American Indian and Alaska Native Patients & Medical Forensic Examination Considerations

ABOUT US

Forensic Health Care
Division of Nursing Services
Office of Clinical and Preventive Services
Indian Health Service

IHS MISSION

to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

The purpose of this guidebook is to enhance care delivery to American Indian and Alaska Native (AI/AN) patients, families, and communities affected by violence by providing resources and support to forensic healthcare providers serving in Indian Health Service (IHS), Tribal, and Urban Indian (I/T/U) settings. The guide does not provide coverage for all patient care situations or scenarios.

This booklet is a companion guide to the **Forensic Health Care & Caring for AI/AN Patients** guidebook and offers reference to the medical forensic examination best practices and special considerations for patient care. Please follow the facility's policies, procedures, and protocols, including patient consent, for the medical forensic examination.

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For questions, technical assistance or education, please contact Nicole Stahlmann, Forensic Nurse Consultant.

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Medical Forensic Examination

Individuals who have experienced violent crimes (e.g., sexual assault, sexual abuse, domestic violence, intimate partner violence, human trafficking, strangulation, etc.), should have access to trauma-informed, patient-centered, medical forensic health care.

The purpose of the medical forensic examination is to assess, diagnose, and provide treatment for individuals who have experienced a violent crime.

The Medical Forensic Examination can include, but is not always limited to:

- Triage, screening, and initial assessment
- Collecting:
  - Patient consent to the examination (written and verbal consent, assent)
  - Demographic information
  - Current medications, past medical, and surgical history - including gynecological history
  - Patient history/narrative related to the assault
- Assessing and evaluating:
  - Physical accommodations and alternative exam needs
  - Potential drug/alcohol facilitated sexual assault
  - Strangulation
- Conducting:
  - Physical, head-to-toe medical forensic examination
  - Collection of evidence using an evidence collection kit
  - Capturing photography
  - Documenting findings
- Offering:
  - Medical intervention (e.g., STI, HIV, and pregnancy evaluation and treatment)
  - Referrals (e.g., behavioral/mental health, advocacy, criminal justice system, local/Tribal coalitions, culturally specific resources, etc.)
  - Safety planning, education, discharge instructions, and follow-up services

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Caring for AI/AN ELDERS

Elder abuse is an intentional act, or failure to act, that causes or creates a risk of harm to an older adult. An older adult is traditionally someone aged 60 or older. In some Tribal communities, it is 55 and older due to local cultural beliefs or lower life expectancies. The abuse can occur at the hands of a caregiver or someone the elder trusts. Common types of elder abuse include:

- Emotional/Psychological
- Neglect
- Financial
- Sexual
- Physical
- Spiritual Abuse

Elders are highly respected in Tribal communities, because they carry invaluable historical knowledge, wisdom, and experience.

Medical Forensic Examination Considerations:

- Obtain patient consent and assent to conduct the medical forensic examination.
- Follow the facility's policies and procedures to care.
- Incorporate Adult Protective Services per mandatory reporting requirements.
- Ongoing intergenerational and historical trauma has created barriers such as trusting the healthcare and criminal justice systems. Building a rapport might not happen immediately. Forensic healthcare providers should practice in a culturally appropriate manner, understand the complexities of trauma, and respect the patient's medical decisions related to their care.
- Recognize that the caregiver/individual who brought them to the clinic/hospital could be the perpetrator, and screen accordingly.
- No matter the patient's past medical history (e.g., dementia/Alzheimer's, mental health, hearing or visual impairments, substance use, etc.), provide the patient with the utmost respect and dignity throughout the medical forensic exam and subsequent healthcare visits.

Caring for AI/AN ELDERS, continued

Medical Forensic Examination Considerations, continued:

- Recognize that elders might have constraints with mobility. Ensure patient comfort by proper positioning throughout the exam, and modify as needed. Patient comfort is the number one priority.
- Understand that the fear of bringing shame to themselves, or their family, and fear of disrupting family systems is a major barrier to seeking health care and reporting to the criminal justice system. Culturally, family/community often takes precedence over individual needs.
- The National Indigenous Elder Justice Initiative training module - Language While Working with Elders: Baker-Demaray (2005) found when asked if they have been abused or neglected, AI/AN elders indicated they have not. However, when the term “disrespect” was used instead of abuse or neglect, elders discussed many incidents that could classify as abuse or neglect. When asking AI/AN women about sexual abuse, no abuse was admitted, but when the term “bothered” was used, descriptions of rape and sexual exploitation were detailed. Below are some questions constructed to illicit narrative information about potential abuse and neglect.
    - Are you being disrespected? If so, in what ways?
    - Has anybody hurt you?
    - Are you afraid of anybody?
    - Is anyone taking or using your money without your permission?
    - Is anyone taking your things without your permission?
    - Are you being bothered? If so, in what ways?

Caring for AI/AN ELDERS, continued

Prevent Elder Abuse: raise awareness, offer education, commit to recognizing signs & symptoms of abuse, listen to elders and their needs, recognize storytelling as an indirect way to expressing themselves.

Rates of elder abuse vary by study, location, and tribal affiliation from 4.3% to 45.9%. Varying rates of abuse suggest healthcare providers should be encouraged to screen and intervene despite the lack of empirical evidence.

Reference and Resources:

- Administration for Community Living, National Center on Elder Abuse
- Elder Justice Initiative - DOJ, Neighborhood Map
- International Association for Indigenous Aging - Native American Elder Justice Initiative
- National Indian Council on Aging, Inc.
- Eldercare Locator - U.S. Administration on Aging
- National Indigenous Elder Justice Initiative & Elder Abuse Training Module
- National Resource Center for Alaska Natives
- National Resource Center on Native American Aging Tribal Law & Policy
- Southwest Center for Law & Policy (legal training and technical assistance to Tribal communities).
- National Adult Protective Services Association
- Centers for Disease Control and Prevention (CDC) - Elder Abuse
- American Indian and Alaska Native Culture Card.
- Crowder J, Burnett C, Laughon K, Dreisbach C. Elder Abuse in American Indian Communities: An Integrative Review. J Forensic Nurs. 2019 Oct/Dec;15(4):250-258. doi: 10.1097/JFN.0000000000000259. PMID: 31764529.

MATERNAL CHILD HEALTH

Approximately 3 million people of all races and ethnicities in the United States (U.S.) will experience pregnancy resulting from rape in their lifetime (Basile et al., 2018). Pregnant women are more vulnerable to intimate partner violence (IPV) than those who are not pregnant. A strong correlation exists between violence in pregnancy and maternal low self-esteem, anxiety, and depression. Individuals who experience violence during pregnancy are more likely to attempt suicide, be diagnosed with depression or mental health disorders, and are more likely to use substances such as alcohol and drugs during pregnancy.

Rape-related pregnancy includes pregnancy that a rape victim attributed to rape. **Reproductive coercion** is a form of IPV that involves exerting power and control over reproduction through interference with contraception use and pregnancy pressure (CDC).

Pregnancy Risk and Evaluation Following Sexual Assault, Intimate Partner Violence, Domestic Violence, & the Medical Forensic Examination:

- Follow the facility's policies and procedures while caring for pregnant women who have been victims of violent crimes.
- Provide patient education regarding risk of pregnancy resulting from rape. Provide emergency contraception counseling and administer up to 5 days post assault.
- If the patient is pregnant and assaulted, obtain patient consent prior to contacting their obstetric provider to discuss care following an assault (obstetric care is necessary and should be priority).
- There is a 2 to 5 percent risk of pregnancy following one sexual encounter. This percentage varies depending on the patient's menstruation cycle and regularity, fertility of the patient and suspect, if ejaculation occurred, contraception use, etc.
- Treatment considerations will vary by patient depending on age, culture, religion and spiritual backgrounds.
- IPV during pregnancy has been associated with poor weight gain, infections, anemia, stillbirth, pelvic fractures, placental abruption, fetal injury, preterm labor and delivery, small-for-gestational age and low birth-weight infants, and maternal or fetal death.
- Obtain a urine or blood sample from the patient to assess pregnancy hormone -human chorionic gonadotropin (hCG).
    - Patients with positive pregnancy tests should be offered referrals for prenatal care provider.
    - Patients with negative pregnancy tests with reported history of intercourse, should be provided follow-up services and repeat testing, as indicated.
- Provide all patients with referrals and follow-up care.

MATERNAL CHILD HEALTH, continued

Access to abortion services and care considerations:

- Follow the facility's policy and procedures with regards to patient's consent to care and pregnancy/abortion related discussions.
- IHS providers/staff are permitted to provide non-directive counseling and information on resources for pregnancy options including contraception, continuation of the pregnancy, adoption, and abortion.
- Patients are encouraged to talk with their health care provider about personal decisions concerning their reproductive health. IHS follows federal law pursuant to the Hyde Amendment. All versions of the Hyde Amendment have included, at a minimum, the life- saving exception. IHS funds may be used to pay or otherwise provide for abortions if a physician has certified as part of the medical record that the pregnancy is the result of an act of rape or incest or the pregnant woman suffers from a physical disorder, injury, or illness that would place that patient in danger of death unless an abortion is performed. IHS is also authorized to pay reasonable emergency and non- emergency patient travel, including an escort, in circumstances where a Hyde-permitted abortion is unavailable from IHS.
- The provider should be aware of Federal and state law regarding abortion care services, including those for minors and emancipated, in order for the provider to offer appropriate resources.

All patients, presenting to the facility for care following an assault, pregnant at time of visit or not, should be offered trauma-informed, patient-centered, medical forensic health care, in collaboration with their obstetrician, nurse midwife, or primary care provider (PCP).

Reference and Resources:

- Use of IHS Funds for Abortion, Circular
- ReproductiveRights.org
- Office on Violence Against Women (OVW). A National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescents.
- Congressional Research Service, The Hyde Amendment: An Overview.
- CDC - Understanding Pregnancy Resulting from Rape in the US
- Strong Hearts Native Helpline: https://strongheartshelpline.org/
- Basile, K.C., Smith, S.G., Liu, y., Kresnow, M., Fasula, A.M., Gilbert, L., Chen, J. (2018). Rape related pregnancy and association with reproductive coercion in the U.S. American Journal of Preventive Medicine, 55(6), 770-776. doi: 10.1016/j.amepre.2018.07.028

CHILD SEXUAL ABUSE & MALTREATMENT

Child maltreatment is an act, or failure to act, which results in, or presents a risk, of death, physical injury, emotional harm, sexual abuse/exploitation of a child including human trafficking and child pornography. Child abuse and neglect are any act(s) of commission or omission by a parent/guardian or other figure (e.g., teacher, coach, healthcare provider), which results in harm of the child. Legal definitions of maltreatment vary in federal and state laws.

Types of child maltreatment:

- Sexual Abuse
- Physical Abuse
- Emotional/Psychological Abuse
- Neglect (omission)

Medical Forensic Examination Considerations:

- Often delayed disclosure of abuse and/or assault (e.g., due to fear, shame, guilt, lack of resources or understanding given development age or cognitive ability).
- Parental/Guardian (or Child Protective Services, if necessary) consent must be obtained prior to starting the examination. The provider must also obtain the patient's assent prior to care (never restrain or hold a patient down to complete a medical forensic examination).
- Build rapport with the patient, provide trauma-informed care, and ask open-ended, non-judgmental questions.
- Be aware of local mandatory reporting laws. Child Protective Services and Law Enforcement must be notified of child sexual abuse and maltreatment.
- Children can be victims of alcohol/drug facilitated sexual assault, as the offender could use drugs or alcohol to sedate the child to facilitate abuse, trafficking, or aid in the production of pornography.
- Ensure child safety and offer the child resources such as connection, referral, and integration within the community.
- Understand that violence can impact multiple generations, and it is important to treat all family members.
- Increase protective factors, offer food safety, basic necessities, and safe housing.

CHILD SEXUAL ABUSE & MALTREATMENT, continued

Medical Forensic Examination Considerations, continued:

- Understand that violence in the home (e.g., domestic/intimate partner violence, abuse, etc.), is a definitive risk factor for child maltreatment.
- Recognize that the Adverse Childhood Experiences (ACEs) Study highlights that when violence is prevalent in the home, children are more likely to suffer higher rates of emotional abuse, physical abuse, and sexual abuse.
- Understand that increase in ACEs can have lasting, negative effects on health, wellbeing in childhood, and life opportunities. These experiences can increase the risks of injury, sexually transmitted infections, maternal and child health problems (including teen pregnancy, pregnancy complications, and fetal death), involvement in sex trafficking, and a wide range of chronic diseases and leading causes of death, such as cancer, diabetes, heart disease, and suicide.

Helpful Resources:

- Office on Violence Against Women (OVW). A National Protocol for Sexual Abuse Medical Forensic Examinations, Pediatric.
- IHM, Part 3, Chapter 36 - Child Maltreatment
- National Indian Child Welfare Association
- National Center for Missing & Exploited Children: Missingkids.org
- National Children's Alliance - National Standards of Accreditation
- Report Child Sexual/Abuse within IHS
- Centers for Disease Control and Prevention: Adverse Childhood Experiences

Helpful Tools:

- Safe Environment for Every Kid – SEEK
  - Evidence-based approach that helps PCPs address targeted social determinants of health or ACEs that are also risk factors for child maltreatment: parental depression, major stress, substance use, intimate partner (or domestic) violence, food insecurity, etc.
- American Academy of Pediatrics - Bright Futures
  - Bright Futures Guidelines: theory-based and evidence-driven guidance for all preventive care screenings and health supervision visits.

Caring for Patients with Disabilities

A disability is any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions). According to the 2022 U.S. Census Report, approximately 15.7 percent of AI/AN people live with a disability.

Medical Forensic Examination Considerations:

- Always provide trauma-informed, patient-centered care.
- Obtain the patient's consent and assent prior to care and parental/guardian consent, if necessary. Follow the facility's jurisdictional policies regarding patient consent to the exam, to evidence collection, and involving protective services.
- Never restrain or hold a patient down for a medical forensic examination.
- Screen the individual (e.g., parent/guardian, caregiver, friend, etc.) who brought the patient in for an examination, as they could be responsible for the assault.
- People with disabilities are often victimized by the same offender.
- Adapt the exam and make reasonable accommodations. Patient safety and comfort takes priority. Adjust the lights and minimize noises.
- If the patient uses an assistive device(s) (e.g., wheelchair, cane, service animal, etc.) or has a sacred item (e.g., ceremonial garment, necklace, moccasins, etc.), and the item/device(s) were a part of the assault, gain consent to swab the item/device(s) for evidence collection. Do not take the items from the patient.
- Provide an examination free of distractions, loud-noises, overpowering scents, and refrain from any potentially startling events. Avoid rushing through the exam.
- Speak directly to patient, even when interpreters or guardians are present.
- Patients with disabilities may be reluctant to report the crime or consent to the exam for a variety of reasons, including fear of not being believed, fear of getting in trouble, and fear of losing their independence.

References:

- CDC, Disability and Health Overview.
- OVW. A National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescents.

Helpful tool: Vera Institute of Justice - Supporting Crime Victims with Disabilities Online Training Toolkit

HUMAN TRAFFICKING

Human trafficking can occur in any community, and victims can be of any age, gender, race, or nationality. Human trafficking is different than smuggling and can occur in one's home community, without the victim being transported to another location. The U.S. Department of Justice describes human trafficking (aka trafficking in persons) as the use of force, fraud, or coercion for a person to provide labor or services (labor trafficking), or to engage in commercial sex acts (sex trafficking). Human trafficking can also include forceful participation in criminal activity or organ harvesting.

"SOAR" is a mnemonic device designed to help healthcare professionals in their work with human trafficking. SOAR for Native Communities online module is for professionals serving indigenous communities, to help understand the issues surrounding human trafficking and its impact on indigenous communities.

- **S**top: Become familiar with the nature of human trafficking.
- **O**bserve: Understand verbal and non-verbal indicators.
- **A**sk: Engage with a possible victim using a trauma-informed approach
- **R**espond to human trafficking: Identify patient needs and secure available resources to provide support.

Victims and survivors of human trafficking are often affected by a trauma response and may not identify as being trafficked. Providing a trauma-informed approach with every patient, at every encounter, enhances the health care provider's ability to build trust with patients without re-traumatizing them, helping to appropriately screen, identify and provide quality, comprehensive care, and resources to meet the unique and complex needs of the human trafficking victim or survivor.

Human Trafficking and Medical Forensic Examination Considerations

- Although healthcare facilities are considered safe environments, patients often do not self-identify as a victim or survivor, of human trafficking when presenting for care. A history of trauma may not be immediately evident, adding to the complexity of identifying a victim or survivor of human trafficking and supporting the importance of trauma-informed care.
- Coordinate facility-wide education to recognizing signs of trafficking - appointment, patient registration, pharmacists, health information management, billing/coding, administration, leadership, healthcare teams, etc., should receive training and education related to signs of human trafficking.
- Collaborate within medical, behavioral health, case/care management to ensure access to resources is available, referrals are made, and follow-up occurs. Collaborate with the facility's Quality Team to develop a continuous quality improvement plan.
- Trauma-informed, culturally appropriate, and patient-centered safety screening should be considered for all patients. Implement a screening process to identify potential victims of human trafficking. Safety screening questions can include:
  - Is the individual in control of their identification documents? If not, who is?
  - Does the individual have someone speaking or interpreting for them?
  - Is the individual's movement or communications restricted or monitored? Including living/housing restrictions?
  - Is the individual afraid to speak about themselves in the presence of others?
  - Is the individual under 18 years old and engaging in commercial sex?
  - Is the individual required to do things against their will, in order to repay a debt owed?
  - Were there incidences, or evidence, of physical or sexual assault?
  - Is the individual doing a job they were recruited for, trapped, or working in unfair, unsafe, or dangerous conditions?
  - Is the individual's salary being confiscated to pay off a debt to an employer?
  - Is the individual being held against their will? Working or spending time with someone who isolates them?
  - Is the individual indebted to someone who has provided housing, money, transportation or other essentials?
  - Has the individual or their family been threatened with harm if the individual attempts to escape or report the abuse? Or instructed to lie about their current situation, including type of work?
- Ensure the safety screening is trauma-informed and follows safety as well as privacy guidelines.
- Understand local laws related to mandatory reporting and Health Insurance Portability and Accountability Act (HIPAA), including this information in the facility's human trafficking response protocol.
- Develop & implement a protocol for human trafficking to ensure a coordinated response is available when a patient screens positive for human trafficking. Identify a safety plan for patients who might disclose an immediate safety risk.
- Coordinating resources across multiple agencies and organizations as a Multidisciplinary Treatment and Referral Response is vital in responding to the unique, yet diverse, and complex needs of an individual who has experienced trafficking. A coordinated response will help establish trust as well as engage and empower the individual throughout the initial response and established multidisciplinary plan of care. Local community partners can include local/Tribal coalitions, social services, public health, legal aid, law enforcement, survivors, school-based professionals, behavioral health services, and housing resource services.
- Plan for sustainability to ensure the facility's ability to safely and effectively address human trafficking in a systemic manner.

MISSING & MURDERED INDIGENOUS PEOPLE

Thousands of indigenous women, girls, and people have gone missing, or been murdered. Their families and communities have been mourning them for generations. Grassroots advocacy efforts have created national attention to this crisis of missing and murdered people (MMIP), also known as missing and murdered indigenous women (MMIW), missing and murdered indigenous relatives (MMIR), or other names specific to a particular Tribal community. This crisis encompasses a wide scope of violent crimes across Indian Country, including human trafficking, domestic, sexual, and intimate partner violence.

To learn more about this crisis and how to support awareness and prevention efforts as well as community response, please see resources listed below.

- Savanna's Act - improving the response, increasing coordination and collaborative efforts for MMIP: Congress.gov and DOJ resources.
- Not Invisible Act of 2019
- Missing or Murdered Indigenous People: Bringing loved ones home. One page flyer with links to information, training, and resources.
- MMIP and Human Trafficking. Department of Justice, Office of Victims of Crime, Human Trafficking Capacity Building Center.
- Missing or Murdered Indigenous Persons, U.S. Department of Justice. Information and resources, including how to Report and Identify Missing Persons.
- National Indigenous Women's Resource Center lifting up the collective voices of grassroots advocates and offering culturally grounded resources, technical assistance and training, and policy development to strengthen tribal sovereignty.
- Tribal Community Response Plan (OJP). Guide to Developing a Tribal Community Response Plan for Missing Person Cases.
- Connect with Tribal Domestic Violence and Sexual Assault Coalitions across Indian Country.

Human Trafficking & MMIP Resources

Reference and Resources:

- Stucky Halley, D, Sullivan, S.L, & Rapp, J. (2015). Providing effective services to victims of human trafficking: Theoretical, practical, and ethical considerations. In M.J. Palmiotto (Ed.), *Combating human trafficking, A multidisciplinary approach* (pp. 231-255). CRC Press.
- Adult Human Trafficking Screening Tool and Guide - Training guide for health professionals to use trauma-informed and survivor-informed assessment and care practices. National Human Trafficking Training and Technical Assistance Center (2018).
- A short Screening Tool to Identify Victims of Child Sex Trafficking in the Health Care Setting (2018).
- Sex Trafficking in Indian Country: Advocacy Curriculum (2020). Tribal Sex Trafficking Resources, Including red flag indicators of trafficking, considerations for interviewing an individual, and selection of a culturally appropriate screening tool.
- Department of Justice, Human Trafficking capacity building center: A partner in human trafficking education, healing support services, and resource identification to Tribes and organizations working with Tribes.
- Combating trafficking: Native Youth Toolkit on Human Trafficking.
- Human trafficking in Tribal communities – Identifying the signs.
- Recognizing the signs of human trafficking. Myths and facts, labor trafficking vs. sex trafficking, National Human Trafficking Referral Directory. Polaris (2023).
- Blue Campaign, Department of Homeland Security - Human trafficking training and resource.
- National Human Trafficking Training and Technical Assistance Center - SOAR Online Training
- National Center for Missing and Exploited Children Links to each state clearinghouse, including District of Columbia, Puerto Rico, US Virgin Islands, Canada, and Netherlands.
- Trafficking Victims Protection Act of 2000 and reauthorizations Federal Law, with revisions through 2018.
- National Indigenous Women's Resource Center - MMIW Toolkit for Families and Communities
- Tribal Sex Trafficking Resources: Federal, Tribal and State sex trafficking laws.
- National Action Plan to Combat Human Trafficking (December 2021).
- National Human Trafficking Hotline:1-888-373-7888, TTY: 711, Text (BE FREE) *233733
- Strong Hearts Native Helpline 1-844-7NATIVE (762-8483), offering 24/7 safe, confidential, and anonymous domestic, dating, and sexual violence helpline for American Indian and Alaska Natives, offering culturally appropriate support and advocacy.
- STTARS Indigenous Safe Housing Center. National workgroup on safe housing for American Indian and Alaska Native survivors of gender-based violence.

Sexual Assault Medical Forensic Examination Treatment Options

Adolescent/Adult, Female, recommended regimen for gonorrhea, chlamydia, and trichomoniasis:

- Ceftriaxone 500 mg intramuscular in a single dose, plus
- Doxycycline 100 mg 2 times/day orally for 7 days, plus
- Metronidazole 500 mg 2 times/day orally for 7 days

Adolescent/Adult, Male, recommended regimen for gonorrhea and chlamydia:

- Ceftriaxone 500 mg intramuscular in a single dose, plus
- Doxycycline 100 mg 2 times/day orally for 7 days

Syphilis: Benzathine Penicillin G, intramuscular in a single dose

Non-Occupational Post Exposure Prophylaxis (nPEP) HIV: Screen patient; collect HIV Ag/Ab, STI, RPR, Hep B/C, LFTs, CMP, and Pregnancy; start nPEP within 72 hours after exposure; ensure follow-up services are available. Treatment can include:

- Truvada (Emtricitabine-tenofovir (TDF)), 1 tab per day, 28 days
- Tivicay (dolutegravir), 1 tab per day, 28 days

Pregnancy/Emergency Contraception:

- Levonorgestrel 1.5 mg (Plan B), single dose
- Ulipristal acetate (UPA/Ella), 30 mg, single dose

Other medications & based on patient scenario/ situation:

- Hepatitis B vaccine (HBV) series
- Human Papillomavirus vaccine (HPV) series
- Zofran for nausea
- Tylenol/Advil for pain

Reference: Center for Disease Control and Prevention. STI Treatment Guidelines.

Special Considerations for Sexual Assault Medical Forensic Examination & Hepatitis B Treatment

Guideline for postexposure: Hepatitis B	Individual/patient is unvaccinated, partially vaccinated, or has a negative titer	Individual/patient is vaccinated
Source is known Hep B positive	Administer vaccine series and HBIG	Administer booster dose of vaccine or complete vaccine series
Source has an unknown Hep B status	Administer vaccine series	No treatment or complete vaccine series

Hepatitis B Virus vaccine:

- Administer first dose at initial visit, second dose in 1 to 2 months, and 3rd dose in 4 to 6 months.
- Retest the patient in 6 weeks and 3 months.

All individuals with HBV infection should be tested for HIV, syphilis, gonorrhea, and chlamydia.

HBIG = hepatitis B immune globulin

Reference:

- Center for Disease Control and Prevention. STI Treatment Guidelines.

Special Considerations for Sexual Assault Medical Forensic Examination & Human Papillomavirus

Human Papillomavirus Vaccine and Considerations:

- HPV vaccination can prevent more than 90 percent of cancers caused by HPV.
- About 85 percent of people will get an HPV infection in their lifetime.
- Administering vaccine starting at age 9 years. Routine HPV vaccination for all adolescents at age 11–12-year-olds can protect them long before they are ever exposed. Catch-up vaccination through age 26 years for those not vaccinated previously.
- Not using HPV vaccination for all adults aged >26 years. Instead, shared clinical decision-making between a patient and a provider regarding HPV vaccination is recommended for certain adults aged 27–45 years not vaccinated previously.
- Three HPV vaccines are licensed in the United States: Ceravrix, Gardasil, a 4-valent vaccine (4vHPV), and Gardasil 9, a 9-valent vaccine (9vHPV).
- A 2-dose vaccine schedule (at 0- and 6–12-month intervals) is recommended for persons who initiate vaccination between 9-14-years-old.
- A 3-dose vaccine schedule (at 0-, 1–2-, and 6-month intervals) for immunocompromised persons regardless of age of initiation.

Reference:

- Center for Disease Control and Prevention. STI Treatment Guidelines.

June 2023

Dear Colleagues,

Unfortunately, there is a surge in syphilis cases in Indian Country. After conferring with the IHS Infectious Disease Consultant, it's clear that we must take definitive action to address syphilis and all STIs at every site across the Agency. Therefore, please initiate the following at each service unit and community-based testing site in coordination with the respective community health teams and public health nursing.

1. **Annual syphilis testing** for persons aged 13-64 to eliminate syphilis transmission by early case recognition.
2. **Turn on the annual EHR reminder** at all sites to facilitate testing for two years or until incidence rates decrease locally to baseline.
3. **Three-point syphilis testing for all pregnant patients:** at the first prenatal visit, the beginning of the third trimester, and delivery.
4. Adoption of an STI/HIV/Viral hepatitis testing bundle at all sites to screen broadly:
    - Syphilis screening test with reflex RPR and TPPA
    - HIV serology (with documentation of consent if required in the local state jurisdiction)
    - Screening for gonorrhea and chlamydia at three sites: Urine, Pharynx, Rectum
    - Screening for hepatitis B and C
    - Pregnancy test
5. Adoption of **"Express STI Testing."** Express STI services refer to triage-based STI testing without needing a full clinical exam.
    - Research shows that express STI services increase clinic capacity and reduce the time to treatment.
    - Find the Express Testing Guide and Toolkit here. Sample Toolkit for Express STI Resources - Indian Country ECHO
6. **Enhance screening rates by screening outside of hospitals and clinics.**
    - Field testing at community centers, sporting events, health fairs, correctional settings, or on the street.
7. Provide **Field treatments for syphilis** for high-risk adults diagnosed with syphilis and their partners. PHNs could provide treatment with Benzathine Penicillin. The Express STI Services Toolkit includes policy examples. For questions, contact Tina Tah or Melissa Wyaco.
8. **Presumptive treatment of syphilis** for anyone having signs or symptoms of syphilis or with known exposure to syphilis.
9. **Create and build awareness** and encourage people to get tested and treated. There is a new AI/AN-specific national campaign called STOP SYPHILIS.
   The campaign offers handouts, posters, and other print materials, as well as social media posts and short educational videos.
    - All materials are free to order at www.stopsyphilis.org.
10. Reference the Syphilis Resources Hub: https://www.indiancountryecho.org/syphilis-resources/

Let's work together to address this serious issue.!

Vr-. C

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STI Considerations, continued

Rates of STI - including syphilis, gonorrhea, and chlamydia, have been on the rise nationally, while Tribal communities have been disproportionately impacted. This requires a proactive clinical and public health response across the IHS system of care.

The IHS National STI Initiative is designed to ensure access to quality community education, prevention, testing, and treatment services for Tribal communities to reduce the burden of STIs, including syphilis, congenital syphilis, gonorrhea, chlamydia, and HIV.

The IHS STI Toolkit contains important resources including:

- IHS STI Treatment Guidance
- Interim IHS Doxy-PEP Guidance
- IHS - Gallup Service Unit Express STI Testing Pathway
- Clinician's Quick Guide to HIV PrEP
- Navajo Area-wide policy and procedure - Syphilis and Gonorrhea Home Treatment
- National Pharmacy and Therapeutics Committee: STI Formulary Briefs & Medication Updates - Part I, Part II, and Part III

Strangulation

Strangulation is a form of asphyxia characterized by external pressure to the neck, occluding blood vessels, air passages and causing cerebral hypoxia. The four forms of strangulation are: hanging, ligature, manual, and positional. Hanging occurs when a person is suspended with a ligature around their neck, which constricts the airway due to the gravitational pull of the person's own body weight. Ligature strangulation occurs when the pressure applied around the neck with the use of ligature (e.g., rope, cord, etc.). Manual strangulation occurs when pressure is applied to the neck with hands, arms, or legs. Positional strangulation occurs when pressure is applied to the neck based on the individual's body position and use of a chair, bed, etc.

Anatomic location of applied force to the neck, quantity of applied force, surface area of applied force, and duration of applied force are all variables regarding strangulation.

Immediate death from strangulation can occur from one of four mechanisms:

- Obstruction of carotid arteries
- Obstruction of jugular veins
- Obstruction of the trachea
- Cardiac arrhythmia

Delayed fatality from strangulation:

- Fractured trachea or larynx
- Cerebral artery infarct
- Carotid Aneurysm
- Post traumatic arterial thrombosis

Strangulation patients are often under-evaluated. Anyone reporting strangulation (or reporting a history of being "choked") should receive a complete medical head-to-toe assessment. Based on the medical assessment and evaluation, a CT angiogram might be warranted.

Strangulation, continued

Strangulation and Medical Forensic Examination Considerations:

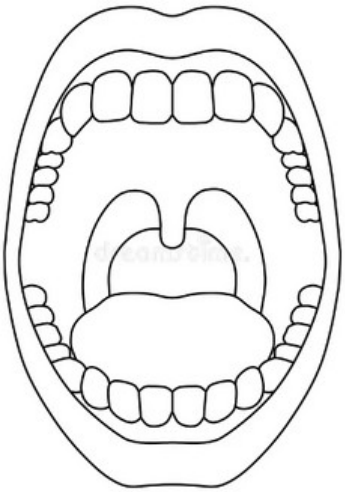
- Follow the facility's policies and procedures regarding assessment and evaluation following reports of strangulation.
- Visible injury following strangulation might not be present, and often correlates with a lack of thorough evaluation.
- Conduct a complete head-to-toe examination following strangulation, which includes thorough assessment of the head, eyes, ears, nose, throat, neck, motor, cranial nerves, and auscultate heart and lungs.
- Pediatric strangulation - understand anatomy and physiology differences, potentially attributing to higher lethality risk. Neck flexion, swelling, and underdeveloped muscles and ligaments can occlude the child's smaller airway.
- Potential signs and symptoms following a strangulation can include, but are not limited to:
  - Airway, breathing, and circulation changes
  - Voice changes
  - Swallowing changes
  - Bowel and bladder incontinence
    - Due to loss of consciousness
  - Mental status changes, altered
    - Restlessness secondary to hypoxia
    - Impaired memory
  - Miscarriage
  - Neurological changes
    - Loss of sensation, unilateral weakness, facial droop, paralysis
    - Can mirror stroke-like symptoms
  - Neck swelling and tenderness
  - Lung injury
    - Aspiration pneumonia
    - Pulmonary edema
  - Bruising, swelling, lacerations, abrasions (including defense marks), redness, pattern injuries, petechiae, subconjunctival hemorrhages, etc.

Voice changes, swallowing changes, and neck swelling are all indicative of injury to internal neck structures.

Helpful Resources:

- IAFN - Non-Fatal Strangulation Documentation Toolkit (includes an example policy, evidence collection, documentation forms, and discharge instructions).
- Training Institute on Strangulation Prevention - Recommendations for the Medical/Radiographic Evaluation of Acute Adult, Non-Fatal Strangulation (2019).

ORAL ASSAULT and ASSESSMENT



The medical forensic examination should follow a trauma-informed, culturally appropriate response, and approach to care. A careful and thorough intraoral and perioral examination is necessary in all oral assault cases, including suspected child abuse and neglect.

Health care provider to assess:

- Lips, gingiva, gums, tongue, frenulum, teeth, hard/soft palates, dental fixtures (e.g., crowns, dentures, braces, bridges, etc.).
- Identify and document potential findings (e.g., tears, abrasions, lacerations, petechiae, pattern injuries, chipped/cracked/fractured/broken teeth, soreness, tenderness, swelling, facial or jaw fractures, etc.).

Health care provider & evidence collection:

- Step One: Oral swabs for evidence (up to 24 hours since assault, depending on the patient's circumstance)
    - Use two dry swabs to swab/rub the oral cavity.
- Step Two: Buccal swabs for the patient's DNA (no restricted timeframe for collection)
    - After oral swabs are collected, have the patient rinse their mouth with water.
    - Using two dry swabs, swab/rub the inner cheeks of the patient's mouth. Package per protocol.

Using dental floss to collect medical forensic evidence is discouraged and could introduce a host of germs, bleeding, and further trauma on the patient.

References:

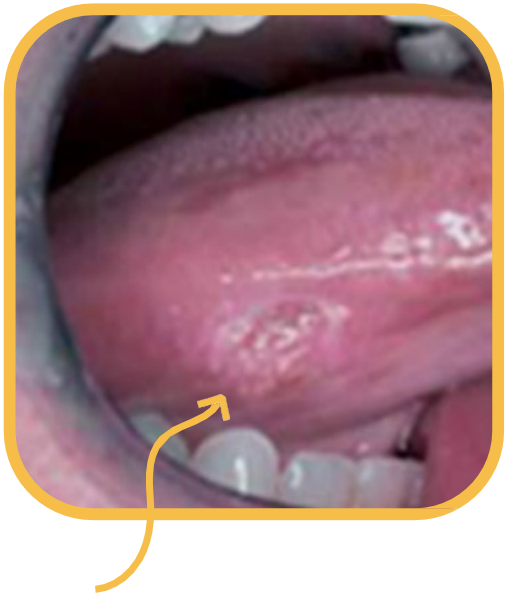
- OVW. A National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescents and Pediatric
- National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach (2017).

ORAL ASSAULT and ASSESSMENT, continued

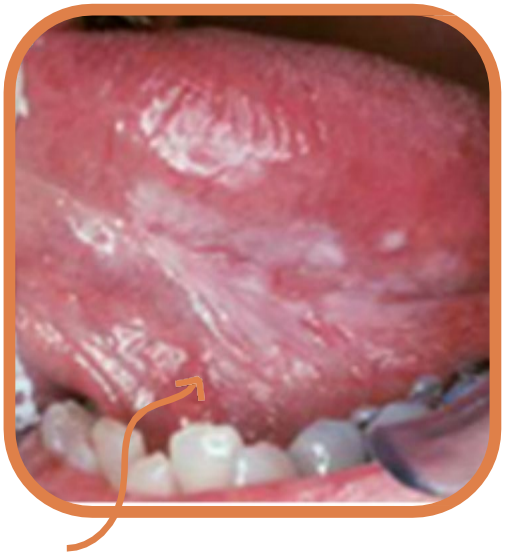
Considerations:

- Sexually Transmitted Infections (STIs) can be passed on through oral assault (e.g., Chlamydia, Gonorrhea, HPV, Herpes, HIV, Syphilis).
- Most STIs do not have symptoms. Oral symptoms someone might experience can include, but are not limited to throat soreness, white spots in mouth, tears/abrasions, sores, swollen glands.
- Findings/injury can sometimes mimic medical issues (see photos).
- Offer the patient referrals and follow-up care with behavioral health, advocacy, social work, primary care provider and dentist.

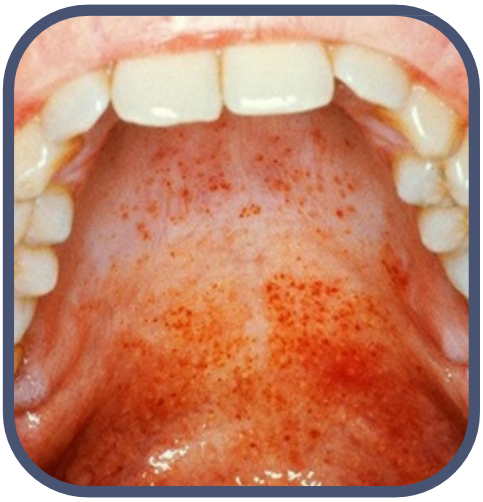
For additional resources, check out IHS Dentistry and the Division of Oral Health webpage & portal.



The right lateral tongue demonstrated the presence of an indurated, painless ulcer.
Diagnosis: Early-stage squamous cell carcinoma



White lesion with irregular margins on the left ventral tongue. At the inferior aspect, there is a prominent red patch of tissue.
Diagnosis: Carcinoma in situ

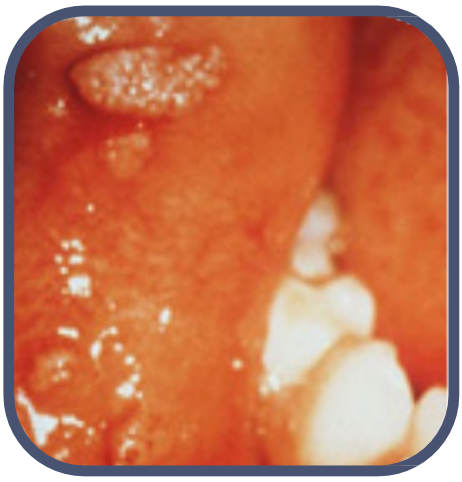


Oral/Palatal Petechiae

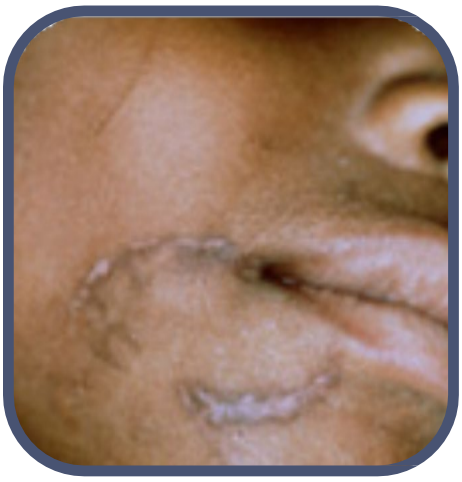
References (Images):

- Oral Cancer Foundation - https://oralcancerfoundation.org/dental/oral-cancer-images/
- MedicineNet: https://www.medicinenet.com/does_oral_sex_cause_palatal_petechiae/article.htm

ORAL ASSAULT and ASSESSMENT, Pediatric Patients



Oral Condyloma



Pattern injury: human bite mark to face

Pediatric oral assault and assessment considerations:

- Oral injuries may be inflicted with instruments such as eating utensils or bottles during forced feedings, hands, fingers, burns from hot liquids or objects, etc.
- Oral assault injuries resulting from abuse tend to be found on cheeks, lips, frenulum, submandibular area, face, and neck. Dental trauma may be an indicator for child abuse because craniofacial, head, face, and neck injuries occur in more than half of the cases of child abuse.
- Dento-facial trauma may be manifested as avulsed teeth, non-vital teeth, lip laceration, tongue injuries, frenum injuries, or jaw fractures. Injuries to the face can be in various forms, including contusions bruising, abrasions and lacerations, burns, bites, and fractures.
- Sexual abuse can be manifested as oral lesions from sexually transmitted infections or as bruising and petechiae of the palate from oral sexual assault.

References:

- National Maternal and Child Oral Health Resource Center. Child Abuse & Neglect, 3.4: https://www.mchoralhealth.org/SpecialCare/3-supervision/3-4.php
- Prevent Abuse and Neglect through Dental Awareness (PANDA) - Dental Public Health Activities & Practices: https://www.astdd.org/bestpractices/DES05002ARpanda.pdf

Medical Forensic Photography

With respect to the patient's consent and assent, which is on a continuum throughout the medical forensic examination, national best practices highlight the importance of capturing photographs of injury, findings, or evidence following a violent crime. Photographic documentation of injury, or other visible evidence on the patient's body, should supplement the medical forensic history and the written documentation of physical findings and evidence. Photographs should not replace written documentation.

Photograph Documentation & Medical Forensic Examination Considerations:

- The SANE/SAFE/FNE must follow the facility's policies and procedures related to medical forensic photography, including securing, storage and release of photos.
- Ensure the examination, including use of a camera to capture photographs is offered in a patient-centered, trauma-informed approach. Explain forensic photography procedures and offer education to patients and any caregivers.
- Consider patient comfort and privacy, as priority over capturing photographs.
- Consider the extent of medical forensic photography necessary.
- Ensure the facility has the appropriate camera equipment, camera supplies, and recognize the importance of regular maintenance of equipment.
- Take initial and follow-up photographs as appropriate, according to program policy.
- Photographs should be listed within the chain of custody.
- Understand and identify how the photos are stored (e.g., using an SD card and stored with records management; using the facilities infrastructure; using camera equipment that stores photos on a secure and encrypted system, etc.).
- Understand that photographs should only be released to the criminal justice system with a subpoena. Local/state law enforcement, FBI, BIA, Sheriff's Department, etc., can capture photos of any findings from the patient's head and extremities, with the individual's consent.
- Findings are captured using a rule-of-thirds, with and without a measuring scale.
- Understand the use of the facility's camera, camera equipment, settings, and the lighting in the exam space. Recognize if the photos are too dark (increase ISO, decrease shutter speed, smaller f/stop), too bright (decrease ISO, increase shutter speed, smaller f/stop), too blurry (increase f/stop, increase shutter speed, use stabilizing equipment like a tripod). Adjust body positions and angles to decrease any potential shadowing, adjust as needed.
- Understand the courtroom process with the use of medical forensic documentation and photography.

Medical Forensic Photography, continued

References:

- American College of Emergency Physicians. (2013). Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient (2nd ed.). American College of Emergency Physicians.
- Bloemen, E. M., Rosen, T., Cline Schiroo, J. A., Clark, S., Mulcare, M. R., Stern, M. E., Mysliwiec, R., Flomenbaum, N. E., Lachs, M. S., and Hargarten, S. (2016).Photographing injuries in the acute care setting: development and evaluation of a standardized protocol for research, forensics, and clinical practice. Academic Emergency Medicine, 23(5), 653–659. https://doi.org/10.1111/acem.12955
- Ledray, L. E. (2008). Consent to photograph. Journal of Forensic Nursing, 4(4), 188–189. https://doi.org/10.1097/01263942-200812000-00008
- Nittis, M., and Hughes, R. (2021). Forensic photo-documentation in adult sexual assault- what do patients think? Journal of Forensic and Legal Medicine, 77, 102092. https://doi.org/10.1016/j.jflm.2020.102092
- Office on Violence Against Women. A National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescents and Pediatric.

Clinical Forensic Photography Courses:

- French Forensics - Clinical Medical Forensic Photography Certificate course: https://www.frenchforensics.com/fnessentials
- Texas A&M University Center of Excellence in Forensic Nursing - clinical medical forensic photography training (course catalog).
- Connect with local/state providers/advocates/educators/etc., for available clinical medical forensic photography training courses in your area or online options.

Alternate Light Source

Alternate Light Source (ALS) is a non-diagnostic tool that can be helpful to further visualize injury and improve evidence collection following a violent crime.

- Injury, such as bruising, can be further assessed and documented as noting positive absorption.
- Fluids or fibers can be assessed and documented as noting positive fluorescence.

Medical Forensic Examination Considerations:

- Obtain the patient's consent prior to using the ALS.
- The ALS is a helpful tool, but it is not necessary to complete a medical forensic examination.
- ALS can sometimes lead to false positives (e.g., make-up, ointments, lotions, sodas, etc., can all fluoresce).
- Positive ALS fluorescence does not mean that bodily fluids are present on the skin.
- During the medical forensic exam, all findings, such as fluorescence or absorption, should be swabbed for crime lab analysis whether or not the patient reported use of topical products.
- Follow the facility's policy, procedures, and guidance on use of ALS equipment, understanding operation, fluorescence and absorption.

References:

- Pollitt EN, Anderson JC, Scafide KN, Holbrook D, D'Silva G, Sheridan DJ. Alternate Light Source Findings of Common Topical Products. J Forensic Nurs. 2016 Jul-Sep;12(3):97-103. doi: 10.1097/JFN.0000000000000116. PMID: 27428790; PMCID: PMC5486918.
- OVW. A National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescents.

Toluidine Blue Dye

Toluidine Blue Dye (TBD) is a nuclear stain that adheres to the exposed nuclei of broken/damaged cells. When applied, the stain can be used to detect or enhance injury or related findings.

Toluidine Blue Dye Examination Considerations:

- Follow the facility's policies and procedures with use of TBD
- Obtain the patients consent prior to examination and use of TBD
- Provide patient education and rationale on the use of TBD
  - Explain why the examiner would apply the dye
  - Explain how the dye might feel when applied and removed
  - Explain that the individual might find blue dye on their underwear, or on toilet paper, following the examination
  - Any potential findings
- Conduct visualization, inspection, and evidence collection prior to TBD application. The TBD should not be used to look for injury, rather applied to what appears to be injury to the naked eye.
- Apply TBD from 3 to 9 o'clock, non-mucosal external genitalia:
  - Posterior Fourchette
  - Labia Minora
  - Fossa Navicularis
  - Perineum
  - Anus
- Remove TBD with water-soluble lubricant/jelly and gauze, a baby wipe, or with diluted 1 percent acetic acid spray.
- After TBD removal, any retained TBD highlights an indigo blue color and can be documented as 'positive uptake,' including location.
- Diffuse, not well removed, or retained TBD can sometimes lead to false-positives but documented as positive uptake.

References:

- OVW. A National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescents.
- Sridharan G, Shankar AA. Toluidine blue: A review of its chemistry and clinical utility. J Oral Maxillofac Pathol. 2012 May;16(2):251-5. doi: 10.4103/0973-029X.99081. PMID: 22923899; PMCID: PMC3424943.

Speculum Examination

If indicated per the patient history and with the patient's consent, the medical forensic examination can include an assessment and evaluation of the vagina and cervix. A speculum is a tool used to help visualize the vagina and cervix, aide to help identify any findings, and aide in evidence collection.

Speculum - Medical Forensic Examination Considerations:

- Follow the facility's speculum policies and procedures, and scope of practice defined by licensure.
- Obtain the patient's consent prior to genital assessment and use of speculums.
- Always provide culturally safe, appropriate, trauma-informed care, respect the patient's wishes to their care, and answer any questions they have regarding the exam.
- Understand the context of historical trauma and the impact on AI/AN patients, their concerns related to their health care, including the use of a speculum and conducting a genital examination.
- Provide patient education regarding the purpose of the examination; what a speculum is; why it is used; inform of all steps throughout the examination; and allow for withdrawal of consent at any point during the examination.
- Assist the patient into lithotomy position (if the patient is unable to tolerate lithotomy, change positions to side-lying or frog-leg).
- The size of the speculum and exam position may vary by patient.
- Prior to speculum insertion, conduct visual assessment of the external genitalia, collect external evidentiary swabs, conduct separation and traction, capture necessary photos and apply TBD, remove, and assess the external genitalia as needed. Hymenal tracing and assessment must also occur prior to speculum insertion.
- Introduce the speculum, obtain visual of the vaginal vault, cervix, and cervical os. With the consent of the patient, obtain medical forensic photographs and collect evidentiary swabs. Make note of any findings, which will be documented in the medical forensic record, including findings that could potentially mimic abuse.
- Evidentiary swabs must be collected prior to collecting medical cultures or swabs.
- Less than 5 percent of children will have any physical signs of sexual trauma or abuse. Speculums should not be inserted into the vagina of a prepubescent child except under limited circumstances and is contraindicated in any child whose hymen is not estrogenized. If deemed necessary, medical specialists need to be consulted.

References:

- OVW. A National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescents.
- Anderson, J.C., & Sheridan, D.J (2012). Female genital injury following consensual and non-consensual sex: state of the science. *J. of Em. Nursing,* 38(6), 518-522. https://doi.org/10.1016/j.jen.2010.10.014
- Joyce A. Adams, Katherine Harper, Sandra Knudson, Juliette Revilla; Examination Findings in Legally Confirmed Child Sexual Abuse: It's Normal to be Normal. Pediatrics September 1994; 94 (3): 310–317. 10.1542/peds.94.3.310

Anoscopy

If indicated per the patient history and with the patient's consent, the medical forensic examination can include an assessment and evaluation of the anus and rectum. An anoscope is a tool used to help visualize the anal canal and rectum, aide to help identify any findings, and aide in evidence collection.

Anoscopy - Medical Forensic Examination Considerations:

- Follow the facility's anoscopy policies and procedures, and scope of practice defined by licensure.
- Anoscopy is not routinely performed. If the patient reports concern for rectal assault, foreign object insertion, bleeding, etc., an anoscopy should be performed.
- Always provide culturally appropriate care and respect the patient's wishes to their care.
- Obtain the patient's consent prior to anal/rectal assessment and use of anoscopes.
- Provide patient education on purpose of the anoscopy examination, information about an anoscope and why it is used, inform of all steps throughout the examination and allow the patient to withdraw consent at any point of the process.
- Assist the patient into supine knee-chest position (comfort takes priority, if the patient is unable to tolerate change positions).
- Prior to anoscope insertion, conduct visual assessment of the anus, collect perianal and anal evidentiary swabs, capture necessary photos and apply TB Dye (remove dye and assess the anus). Document any findings in the medical forensic record, including findings that could potentially mimic abuse.
- Introduce the anoscope and obtain visual of the pectinate/dentate line and rectum. With the consent of the patient, obtain medical forensic photographs and collect evidentiary swabs. Document any findings.

References:

- OVW. A National Protocol for Sexual Assault Medical Forensic Examinations, 2nd Edi., Adult/Adolescents.
- Ernst AA, Green E, Ferguson, MT, Weiss SJ, Green, WM. The utility of anoscopy and colposcopy in the evaluation of male sexual assault victims. Ann Emerg Med. 2000; 36(5):432-473. doi:10.1067/mem.2000.110993
- International Association of Forensic Nurses. *Atlas of Sexual Violence. 1st Ed.* (Henry T, ed.). Mosby; 2012.

Toxicology

Alcohol/drug-facilitated sexual assault (A/DFSA) occurs when a person is subjected to nonconsensual sexual acts while they are incapacitated or unconscious due to the effect(s) of ethanol, a drug and/or other intoxicating substance and are therefore prevented from resisting and/or unable to consent (SOFT).

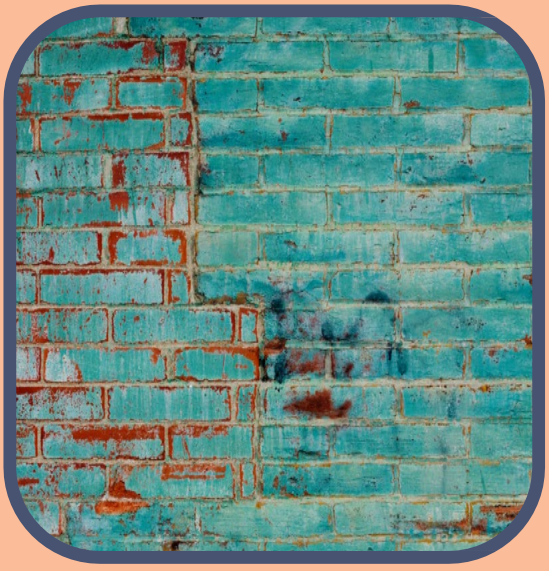
Toxicology Collection:

- Follow the facility's and multidisciplinary team's procedures to specimen collection, preservation, release, and testing.
- The health care provider should be familiar with the facility's policy and procedures with collection of toxicology samples following potential alcohol and/or drug facilitated sexual assault (A/DFSA).
- Obtain the patient's consent to screen for and collect samples for A/DFSA.
- Routine toxicology testing is not recommended. One or more of the following circumstances should prompt collection of blood and/or urine, as soon as possible following the suspected assault:
  - The patient reports nausea or vomiting post assault
  - The patient reported loss of consciousness or lapse of memory
  - The patient voluntarily used drugs or alcohol
  - The patient has concerns for being drugged
- 100cc's of urine can be collected up to 120 hours post assault
- 3 gray top, glass tubes containing preservative sodium fluoride and anticoagulant potassium oxalate should be used to collect blood, up to 24 hours post assault
- Specimen collection for medical evaluation (e.g., urine or blood for pregnancy) should be sent separately from A/DFSA samples.

Toxicology, continued

Toxicology considerations:

- Identify toxicology laboratories, either at your facility or crime lab. Exam facility laboratories should not analyze toxicology samples in suspected drug-facilitated sexual assault cases. Instead, involved criminal justice agencies should identify forensic laboratories that can analyze these toxicology samples (they should have the capacity to detect drugs in very small qualities). Information, policy, and procedures about these labs (e.g., contact information, evidence collection and packaging procedures, and transfer procedures) should be provided to law enforcement representatives investigating these cases, exam facilities, and examiner programs.
- Preserve evidence and maintain chain of custody. Understand the lab's requirements on collection, packaging, labeling, storage, handling, transportation, and delivery of specimens.



References:

- OVW. A National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescents.
- Society of Forensic Toxicologist, Inc. (SOFT). Drug Facilitated Sexual Assault Fact Sheet.

Chain of Custody

Medical Forensic Examination - Chain of Custody:

- Follow the facility's policy and procedure on evidence collection and chain of custody (COC).
- With the patient's consent, health care providers (e.g., SANEs/FNEs/SAFEs, etc.) can collect medical forensic evidence for patients following violent crimes.
- All evidence collected during the examination (e.g., documentation, swabs, clothing, photographs, specimens, etc.), should be listed within the medical forensic record as evidence collected. The collection of these items in a healthcare settings establishes the first link in the chain of custody.
- The COC should highlight every individual and location in contact with the evidence, leaving no room to question proper handling and storage. It is critical in establishing authentication and relevance for purposes of admissibility of the evidence in court.
- The COC should include:
  - Date/time/identity of individual who collected evidence.
  - Any person(s) in possession of the evidence at scene and during transport. Date/time/identity of person who submitted the evidence.
  - Date/time/identity of property/evidence custodian who accepted/received the evidence.
  - Date/time/identity of any person to whom the evidence was released and from whom it was returned.
- After release of evidence, the COC should be stored within the medical forensic record and copies of the COC should be shared with those retrieving the evidence.
- The medical forensic record includes personal health information; therefore, if released, compliance with all federal and state privacy protections, including the protections of the HIPAA, are required.

References:

- DOJ, OJP. National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach.
- OVW. A National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescents.

Thank you to the reviewers and contributors

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Division of Nursing Services Team

Indian Health Service

2024