ASSAULT, AND SUBSEQUENTLY DURING THE VISIT PROVIDED A DIFFERENT RENDITION. DOES THE EXAMINER HAVE TO FILL OUT A WHOLE NEW CHART?

No. Simply put an addendum to the first chart, explaining what happened—that the patient provided new or additional information. It's important not to view these discrepancies as an annoyance, but as potentially resulting from trauma or other unknown factors. An accepting manner must be maintained.

AFTER THE SAFE EXAM WAS COMPLETED, IT BECAME CLEAR THAT THE PATIENT HAD REGISTERED UNDER A FALSE NAME. WHAT STEPS SHOULD BE TAKEN?

Personnel should maintain medical records in accordance with hospital policy. Whatever rules exist for correcting the record should be applied here. What has been written by the examiner (e.g., the patient's name, etc.) should not be crossed out at a later time.

ISSUES OF DISCLOSURE

WHEN DOES THE LAW REQUIRE THAT A REPORT BE MADE TO CHILD PROTECTIVE SERVICES (CPS)¹⁵ OR TO THE POLICE?

Health care providers may not disclose medical information without the patient's consent unless otherwise required by law. The law requires all "mandatory reporters" to make a report to CPS when they have a reasonable suspicion that a minor has been abused or neglected by a parent, guardian, or person legally responsible for the minor's care.¹⁶ Abuse or maltreatment is defined as the parent or caregiver directly harming the child or allowing the child to be physically, emotionally, or sexually abused.

When a minor is having sexual relations with someone within her household, or where sex is forced or coerced and parents are aware and fail to intervene, a report to CPS is usually appropriate.

The law allows for a breach of confidentiality if a patient poses a serious danger to a third party.¹⁷ Providers are also required to report to the police when patients present with gunshot wounds or life-threatening stab wounds.¹⁸

SHOULD WE INFORM CPS IF WE LEARN THAT A MINOR UNDER THE AGE OF 17 HAS BEEN HAVING SEX?

Even though young people under 17 are not by law capable of consent for sexual activity, a mandated reporter who learns that a minor has had sex should not automatically make a child abuse report. In

15. Calls to the statewide Central Register of Child Abuse and Maltreatment result in information being relayed to the local CPS for investigation; the Central Register also monitors that agency's prompt response and identifies if there are prior child abuse or maltreatment reports. In New York City, the local agency is known as ACS.

16. NY Social Service Law (SOS) § 413

17. NY Civil Practice Law & Rules (CPLR) § 4508(a)(2)

18. 10 NY Codes Rules and Regulations (NYCRR) § 405.9(c)(2)(v)

addition, a report is typically not necessary when parents are found to possess knowledge that their child is voluntarily sexually active with a peer.¹⁹

IF A MINOR HAS BEEN SEXUALLY ASSAULTED OR IS A VICTIM OF STATUTORY RAPE, WOULD A REPORT TO CPS BE REQUIRED?

No. As noted above, unless a parent, guardian, or other person legally responsible for the child is the perpetrator of sexual assault (or a sexual assault against an adult was witnessed by a child), a report would not be required. In general, if a parent/guardian does not know about a harmful situation, a report would not be mandated. However, if a parent knows (or should have known) of danger posed to his/her child and has not taken appropriate steps, a CPS report may be called for. Social Work should be involved in making these determinations.

MAY WE TELL CPS THE RESULTS OF MEDICAL EXAMS PERFORMED ON A SEXUAL ASSAULT VICTIM?

If hospital staff called in the suspected child abuse report to CPS, it is permissible to share exam results with this agency. Otherwise, the request must be by court order and should be referred to the appropriate department, such as Risk Management and/or Medical Records.

SHOULD MANDATORY REPORTERS INFORM LAW ENFORCEMENT ABOUT INSTANCES OF STATUTORY RAPE WITHOUT THE PATIENT'S PERMISSION?

No. In health care settings, staff should not report crimes committed against their patients, including capable minors, if patients do not wish to do so.

19. For more detailed information regarding reporting obligations, see New York Civil Liberties Union, *Child Abuse Reporting and Teen Sexual Activity: Clarifying Some Common Misunderstandings (FAQ)* (March 2008): <http://www.nyclu.org/node/1707>.

THE POLICE ARE STRONGLY REQUESTING RESULTS OF THE MEDICAL EXAM; THEY WANT TO KNOW IF WE "SEE EVIDENCE OF A RAPE." WHAT MAY WE TELL THEM?

Make sure your patient has signed the authorization form to disclose confidential medical information before discussing the medical exam, even if you know the patient intends to cooperate with law enforcement. There is no reason, if the form is signed, to withhold your findings from detectives and/or the ADA.

Absence of injury can be consistent with sexual assault. However, in some instances detectives may feel they don't have much to proceed on unless injuries are present. Injuries can also result in the setting of higher bail.

A "strong-arming" tone is not appropriate for police to use in interactions with an examiner or any ED personnel and must not be allowed to provoke anxiety or to circumvent procedures related to signing the authorization form.

IF THE AUTHORIZATION TO DISCLOSE HEALTH INFORMATION HAS BEEN SIGNED, IS IT PERMISSIBLE TO ALLOW POLICE AND/OR ADAs TO LOOK AT THE MEDICAL CHART IN THE ED WITHOUT TAKING A COPY?

Generally, it is not necessary to allow police to look at patients' medical records. However, what is protected is the information, so if the patient has authorized disclosure of information related to their current hospital visit, the difference between verbal and written authorization is not significant.

ARE POLICE GOING TO INFORM A PATIENT'S PARENTS?

Unlike medical professionals, police are not mandated by the rules of confidentiality. They use their discretion about whether to inform the parents and how much detail to disclose. Minors should know that whatever they tell the police does have the potential to be communicated to their parents so that they can then make an informed decision about their course of action. Minors who elect to report should be encouraged to speak directly to the police about their concerns.

SAFE PATIENTS AND LAW ENFORCEMENT

THE EXAMINER ARRIVES TO FIND THE PATIENT ALREADY BEHIND CLOSED DOORS, BEING INTERVIEWED ALONE BY DETECTIVES. WHAT IS THE BEST COURSE OF ACTION?

The examiner can ask to talk to the detectives outside the room. It is important to remind the police that the patient has come to the hospital for health care and that the health care must be provided within a clinically appropriate timeframe. The examiner can explain that the patient may need emergency medical care and that some medications, such as HIV prophylaxis or emergency contraception, need to be given within certain time windows to be effective.

If you think it is a concern, find out if the patient has been informed that she has a right to have an advocate present during police interviews. She should also be aware that it is her choice whether or not to have police involvement. Ideally, there will be a built-in means of informing patients of their rights upon presentation at the hospital.

Police prefer that interviews not be disrupted once they are underway. However, if the interview seems to be taking an inordinately long time, examiners might request that the medical/forensic exam begin. Ideally, the two disciplines will cooperate as a team, putting the best interests of the patient first.

WHEN MIGHT LAW ENFORCEMENT REQUEST PRIORITY IN TERMS OF CONDUCTING THE PATIENT INTERVIEW?

Once the basic facts of the case are known, law enforcement typically conducts the bulk of their interview after the SAFE exam has taken place. Exceptions include when evidence at the scene needs to be promptly gathered or police need information from the patient immediately in order to find an assailant who is at large.

WHY DO DETECTIVES WANT TO BE ALONE WITH THE PATIENT?

Having an audience during interviews can hinder the process of disclosure. Detectives want to prevent cues from being taken from people in the room. They also recognize that some patients edit their accounts in the presence of others and/or fail to share embarrassing details.

POLICE INTERVIEWING TECHNIQUES CAN BE AGGRESSIVE. WHY IS THIS?

Police may believe a “kid gloves” approach is not effective in discovering the truth. Most draw a distinction between being stern—letting the patient know the potential consequences of what is said—and police brutality, which is not acceptable. Advocates and social workers may not have access to all the information held by police during an interview, which would explain the use of a stronger approach.

Aggressive interviews should not take place on hospital premises. When interviews become threatening in tone the advocate (or other personnel) can intervene and suspend questioning while the patient is in the hospital.

Patients are more likely to get “cold feet” about going forward when they feel threatened, disbelieved, or unsafe during the interview process.

WHAT SHOULD WE DO IF WE FEEL POLICE ARE BEING TOO AGGRESSIVE WITH A PATIENT?

Ask the officer to step outside the room in order to discuss issues; it is best not to express reservations about interview tactics in the presence of the patient. If this fails, call for guidance from the ADA on duty. Cultivate relationships with your police department's Special Victims Liaison Unit, the head of Special Victims, and your DA's office so that you can call on these colleagues in situations such as this. Patients should know they have the right to halt police interviews at any time.

IF A PATIENT BEING INTERVIEWED BY POLICE IS HIGHLY DISTRAUGHT, WHAT CAN BE DONE?

Speak to the police officer in private, and try to arrive at a reasonable compromise. For example, it might be possible to dedicate a few moments to helping the patient collect herself. It is especially important to adjust the pace of the interview when memories of the assault trigger the patient's distress.

Ultimately, hospital staff have final say about whether it is clinically safe for an interview to proceed.

PATIENTS OFTEN COME TO THE HOSPITAL DIRECTLY FROM A POLICE PRECINCT. SOMETIMES THEY HAVE POLICE PAPERWORK IN HAND; SOMETIMES THEY DO NOT. WHY IS THIS?

If a person has filed a police report, they should possess a complaint number and the business card of the detective with whom they were working. Typically, a police officer would accompany the patient from the station to the emergency room.

Reasons for absence of police paperwork could be as simple as the computer system being down while the patient is at the precinct. Reconfirm whether the patient consents to notify the police and if the police were in fact informed.

When police unfound a case at the hospital (for example, when the patient recants), a report is still generated by the police and a second piece of paperwork closing the case signed off on.

SOMETIMES PATIENTS PRESENT HAVING BEEN ARRESTED THEMSELVES (FOR EXAMPLE, DUE TO AGGRESSION TOWARD THE PERPETRATOR). IS THERE ANY DIFFERENCE IN HOW THE REPORT SHOULD BE HANDLED?

Cases involving cross-complaints are most common in the domestic violence (DV) arena. No matter what the circumstances, patients should not be treated like criminals. If a patient is treated disrespectfully, be sure to take down the name, precinct, and badge number of the personnel involved. If possible, share your observations and concerns with the officer in question out of the patient's earshot. If this is not sufficient, reach out to your contacts for help in intervening. Again, it is of value to have an ongoing relationship with the head of Special Victims Detectives in your area, the Special Victims Liaison Unit, and your DA's office.

CAN A PATIENT WHO MAKES A FALSE REPORT FACE CRIMINAL CHARGES?

Falsely reporting a crime to the police is a criminal offense. Law enforcement strives to prevent people from exposing themselves to this kind of liability. Often, ADAs grant immunity to victims in early interviews: "if you come clean now, there will be no consequences." However, if a person goes before a grand jury under oath and lies about the allegation, she can be arrested.

Difficult questions may be asked to ensure the police are not sent on a wild goose chase or wrongly arrest an innocent person. In reality, it is rare for sexual assault patients to be prosecuted for making false claims.

SOMETIMES MEDICAL STAFF AND LAW ENFORCEMENT BOTH NEED TO SCHEDULE FOLLOW-UP APPOINTMENTS. ARE THERE ACTIVITIES FOR WHICH HOSPITAL STAFF SHOULD DEFER TO THE CRIMINAL JUSTICE PROCESS?

If medical treatment would not be compromised, it makes sense to allow the police process priority in urgent cases. Enlisting the patient's help in doing sketches, viewing police line-ups, returning to the crime scene, drawing up search warrants, and participating in law enforcement interviews are critical steps meriting cooperation on the part of SAFE programs. Whenever possible, SAFE examiners, law enforcement officers, and social workers should coordinate follow-up.

SAFE PATIENTS AND THE CRIMINAL JUSTICE PROCESS

WHAT SHOULD WE COUNSEL PATIENTS TO EXPECT REGARDING THE WORKINGS OF THE LEGAL SYSTEM?

It's important not to sugarcoat how arduous pursuing criminal justice can be; patients often find the process emotionally grueling and time-consuming. However, there will be ongoing support available to patients, either through hospital-based programs, the DA's office, or a local rape crisis program.

SAFE team members should have working familiarity with how sex crimes are prosecuted in their locale.

How the criminal justice process works in Queens:

The Sex Crimes ADA is notified when an arrest is made for crimes against children and first degree felony sex crimes. As a general rule, the role of the police is to identify the perpetrator and the role of the ADA is to prove the case beyond a reasonable doubt. Arraignment of the defendant ordinarily occurs within 24 hours of arrest. At the arraignment the defendant is informed of the charges against him, bail is set by the court, and (if applicable) an order of protection issued.

Many defendants plead guilty prior to the case being presented to a grand jury for indictment. Others plead guilty after indictment but before the trial. (Approximately 2% of cases are tried; most are resolved during the negotiations process.) Plea offers are typically discussed with the victim prior to being made in court. While prosecution decisions are made at the discretion of the ADA, the victim's feelings about the case are a consideration in how the ADA elects to go forward.

In Queens, the results of the evidence collection kit are generally available within one to three months. They can be obtained from the ADA assigned to the case. Arrest to disposition of the case takes approximately one year but can vary widely.

These procedures may vary based on locale.

WHAT IS THE ROLE OF "UNIFORMED OFFICERS" (THOSE RESPONDING FROM THE PRECINCTS) COMPARED TO THAT OF THE DETECTIVES?

In Queens, the uniformed officers from the appropriate precinct (where the sexual assault occurred) take the initial complaint report, secure the crime scene, and get the victim medical attention. They establish that an assault is being reported and get the general facts of what occurred. The officers then contact Special Victims detectives, who conduct a detailed interview. It is the detectives who work in conjunction with the DA's Office.

ALTHOUGH IT IS THE PATIENT'S DECISION TO GO FORWARD IN THE CRIMINAL JUSTICE SYSTEM, HOW MUCH SHOULD WE PROVIDE "ENCOURAGEMENT?"

Patients should not feel pressured by examiners or any other staff. The areas to discuss are 1) education about the sexual offense committed, and 2) issues that may prevent a person from wanting to press charges. The potential benefits of reporting might be shared with the patient: feeling empowered or reducing the likelihood that the perpetrator would harm others.

It is important not to judge a patient's decision to forego reporting and not to lead her to feel guilty about her choice to not report. The patient herself is the only one who has a full understanding of the factors and risks involved.

WHAT ARE SOME THINGS WE COULD SAY TO BE REASSURING?

- The patient is fortunate to have come to a hospital where a special program is in place, and to be in a county where this kind of offense is treated very seriously.
- Everyone involved in the case will be a trained professional specializing in the prosecution of sexual assault.
- The process provides an opportunity to speak out against what the defendant did and to reclaim the power and control that he tried to take during the assault.
- When handled well, the criminal justice process can be a crucial part of the healing process.

IS THERE A DIFFERENCE BETWEEN FILING A REPORT AND MAKING A REPORT? CAN A PATIENT TELL THE POLICE AN ASSAULT HAPPENED AND LEAVE IT AT THAT?

In New York City “filing a report,” “making a report,” and “pressing charges” are all the same thing. If a complaint is made to the police, the victim is expected to be willing to cooperate with the investigation.

To be certain a report has been filed, patients should have a piece of paper with a complaint number on it in hand. They should also note the name, phone number, shield number, and precinct of the officer with whom they filed the report.

PATIENTS OFTEN FEEL OVERWHELMED BY THE THOUGHT OF TELLING THE STORY OF THEIR RAPE. HOW MANY TIMES WILL THEY HAVE TO DO SO?

Realistically, they will probably have to provide the narrative numerous times. Further, detectives and ADAs may ask the same questions repeatedly, from multiple angles, in an effort to establish consistency.

In Queens, victims work with the same ADA from the beginning to the end of a case. The ADA strives for a personal bond, so as to minimize trauma to the victim. As noted previously, counselors are available to help with this process.

OUR PATIENTS SOMETIMES HAVE PRECONCEIVED IDEAS ABOUT WHAT WILL HURT THEIR CASE. WHAT ARE SOME CIRCUMSTANCES TO BE ALERT FOR, AND HOW MIGHT WE COUNSEL THE PATIENT IN RESPONSE?

There are four main categories that patients tend to feel concerned about: drinking, drug use, the degree of force used, and prior contact with the suspect. The victim may feel partly responsible for what happened because she was intoxicated and so may minimize the alcohol use in her narrative. Maybe she invited him up for a drink and feels ashamed that some part of the evening was voluntary. Some victims regret not resisting more aggressively, but it's important to underscore that this lack of resistance may have saved their lives. Plus, some victims feel it casts doubt on their account if they knew the perpetrator prior to the assault or had even been on a date with him.

Patients should be reassured that cases can be won despite all these things. If the victim fails to tell the truth at the beginning, the untrue story will appear in the police reports and the hospital record, and she will be cross-examined about such discrepancies at trial. The importance of being truthful right from the start should be emphasized to the patient; inconsistencies in complaint reports can damage a victim's case.

VICTIMS OF SEXUAL ASSAULT WHO KNOW THEIR ASSAILANT, INCLUDING ADOLESCENTS IN STATUTORY RAPE CASES, ARE OFTEN RELUCTANT TO GO FORWARD WITH THE CRIMINAL JUSTICE PROCESS. WHAT INFORMATION CAN WE GIVE SUCH PATIENTS?

Sometimes the patient is afraid her partner will go to jail. However, this is not the only possible outcome; often courts order counseling services for the offender as part of probationary sentences. The bottom line is that the perpetrator is responsible for his decisions, and the fact that the patient told someone is not the equivalent of "putting him in jail."

A PATIENT IS CONSIDERING PRESSING CHARGES AGAINST HER HUSBAND FOR SEXUAL ASSAULT BUT IS CONVINCED THAT NO ONE WILL TAKE HER SERIOUSLY.

This patient can be assured that marital status plays no role in the consideration of whether a crime occurred. Her case will be investigated as thoroughly as any other case. In fact, most precincts have officers specifically assigned to the area of domestic violence.

WHAT ARE SOME OTHER THINGS PATIENTS TEND TO WORRY ABOUT?

Patients may fear that recreational drug use will be revealed – for example, when considering use of a Drug Facilitated Sexual Assault (DFSA) evidence collection kit. However, most DA's offices maintain that a patient

would not be prosecuted for a positive result for recreational drug use, especially if the patient has acknowledged the drug use all along.

In addition, many patients fear immigration issues; they think the US Citizenship and Immigration Services (USCIS, previously the INS) will discover their undocumented status and deport them. However, New York City law enforcement is prohibited through Executive Order by the Mayor's Office from reporting crime victims to immigration authorities. The Queens DA's office is unaware of any instance in which there was a deportation in connection with a crime report.

In some instances, a sexual assault patient can petition for a U Visa (non-immigrant status), permitting a stay of up to four years and the option to apply for permanent residency.²⁰ Refer such patients to appropriate social or legal service providers for assistance.

WHAT ABOUT PERPETRATORS WHO THREATEN THEIR VICTIMS THAT IF THEY REPORT TO THE POLICE, A REPORT WILL BE MADE TO THE USCIS?

The USCIS will not take action if a perpetrator reports that his victim is here illegally. Intimidating a victim or tampering with a witness are crimes and could subject a defendant to re-arrest and additional charges.

THE PATIENT IS CONSIDERING PRESSING CHARGES, BUT SAYS SHE NEVER WANTS TO SEE HER ATTACKER AGAIN. WHAT CAN WE TELL HER?

In reality, she won't have to see him very much. The first possible viewing, lasting only a moment, would be at a line-up if this was called for in the case. (One-way glass prevents the victim from being seen.) If a trial took place, the patient would be asked to identify the defendant with a quick glance. Guards ensure the defendant remains seated, and he is not permitted to move when a witness is testifying.

WHEN A CASE GOES TO TRIAL, HOW MUCH TIME CAN A VICTIM EXPECT TO SPEND IN LEGAL PROCEEDINGS?

Each legal proceeding is different and the amount of time it takes to prosecute sexual assault cases varies. On average, a victim might spend parts of 1 to 4 days in total. During the initial investigation, the patient

20. Violence Against Women Act (VAWA), 2005

may be asked to visit the police precinct several times to provide necessary background information, look at mugshot profile books, help with a police sketch, etc. Shortly after the arrest, usually between five days and a few months, a victim might meet with a prosecutor and spend up to an hour in the grand jury. Prior to trial, twelve to eighteen months might have passed.

If the case proceeds to trial, additional hours of preparation will be needed and, of course, the day(s) she is to testify in court. If asked, an ADA will provide letters to a victim's employer/school, stating she appeared at the DA's office and/or court at the DA's request as a witness in a matter. No specifics will be disclosed in either letters or calls unless the patient requests otherwise.

However, the literal number of days spent may pale beside the length of time the victim is emotionally impacted by what happened, including feeling "re-triggered" by days devoted to the criminal justice process. It may be years before the victim feels she has truly finished the process.

WHAT SHOULD A VICTIM EXPECT IF SHE HAS TO TESTIFY BEFORE A GRAND JURY?

Many victims are surprised to learn that their grand jury testimony, if needed at all, typically lasts no longer than fifteen minutes. The only person speaking to the witness is the prosecutor. There is no judge present and neither the defendant nor his attorney is there; the only people who hear the witness are twenty-three citizens who have been sworn to secrecy. The purpose of the grand jury is to formalize the charges and determine that enough evidence exists for the case to continue in the New York Supreme Court. Questions will be discussed with the witness beforehand. If the grand jurors have additional questions (and they usually do not), they inform the ADA. Should the ADA agree that the questions are appropriate, he or she will pose them to the witness. There is no cross examination of anyone except the defendant and defense witnesses in a grand jury.

WHAT INFORMATION ABOUT THE PATIENT IS PROTECTED, I.E., NOT ADMISSIBLE DURING TRIAL?

New York State's rape shield laws²¹ prevent the prior sexual history of a victim from being revealed at trial, with a few exceptions. Admissible information must be directly relevant to the effort to prove or disprove the alleged crime. Psychiatric histories are protected unless they have a bearing on the ability to perceive

21. NY Criminal Procedure Law (CPL) § 60.42

or recall, or to understand the nature of an oath. A victim's experiences of depression, suicidal ideation, or past abuse are unlikely to be admissible in court; past rape allegations, however, can come in. Similarly, information about sexual conduct with partners other than the perpetrator, abortions, STDs, and the like would typically be kept out of the proceedings. Sometimes, independent psychological reports are called for, but this happens only rarely. Advocate report forms are protected by New York State law²² and cannot be subpoenaed in any form.

The ADA redacts sensitive information him/herself, or makes a motion for a protective order. Whether or not the information is allowed depends on the ruling of the trial judge.

VICTIMS ARE AFRAID OF RETRIBUTION. HOW SERIOUS ARE THE RISKS?

Upon arraignment, the court will usually issue an order of protection and inform the defendant that any contact with the patient is forbidden and may result in his re-arrest, additional charges, and increased bail. The order remains in effect throughout the case and for years to follow. It is rare for a defendant to interfere with a victim after he is arrested.

If a defendant attempts to contact the victim, the police should be notified immediately and actions will be taken to ensure the victim's safety. Records of phone calls made or emails sent can create leverage resulting in a plea bargain or stiffer sentence. In addition, counselors are available to help victims regain a sense of security in the aftermath of crime.

A PATIENT WAS RAPED BY A GANG MEMBER WHO KNEW WHERE SHE LIVED. WHAT CAN BE DONE TO PROTECT SUCH VICTIMS?

There are specialized units of the New York Police Department (NYPD) available to address safety issues related to gang activity. Orders of protection are issued in virtually every case, hourly patrols may be ordered by the local precinct, and in extreme circumstances, assistance may be available to relocate the patient. Consult your local law enforcement and/or ADA for the policies, procedures, and resources in your community. Even with these protections, fear about safety remains reasonable.

22. NY Civil Practice Law (CVP) § 4510

CAN A PATIENT CHANGE HER MIND AND DROP CHARGES?

Once the case has been reported, it is essentially not the victim's case; it is the DA's case, and the victim becomes a key witness. The decision about whether to proceed rests with the police and the DA's office. Of course, if the patient becomes reluctant to continue, this is a significant factor in the DA's decision to prosecute. (In some jurisdictions, the case would be immediately dropped.) Agencies always consider victim preferences, but the filing of a criminal complaint is a serious matter and, once initiated, the process may be difficult to stop.

IF THE VICTIM REFUSES TO COOPERATE, WHAT HAPPENS?

A victim who elects not to go forward once a case has progressed can be served a subpoena to appear at court, issued a material witness order, and in some cases could even be arrested. Material witness orders authorize law enforcement to bring the victim to court to explain why she is not cooperating.

All parties avoid these more drastic measures at all costs. If a victim becomes reluctant to continue, she should schedule an appointment with the police or ADA to discuss her feelings. In the majority of cases, a mutually agreeable resolution can be reached.

TO PROSECUTE RAPE CASES, IS VICTIM COOPERATION NEEDED?

It is possible to prosecute without victim cooperation, as long as there is some non-hearsay evidence²³ establishing that sexual relations occurred. For example, semen is present in an underage child or products of conception yield the perpetrator's DNA.

Forcible sex crimes can only be charged if the victim testifies to the force that was used; there is generally no other way to establish this aspect of the crime.

WHAT IF THE OPPOSITE HAPPENS: THE DA'S OFFICE DECIDES TO CLOSE A CASE BUT THE VICTIM WANTS TO CONTINUE?

23. *Hearsay* statements are those where a third party, rather than someone with first-hand knowledge, is used to establish the truth of what happened.

Unfortunately, there has been little recourse when police and the ADA decide to close a case. If a victim wants to know more about why such a decision was made, the police or ADA may be able to provide information. The victim could reach out herself, or (permission granted) staff can contact the police or DA and explain the situation: "I have an upset patient who doesn't understand why her case was closed. I'm hoping to understand it better myself so I can best support my patient." If there seem to be facts about which law enforcement was unaware, additional information can be shared.

ARE DETECTIVES USUALLY CORRECT WHEN THEY DECIDE A CASE IS UNFOUNDED?

Special Victims detectives are careful in their decisions not to pursue cases, and do so in consultation with the DA's Special Victims Bureau.

It may be of some comfort to know that when a case is not pursued, it does not necessarily mean that the victim is being considered untruthful or that something traumatic did not occur. Legally sufficient evidence must exist to sustain charges "beyond a reasonable doubt." The circumstances of a particular case may make it inhumane to put a victim through an arduous legal process involving charges that cannot be proved.

IF A CASE IS CLOSED, CAN A VICTIM HAVE HER EVIDENCE COLLECTION KIT ANALYZED ANYWAY? WHAT HAPPENS TO THESE KITS?

Once signed over to law enforcement, evidence collection kits are the property of the police and, counterintuitive as it may seem, a victim has no proprietary right to the evidence. If detectives properly unfound a case, generally any DNA found would be of little help. Sex may have taken place but no crime is determined to have occurred.

There are laboratories that test evidence kits privately for a fee, but these results are not admissible in a court of law. Once a patient, or the parent of a patient, takes the kit into their possession, the chain of custody is broken. In addition, results of DNA testing are only meaningful when compared against state and federal DNA databases.

If the police have already vouchered the kit and the case is closed/unfounded, they are tasked with informing the ME's Office/Crime Lab. Processing then may be halted.

CAN EVIDENCE COLLECTION KITS BE ANALYZED AGAINST THE PATIENT'S WISHES, OR WHEN POLICE DECIDE NOT TO PURSUE A GIVEN CASE?

In New York City, the ME's office generally stops work on a kit if they learn that no crime was committed. However, the DA's office can ask the ME's office to analyze a kit even if the police unfound the case or a victim changes her mind about pursuing it. For example, analysis of a kit may continue when the alleged perpetrator is suspected of assaulting other people.

CAN A CASE BE REOPENED AT A LATER DATE?

Yes. A victim can be informed that if any other information surfaces that has bearing on her case (for example, allegations against the perpetrator by someone else in a case of workplace sexual harassment), the detective can be contacted.

IF A VICTIM IS UNABLE TO PURSUE HER CASE CRIMINALLY THROUGH THE DA'S OFFICE, IS THERE ANY OTHER RECOURSE?

If someone has been negligent (for example, a landlord not providing locks on doors, or a place of employment leaving stairwells dark), pursuing a civil suit might be an option. In these types of cases, victims sue for emotional or physical injuries, and damages are monetarily awarded. The assailant does not have to be identified. Instead, the focus is on whether or not someone's failure to comply with existing codes and regulations contributed to a sexual assault.

Cases of sexual harassment that do not meet standards of criminality can also be pursued through a civil suit. Civil cases need to be initiated within certain time periods. A patient who believes she has grounds for a civil case should consult a private lawyer as soon as possible.

WHAT IF A VICTIM MAKES A REPORT BUT HER CASE IS NOT PURSUED BY THE DA'S OFFICE?

Reporting a crime and cooperating with the prosecution can be an affirming experience, even if the assailant isn't convicted. Electing not to come forward may leave a victim to live forever with the knowledge that she did not act or speak out. In addition, a rapist emboldened by the fact that the victim did not prosecute may be more likely to rape again.

FOR VICTIMS WHO DON'T WANT TO GO FORWARD IN PRESSING CHARGES, WHAT OTHER RECOURSE CAN BE OFFERED?

Examiners, advocates, social workers, and all team members involved in SAFE cases should strongly encourage patients to seek counseling and support to help heal from what has happened, regardless of whether or not they decide to move forward within the legal system. Help with OVS paperwork and developing a safety plan are among the other interventions that can be offered.

CASE SCENARIOS

1 A 15-year-old patient called up a much older man she had met the previous day. When he invited her to his house and proposed sex, she went along because she felt "lonely." She doesn't want to press charges because she agreed to go. What can we say?

Point out that from a legal standpoint she's not of an age to be able to consent to sexual activity, and it was a criminal offense for him to engage in sex with her. What the perpetrator did is considered a serious crime.

This teen may not be getting the support she needs from other avenues in her life. Counseling might be helpful to address her feelings of isolation, possibly with the involvement of her parents, with her consent. Be sure to keep the tone of conversations one of education, not coercion, pressure, or judgment.

2 A 14-year-old reports having met a 22-year-old man and twice accompanying him back to his apartment where they engaged in sex. In the ED, she states she does not want a forensic exam because the sex was consensual. However, her mother and the police appear to be pressuring the patient, and she finally consents to an exam. The examiner is uncomfortable proceeding, feeling the consent has been coerced. Should an exam take place?

Part of the definition of "consent" is that it has been freely provided; in other words, consent must be granted in an atmosphere free of pressure and coercion. Some situations create a strong sense of urgency in parents and providers, and understandably so. However, capable minors may consent to their own confidential post-sexual assault care, which includes the right to refuse such care.

Steps this examiner could take include meeting with the patient privately to review her rights and options and confirming whether or not she feels she has a choice in going forward. The examiner could enlist the help of a social worker or an advocate who could reinforce conversations honoring the patient's rights and speak with the parent(s) and police to ensure they are fully aware of the law. If the examiner continues to feel misgivings, he or she could wait a bit before beginning, to allow the patient to "sit with" her decision.

Ultimately the examiner must abide by what the patient says she wants as long as the requisite support

and education have been provided.

3 An adolescent girl doesn't want us to communicate with her parents, but the police are involved and have told the mother that her daughter was raped. The mother is pleading with us to tell her what's going on. What should we do?

The SAFE examiner is bound by laws of confidentiality to the patient and must explain this to the parent, as difficult as this may be. Discuss the situation with the patient; perhaps some part of what is going on can be shared with the mother to ease her anxiety. Often, asking the teen what is holding her back from wanting to inform her parent can result in a comfortable amount of information being shared.

If the parent seems inclined to support the patient, this should be facilitated. However, a deferential stance must be kept as we have no way to know what a given parent's reaction will be.

4 A 12-year-old child is assaulted by a peer at a sleep-over party. She is brought in by the friend's parents and adamantly declines an exam. She says she does not want anyone to know what occurred, including her parents, because she's afraid she will get in trouble. What should we do?

First and foremost, make sure she gets the necessary medical care. As to whether to tell her parents, collaborate with your hospital's Child Protection Coordinator or equivalent pediatric specialist and multidisciplinary team members. It will be important to explore what the child fears should she share what happened with her parent(s); might there be a parental abuse or neglect issue? Find out whether there is any trusted adult in this child's life who could provide emotional support and who the minor feels could be included in decision-making.

In cases involving very young minors, ED staff may feel caught between contradictory tenets of reproductive rights law and the criminal justice system, to say nothing of their own strongly held values and beliefs. Legally, if the child has the capacity to provide informed consent and she declines an exam and/or informing her parents, these wishes must be respected. As always, clinical judgment regarding the child's best interests remains the utmost priority.

5 A 16 year old is raped by a patient in the bathroom on the inpatient psychiatry floor of another hospital. She does not want to do the kit or report the assault to the police. Do

the usual consent guidelines apply in these settings? Or are hospitals mandated to report any felony occurring on their premises to the police?

Different rules of confidentiality and reporting apply in certain inpatient mental health settings. It will be important to consult with hospital counsel. If a felony-level crime such as sexual assault is committed against a patient on hospital premises, then the hospital is required to report it to police, even against the patient's wishes.²⁴ As always, a patient can't be forced to submit to a forensic exam against her will and may exercise her option not to speak with the police. Medical treatment, emotional support, and the comfort of the adolescent should be the hospital's focus and priority.

6 A 16 year old comes to the ED because of pain on urination. During the taking of her history, the MD learns that the patient is in a relationship with a 22-year-old boyfriend. Is the provider obligated to educate the young woman that technically she is the victim of statutory rape?

A clinician's role is to provide appropriate medical treatment, not be a watchdog for sexual assault. However, if there is concern about the dynamics of a given relationship, then a social work referral could be made. For patients reporting being coerced in the relationship and/or forced sex, the possibility of a SAFE exam could be raised.

In statutory rape situations, like any other, consent must be given by the teen to conduct a sexual assault exam. In most such cases, it is unlikely that the patient would agree to the exam or to reporting the case to law enforcement.

7 A 14-year-old adolescent has been brought to the ED by her father; they have recently been reunited. The father is distraught. In his absence, his daughter married a man twice her age. The father demands treatment for statutory rape. What are the relevant legalities of the situation?

Regardless of her marital status, the 14 year old still has the right to decline the exam and any kind of legal involvement. The father must be informed of New York State law.

24. NY Mental Hygiene Law (MHY) § 13.21(b); NY Public Health Law (PBH) § 2805-i

A person must be at least 17 to be legally married in New York State, with a few exceptions. In addition, New York State recognizes any out-of-state marriage that is legal in the jurisdiction in which it was formed; this may not be true for non-US marriages. If there is any question as to the legality of sexual activity because of a patient's young age, an ADA can be consulted without breaching confidentiality.

8 A 16-year-old female reports being videotaped during a sexual assault that took place in a shower. Is there any special action required of the examiner?

Notify the police if the patient consents, and include the information in the narrative of the patient's account. Law enforcement will determine what the appropriate charges should be.

This question touches on the larger issue of crimes that occur simultaneous with sexual assault. The most common are physical assault, theft, kidnapping, burglary, and use of a weapon. Examiners should continue to focus their documentation on a description of the sexual assault and any injuries observed; detectives will closely interview the patient about the range of crimes that may have occurred.

Statutory Rape: Issues and Approaches

Statutory rape cases can evoke strong emotions and opinions for SAFE team members. Caregivers have brought up concerns including:

- How well statutory laws reflect current social mores
- Whether a "law enforcement approach" (rather than a mental health or education approach) is best for all such situations
- Whether very young minors can truly be said to "have capacity" regarding informed consent for post-sexual assault care
- The ethics of offering young minors the same rights of confidentiality afforded their older counterparts.

Even as they can be a lightning rod for controversy, statutory rape cases present an opportunity for intervention: seeds can be planted for teens to make healthier choices in the future. Social workers might ask about power dynamics in the couple's relationship, or what would happen if the teen said "no" to sex.

9 A patient says she wants to make a report to police, but is not willing to share the story of what happened. Should we proceed with the forensic exam?

If the patient states she was sexually assaulted in a manner potentially leaving evidence, and she provides consent, the exam and the kit may be done. The crucial issue here is why the patient is unable to share the story of what has happened. Is she traumatized? Does she not trust authority figures? Is her cultural or religious affiliation lending meaning to the assault in a way that can be more fully understood?

Every effort should be made to address this patient's concerns so that a full narrative of the assault can be gathered. If the patient appears to be traumatized by what happened and cannot provide the account for this reason, the pace of the exam can be adjusted. Extra time can be afforded, and the advocate/social worker can provide ongoing support.

Distressing aspects of the assault can be discussed at a later time with the ADA; however, the parts of the history that bear on evidence collection, such as location, should ideally be elicited during the initial ED visit.

10 A young woman was found intoxicated. She doesn't remember a sexual assault, and isn't aware of having any pain/injuries. A relative insists on an evidence collection kit "just in case"; the patient, increasingly frightened, begins to request this too. Should we do the forensic exam, even though the patient is pretty sure nothing happened?

The SAFE team might assist this patient with the informed consent aspect of the exam, that is, help her consider the time and invasiveness of evidence collection, weighed against the improbability of this case moving forward in the criminal justice system. Emphasize to the patient the importance of following her own wishes, rather than those of a relative or anyone else.

If a patient account, eye-witness, vaginal discomfort, or some other corroboration is not available,

it typically would not make sense to do a kit “just in case.” Inability to recall does not equal criminality; just because there is a lapse in memory of what has occurred does not necessarily mean a sexual assault as legally defined has taken place. For example, without some indication that consent was lacking, the presence of DNA in a kit would not in and of itself denote a crime.

The patient should contact anyone who was on the scene and ask for recollections. If new memories surface, if bruises emerge, or any other indicators of a crime, she should return promptly to the ED.

11 A woman was found unconscious after falling or being thrown from a window. She’s groggy as she comes to and states she can’t remember anything. Theoretically, she could have been raped. If a kit was done and DNA found, could this be helpful even if the patient has no memory of a sexual assault?

Keep this patient from showering and in a secure location until she is able to think clearly about what happened. As with the patient described above, if she has absolutely no memory/suspicion of an assault and there are no witnesses and/or injuries consistent with sexual assault, then it probably would not be indicated to do the evidence collection kit.

In this scenario, it is not clear that a crime of any sort (for example, assault) was even committed. Upon looking into the matter, police will make a determination. An evidence collection kit would be taken into police custody only if there is an on-going investigation of a crime.

With no indication of sexual assault, the significant costs of collecting evidence (to the examiner, ED, crime lab, etc.) are unwarranted.

12 A patient presents stating she has been raped by her husband. Over the course of the exam it emerges that she is having an extramarital affair. She is concerned the identity of that partner would be exposed if the rape kit were to be done.

Hospital workers are bound by confidentiality; ED staff, including the examiner and social worker, would not disclose this information. However, the defense lawyer might try to introduce the second DNA profile at trial; in general, the criminal justice team is not bound by the same stringent confidentiality rules as hospital employees. Rape shield laws have been passed that render inadmissible information about manner of dress, prior sexual contact, etc.; however, sometimes these protections do not apply. In sum, DNA results could in fact reveal the presence of a partner other than her husband (though not the identity), and the SAFE examiner cannot guarantee that this information would remain private.

13 A patient's husband (not the perpetrator) accompanied her to the ED. She requested that he be allowed in the room during the exam. At some point, the examiner referred to having him present; the patient shook her head "no," when he was standing behind the curtain and couldn't see. She had been too fearful to request privacy.

Questions about who should be present during the exam should be asked one-on-one, with no one else present. This should be done at the very beginning of the process, and should include minors who are presenting to the ED with a parent or guardian. This scenario has hallmarks of a DV situation. The ED social worker and/or hospital DV coordinator should be made aware, and if DV is in fact an issue the patient can be informed in private about counseling, shelter, and other options available.

Asking the husband to leave has the potential to escalate the situation. Hospital DV policies provide for forcible removal using hospital police when necessary. In this case, the benefits of performing the exam in an atmosphere of calm must be weighed against the compromises inherent in doing an exam with a person unwanted by the patient present.

The most important parts of the process to conduct without the husband present are the taking of the history and the sharing of the results of the exam. If this proves impossible to engineer, ensure the patient is counseled privately by another member of the medical team at some point subsequent to this hospital visit.

14 An 18-year-old patient presents with a developmental disability. What issues are particularly important for this patient?²⁵

First, decide whether or not this patient is able to understand the situation sufficiently to provide informed consent to a forensic exam.

Carefully consider the patient's level and style of communication. Most developmentally disabled patients can make themselves understood if examiners are willing to adapt. Some hospitals have a designated staff member for patients with developmental disabilities; if so, this person can be called to assist.

People sometimes hold the misconception that because a patient has a developmental disability, she is unable to consent to sex altogether, making any sexual contact illegal. This is not the case, unless the disability precludes the patient from comprehending it is an option to refuse sex. For such a patient, the ADA will determine whether the incident meets the criteria of "no means no" or "forcible compulsion," just as they would with any other complainant.

25. We are grateful to Catherine Jones, LMSW, and Project Shield at the Kings County DA's Office for sharing expertise about patients with developmental disabilities.

Conducting an exam with a patient with a developmental disability

- 1) Keep statements short and simple, using basic vocabulary. Avoid leading and overly abstract questions and make sure to leave plenty of time for the patient to respond. (A ten-second pause is generally used as a guideline.) Check frequently for understanding and build in plenty of breaks. Be mindful of tendencies for over-compliance and listen for an "echo effect," where patients repeat the last word or phrase they have heard.
- 2) Don't rely too heavily on the report or assistance of caregivers; remember, this person may have been the abuser. Use caregivers as a primary source of information only when direct communication with the patient proves to be impossible. If there is an MD available who knows the patient, consult with him/her regarding the patient's baseline functioning.
- 3) Be sensitive to issues of demeanor, in particular the possibility of appearing threatening to the patient, and/or treating adult patients as if they were children.

15 A 16-year-old patient with a developmental disability presents to the ED. The patient is distressed, shaking her head "no," but we are unable to determine what happened. An older male was seen hovering outside her room in the group home in which she lives. If we are unable to elicit a narrative regarding sexual assault, should we perform the evidence collection kit?

If no narrative is forthcoming, then corroborating evidence such as injuries, a witness, or the disappearance of clothes must be available for the case to move forward legally. What created suspicion that a sexual assault occurred? Be sure to document these factors. Err on the side of collecting evidence.

Because the patient may not be able to fully describe what happened, issues related to timing could be important. Record when the acts might have occurred, especially if the patient was only at a certain location during a particular time period, under the supervision of a given individual, etc.

16 A 14 year old with mental retardation and epilepsy is found unconscious outside her group home. She has on a different shirt from the one she was wearing earlier. She does not report any episode of sexual assault. Her mother, however, wants a kit to be done "just in case." How should we proceed?

Attempt to communicate with the patient first in a private setting to determine exactly what happened and whether anything is preventing her from fully disclosing. Unless there is some kind of suggestion of a crime, an evidence collection kit would not be called for. If this patient has the capacity to provide informed consent, whether is up to her, and not her mother or other caregivers, to make decisions regarding whether or not a forensic exam will take place.

If no additional information comes to light, this patient may be provided with a thorough physical exam, with careful attention to whether injuries are present. Also, the patient can be held in a secure location while the group home determines whether any witnesses can be found. The mother may be reassured by the fact that the matter of a forensic exam will be revisited if any injuries are found or witnesses come forward. She can also be supported in inquiring about the circumstances in this group home that led to inadequate monitoring and supervision.

17 The police arrive to interview a sexual assault patient. She tells them different facts from those she told you, leaving out her psychiatric history. What should you do?

Some patient education might be helpful. Ask for a moment to speak with the patient alone, and explain the fact that a patient's mental health history does not preclude her case from being taken seriously. Let her know that the police will generally find out about a patient's past, and that it's better for patients to tell the police complete and accurate information right from the beginning. If alternative facts are discovered at a later point, this will compromise the patient's credibility.

If the patient has signed the authorization form²⁶ allowing communication about health information between the hospital, the police, and the DA's office, it is acceptable to share knowledge on the patient's behalf. In cases where the story has been inconsistent, maintain trust with the patient by outlining what you plan to share with the police, and encourage direct communication of these facts whenever possible.

26. Authorization to Disclose Health Information – Sexual Assault

18 A woman seems to be suffering from psychosis. Her account of the sexual assault involves multiple Hispanic men, black men, and white men—all of them castrated with a knife. When is it acceptable to refer someone to the Psychiatric ED and not collect evidence?

Regardless of how outlandish an account may seem, it is not the role of the medical team to decide if events did or did not occur. In this instance, it may be best to consult Psychiatry to determine whether or not the patient is capable of providing consent. If a patient's reality testing is grossly compromised, it likely follows that she will not be able to consent to an exam. Team consultations involving Social Work, Psychiatry, and Medicine are of value in these instances, and conclusions should be carefully documented in the patient's chart.

A patient such as this may be held in a secure location so that evidence will not be lost, provided with psychiatric medication(s) as appropriate, and reevaluated once she is thinking more clearly.

19 A woman presents in distress, stating she's been raped by a man with a gun who broke into her apartment. The social worker learns from the electronic record that the patient reported the same story four months ago, at which time it was determined by police to be unfounded.

Typically, SAFE programs collect evidence if they have any measure of uncertainty and the patient requests the exam. That the previous report was determined to be unfounded does not necessarily indicate that that report was untrue.

Consult with your Psychiatric ED to see if the patient is deemed capable of providing consent. Be sure that steps are taken to preserve evidence during this consultation.

20 In the case presented in the previous scenario, is it acceptable to discuss with police the information contained in the patient's past medical records?

In the best case scenario, the patient herself will share with the police what her experiences have been. If she seems reticent, the examiner might reinforce how helpful this information would be for law enforcement. When patients have signed the authorization form, it is acceptable, with the patient's knowledge, to share the current report of sexual assault with the police. However, legally speaking, unless the patient has specifically given permission and this is documented on the authorization form, it is not allowable to share the circumstances of prior visits.²⁷ Police will likely run the patient's name themselves to establish whether prior complaints have been filed.

21 The police have decided not to accept the case of a homeless man who frequently comes to the ED; the man is known to both ED staff and police because of problems related to his drinking and psychiatric issues. After conducting the assessment and exam, we feel that his case should be taken seriously. How much should we advocate for him?

If you are concerned about decisions made by police or the ADA, it is fine to make exploratory phone calls to these parties. What is important to remember is that the DA's office must feel a case is provable in court "beyond a reasonable doubt." Without corroborating evidence, the criminal justice team may have concluded that this man's chances of being credible to a jury are not sufficiently strong.

As long as the patient has signed an authorization form, it is an option for you to speak with police and share factors leading you to believe the validity of the story. This can sometimes prompt police to take additional action, such as looking for surveillance cameras to see if the crime was caught on film.

For the most part, examiners best serve their patients by remaining "neutral" and leaving the "advocating" to the rape crisis advocate or the social worker.

22 A woman with schizophrenia is brought to the ED by a group home worker because she states she was raped by another resident at the home. Her illness appears under control, and she is determined by Psychiatry to have capacity to give consent. She does not want a sexual assault evidence kit collected. The group home administrator does; she has concerns about liability. What should be done?

It is never the right course of action to conduct a SAFE exam against a patient's will. However, perhaps through conversations with this patient the issues underlying her reluctance to have the kit done can be addressed. For example, is she afraid of reprisals by the perpetrating resident? If so, could she be reassured of her safety and protection going forward?

It's important that the group home administrator take safety measures to protect her residents, regardless of whether or not an assault took place. If this is an Office of Mental Retardation and Developmental Disabilities (OMRDD) group home, then the administrator needs to file a report of suspected abuse with OMRDD. (This is also policy for Office of Mental Health facilities.) The administrator may need reminding that evidence collection kit results cannot be obtained outside of the context of a criminal justice investigation.

27. The authorization form expires at the conclusion of each investigation.

23 A crack-addicted woman presents stating that, although she didn't want to have sex, she did so in order to obtain drugs. She is now asking for an evidence collection kit. What course of action should we take?

This case, as it's been described, is not something the law could prosecute. It's important to note that, in general, cases involving the sexual assault of prostitutes are given fair consideration by detectives. However, in this instance, the woman consensually traded sex for drugs. Explain this to the patient as empathically as possible so she can decide how to proceed. While an evidence collection kit might not be called for, a medical exam, treatment for STDs, etc., should be provided. If this patient continues to insist that she wants the kit done, it is fine to do so.

24 A detective requests that ED staff do a toxicology screen on a particular victim. The victim says she didn't use recreational drugs, but he suspects otherwise. From a medical standpoint, the toxicology screen is unnecessary.

ED providers should not provide medically unnecessary tests and procedures. Moreover, only a patient with the capacity to provide informed consent can decide to undergo medical tests and procedures; this decision is not pursuant to police demand. Although examiners may use the DFSA kit, which yields results for recreational drugs as well as date rape drugs, patients must be informed of the full range of possible "positive" results and allowed to decline if they wish.

25 A 21-year-old male reports he was assaulted by several men after an evening of bar-hopping. The police are stating that the case is compromised because alcohol was involved, and are discouraging him from reporting the crime.

Contact your DA's office or Special Victims Liaison Unit; police may be providing this patient with inaccurate information. From the prosecutor's point of view, alcohol is the number one drug used to commit DFSA. The patient should continue his truthful accounts and by no means be steered away from legal action. He may also be provided with the range of services usually afforded to sexual assault victims, including counseling and victim advocacy.

26 A 26-year-old female presents stating she's not sure if she was sexually assaulted. She was drinking the previous evening and has little memory of the time period after midnight. Detectives elect not to take the case. However, the patient confides to the examiner that she has hazy recollections of trying to "fight someone off."

Perform the evidence collection kit (and possibly the DFSA kit), if this is what the patient wants. Tailor your exam and interview to the patient's history and wishes, not to the decisions of law enforcement.

With the patient's permission, discuss with detectives the patient's disclosure. If you and the patient remain uncomfortable about the detective's decision to close the case, your DA's office or Special Victims Liaison Unit can be contacted.

27 A student presents stating she had been raped by her suitemate's boyfriend over multiple hours. During the hospital visit, the examiner began to suspect that she may have an ulterior motive for the report. By the end of the hospital visit, video footage was recovered that revealed the patient playing ping pong during the time period in question. Should examiners wait for this kind of evidence before starting forensic exams?

It is not up to examiners to decide whether or not an assault occurred. Their role is to provide treatment and respond to the history provided, regardless of any suspicions. In this case, the examiner would go ahead and collect evidence because the patient presents an account of rape and requests evidence collection, despite the numerous "red flags."

This being said, if decisive information contradicting the patient's story is imminently available it may make sense to discuss the situation with the patient and plan accordingly. The evidence would have to be definite in order for the team to consider delaying the forensic aspects of care.

28 A prison inmate presents stating he stole keys from a guard and swallowed them (which x-rays later confirmed). Correctional staff stripped him and digitally searched for the keys. The inmate feels violated and is requesting a sexual assault exam. What should we do?

These kinds of "cavity searches" are typically not permitted by either police or prison personnel. A legal case would depend on factors such as the severity of the incident and whether it occurred in the context of a security risk. The patient may be given the contact information for the New York City Department of

Investigations or similar local agency. If the patient requests a forensic exam, it is fine to complete one. In addition, the inmate should receive supportive counseling and a medical exam to ensure absence of injuries.

29 Is there anything we should keep in mind for patients who are sexually assaulted in a correctional setting?

Sex between staff and inmates at correctional facilities is a criminal act, even if force was not involved. These patients should get a formal social work assessment and advocate even though they have their own prison-based services. If the inmate was assaulted by a guard, or prison security was a salient factor in the assault, the involvement of Social Work is especially crucial.

Security may be present during the SAFE examination, to ensure the inmate's and the examiner's safety. If the presence of a guard inhibits the patient's willingness to be fully examined, explore solutions balancing everyone's sense of safety with the inmate's need for privacy. For example, the guard could be asked to stand just outside the door or behind a drawn curtain.

Contact the precinct in the appropriate jurisdiction to come to the hospital to pick up the kit; do not release the kit to prison personnel.

30 A male had consensual sex with a male stranger who agreed to use a condom. Afterwards he realized that protection was not used. Now the patient wants us to do an evidence collection kit; he wants to find the man and sue him if he (the patient) turns out to be HIV positive. Are we obliged to do a kit?

This would not be a situation involving the criminal justice system since consent was given for the sex; there was no crime of sexual assault committed. It might help to explain that DNA results can only be uploaded into the system if there is a criminal case, and would only result in a match if the man in question had previously been convicted of a crime. An evidence collection kit would not be recommended but it would be important to provide all necessary medical attention, including HIV prophylaxis. An HIV-positive person who knowingly has unprotected sex could potentially be charged with reckless endangerment.²⁸

28. NY Public Health Law (PBH) § 2783

31 A patient reported a sexual assault that took place in Italy. How should we approach this situation?

Rapes have to be investigated by law enforcement in the jurisdiction of occurrence. However, forensic evidence can be collected in any hospital. Proceed with the SAFE examination as you would with any patient presenting after a sexual assault.

Contact local law enforcement (911) to seek guidance as to what steps the patient should take if she wants to report the incident to police in another state or country. In most instances, a visit to precinct offices in that locale will be necessary. The patient must present in person for interviews and court appearances.

When kits need to be mailed, FedEx and similar carriers are adequate to maintain chain of custody.

32 A patient states she was raped on a cruise ship. What law enforcement entity has jurisdiction in this type of case?

If the ship is at sea, the FBI should be contacted by satellite phone or by fax. If the incident occurs while the ship is at the loading dock, the police in the local jurisdiction must respond.

Cruise ship physicians are supposed to be competent in evidence collection; however, if this is not the case the patient should present to an ED with expertise in sexual assault as soon as possible. All standard procedures following a sexual assault should be followed, including securing the area, refraining from bathing and changing clothes, etc.

Pursuing a civil suit may be an option; the patient may consult a specialist in maritime law.

33 A 22-year-old woman states she's pregnant from a rape. She wants an abortion and has decided to press charges. Would there be a way to obtain DNA in this instance?

Yes. DNA can be obtained from products of conception. Make arrangements with Risk Management, your medical specialty performing abortions, Pathology, and the detectives who will pick up the sample. The ADA on the case should ideally be involved from the beginning. Typically, SAFE examiners are not involved in these cases.

Generally, the DA's office provides instructions on how the ME/Crime Lab wants remains of conception preserved. The sample should be picked up on the spot. The patient should be encouraged to file a report with the police beforehand so a designated receiver can take the sample to the ME's office.

If this is not possible, the specimen should be sent to the Pathology Department, where it should be frozen in water or saline and not put in formaldehyde.

34 A patient presents stating she was raped 15 years ago. How long after a crime can charges be brought?

Because there are often so many complicated variables, consult with your DA's office for this type of question.

Recently passed legislation has done away with the statute of limitations for most first-degree sex crimes occurring after June 23, 2006 so there is no time limit on reporting those crimes. Such crimes occurring before this 2006 date, but still within the statute of limitations at that time, also fall in this "no deadline" category. However, generally, for all other felonies involving a victim over 18 years old, the statute of limitations is five years. For the patient in this scenario, the answer depends in part on how old she was at the time of the crime. Most likely, she will not be able to pursue criminal charges. Sometimes civil action can be taken when criminal prosecution is no longer an option.

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ABOUT THE AUTHOR AND HER HOSPITAL

REBECCA CARMAN served as SAFE Coordinator for two years at Elmhurst Hospital Center; during this period the hospital was designated a 24-hour SAFE Center of Excellence by the State of New York Department of Health. She continues to help administer EHC's SART program and is a psychotherapist in private practice in New York City.

ELMHURST HOSPITAL CENTER has long been dedicated to providing the highest quality of care to patients with histories of sexual assault. In the early 1990s, the Department of Social Work initiated programming for this population and has continued its advocacy for a full spectrum of comprehensive care. The SAFE Program Medical Director, Sheree Givre, MD, has volunteered her time and expertise for nearly a decade; our Infectious Disease Clinic provides follow-up and medication for sexual assault patients free of charge. Core funds were allocated towards on-call SAFE coverage years before outside support was granted. EHC's SART team includes numerous veteran examiners; at this point, many have conducted over fifty SAFE exams apiece. Primarily Physician Assistants in Elmhurst's ED, these examiners have been committed to providing care for sexual assault patients from the very beginning – well before formal programming and compensation for being on call.

Elmhurst Hospital Center's SART Program currently receives funding from the New York City Office of the Mayor and the State of New York Division of Criminal Justice Services (DCJS). Through its SART initiative, the Mayor's Office ensures state-of-the-art care for acute sexual assault patients 24 hours a day at every HHC facility throughout New York City.

Elmhurst Hospital Center is a member of the New York City Health and Hospitals Corporation.



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The New York State Coalition
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A nonprofit organization dedicated
to ending sexual violence.
www.nyscasa.org

ISBN 978-0-9823192-0-8