HAWAII SEXUAL ASSAULT RESPONSE & TRAINING (HSART)

MEDICAL-LEGAL SERVICES FORENSIC EXAM GUIDELINES

(revised 9/2022)

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INTRODUCTION

The guidelines for evidence collection and the Hawaii State Sexual Assault Evidence Collection Kit[1] are designed to promote uniform evidence collection procedures, standardized medical protocols, and consistency in the investigation of sexual assault cases statewide. The first guidelines were issued in 2000 by The Sex Abuse Treatment Center, through a Violence Against Women Grant-funded project titled Standard Medical/Legal Protocol for Sexual Assault. The date(s) of subsequent revisions to the guidelines are noted accordingly.

This manual is a procedural guide for use in the provision of medical-legal services for victims of sexual assault. It is for informal purposes and is not intended to, nor does it provide legal advice. Forms described in the text have been included in the manual's appendix. Each island may find it necessary to make minor adjustments to the guidelines/procedures to accommodate specific island needs. Should this occur, the adjustments should be documented in writing and included in the manual.

The guidelines are considered confidential. Distribution of the guidelines needs to be controlled and issued only to the agencies and users for which they are intended. Each user agency needs to set up its internal procedure to ensure confidentiality.

The Standard Medical/Legal Protocol for Sexual Assault Project to promote uniform evidence collection procedures, standardized medical protocols, and consistency in the investigation of sexual assault cases statewide was led by the Kapiolani Medical Center for Women & Children, The Sex Abuse Treatment Center (SATC). This project was the predecessor of the State program, now known as the Hawaii Sexual Assault Response and Training Program (HSART). In 2018, Act 113 was passed, and a new section, Hawaii Revised Statutes 844G-2 Sexual Assault Evidence Collection Kits established the HSART Program within the Department of the Attorney General. Chapter 844G-2 states that HSART "shall have regularly scheduled meetings to strengthen the coordinated community response and level of quality of care for victims of sexual assault, and shall develop and maintain: (1) Specific guidelines for all medical forensic examinations in the State that shall be issued to all sex assault programs and centers, county contractors, and any other facilities that perform medical forensic examinations;" and "(2) A protocol for the collection of forensic evidence included within a sexual assault evidence collection kit".

[1] This project was supported by Grant No. 96-VAWA-1A awarded by the Violence Against Women Grants Office, Office of the Justice Programs, U.S. Department of Justice. Points of view in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

It is important to acknowledge that SATC's project included documents that promoted uniform evidence collection procedures, standardized medical protocols, and consistency in the investigation of sexual assault cases statewide. As the HSART Program under Chapter 844G supersedes the federally funded project, the following documents, which were contained in the initial HSART Exam Guidelines, are no longer necessary and have been removed. For historical purposes, the documents are included in Section 8. Historical Background.

> Memorandum Agreement dated September 10, 1999 and signed by the county police chief, county prosecuting attorney, and the state attorney general, to promote uniform evidence collection procedures, standardized medical protocols, and consistency in the investigations of sexual assault cases.
>
> Memo dated August 7, 2009, from the Department of the Attorney General, Crime Prevention and Justice Assistance Division, Grants and Planning Branch Chief to the Sex Abuse Treatment Center, Hawaii SART Program Manager and Sex Abuse Treatment Center, Crisis Intervention Program Manager. *Subject: Confidentiality of Medical-Legal Forensic Examination Protocols, Statewide Medical-Legal Collaborative Project.*
>
> Statewide Sexual Assault Medical-Legal Protocol Participants Listing

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SECTION 8: HISTORICAL BACKGROUND

1. Memorandum Agreement dated September 10, 1999 and signed by the county police chief, county prosecuting attorney, and the state attorney general, to promote uniform evidence collection procedures, standardized medical protocols, and consistency in the investigations of sexual assault cases.

2. Memo dated August 7, 2009, from the Department of the Attorney General, Crime Prevention and Justice Assistance Division, Grants and Planning Branch Chief to the Sex Abuse Treatment Center, Hawaii SART Program Manager and Sex Abuse Treatment Center, Crisis Intervention Program Manager. *Subject: Confidentiality of Medical-Legal Forensic Examination Protocols, Statewide Medical-Legal Collaborative Project.*

3. Statewide Sexual Assault Medical-Legal Protocol Participants Listing

Guideline

SUBJECT: **OVERVIEW OF MEDICAL-LEGAL SERVICES FORENSIC EXAMINATIONS**

SECTION #: **1**

GUIDELINE #: **1**

DATE: **5/00, 10/11, 5/12, 9/19, 4/21**

General Statement: Victims of sexual assault are referred for specialized medical-legal services. The specific needs of each individual referred are assessed and the appropriateness of the acute or non-acute forensic examination is determined. The acute forensic examination is performed by the forensic examiner within 120 hours of a reported sexual assault, and under certain circumstances, post-120 hours of a reported sexual assault. During the acute forensic examination, the Hawaii State Sexual Assault Evidence Collection Kit (evidence kit) may be used by the forensic examiner in the collection of the forensic evidence. The primary objectives of the forensic examiner during a forensic examination are: a) performance of the physical examination which includes history taking of the presenting complaint, for the purposes of medical diagnosis and treatment; b) collection of medical-legal evidence; c) testing for and treatment of sexually transmitted diseases or other medical issues when applicable; d) documentation of findings; and/or e) consultation for follow-up medical and emotional care.

Purpose: To establish the guidelines used in determining the appropriateness of the acute and non-acute forensic examination.

Procedure:

A. The Acute Forensic Examination

The following guidelines will be used to assess the appropriateness of the acute forensic examination for the patient.

1. The acute forensic examination will be offered in the following circumstances:

a) An adult or minor patient reports attempted or completed sexual penetration occurred within the past 120 hours.

- If the patient reports decreased level of consciousness (e.g., due to alcohol or drugs, loss of memory, etc.) and/or is unsure if attempted or completed sexual penetration has occurred, an acute forensic examination will be offered.

- If the patient is a minor and there is reason to believe that the sexual assault may have entailed more than the fondling disclosed, the provision of the acute forensic examination will be left to the discretion of the forensic examiner.

b) The patient reports that attempted or completed sexual penetration occurred beyond the past 120 hours, and one of the following circumstances are present:

- There is indication of physical trauma as a result of the sexual assault that needs to be evaluated (e.g., pain, bleeding, lacerations, discharge, inflammation, etc.).

- The patient reports there was physical force involved and injuries may not be visible (e.g., the person was hit on the head, the person was hit in the face but bruising may not yet be visible, etc.).

B. The Non-Acute Forensic Examination

The following guidelines will be used to assess the appropriateness of the non-acute forensic examination for the patient.

1. The non-acute forensic examination will be offered to patients under the age of 18 who report attempted or completed sexual penetration that occurred beyond 120 hours of a reported assault. This exam will be offered regardless of the amount of time that has passed since the sexual assault has occurred.

   - If there is reason to believe that the sexual assault may have entailed more than the fondling disclosed, the provision of the non-acute forensic examination will be left to the discretion of the forensic examiner.

   - Situations that require further assessment (such as repeated custody allegations) will be managed on a case-by-case basis.

Guideline

SUBJECT: **SEXUAL ASSAULT FORENSIC EXAMINER TRAINING STANDARDS**
SECTION #: **2**
GUIDELINE #: **1**
DATE: **10/11, 9/19, 4/21**

General Statement: Sexual assault forensic examiners (SAFEs) perform medical-forensic examinations on victims of sexual assault. SAFEs, whether they are a physician or a Sexual Assault Nurse Examiner (SANE), are specially trained in the area of sexual assault. The primary objectives of the SAFE during the acute medical-forensic examination are:
a) performance of the physical examination which includes history taking of the presenting complaint, for the purpose of medical diagnosis and treatment; b) collection of medical-legal evidence using the Hawaii State Sexual Assault Evidence Collection Kit;
c) testing for and treatment of sexually transmitted diseases when applicable; d) documentation of findings; and e) consultation for follow-up medical and emotional care.

Purpose: To establish the guidelines with which physicians and nurses are trained to become SAFEs.

Procedure:

A. Orientation

1. Physicians and nurses training to become a SAFE (trainees) will participate in an orientation process conducted by the appropriate agency within their county.

2. During the orientation the trainees will receive the following types of information:
   a) The incidence and prevalence of sexual violence.
   b) Common sexual assault myths and facts.
   c) The dynamics and impact of sexual victimization.
   d) Offender typology.
   e) Community resources and protocols for comprehensive response.
   f) The relationship of sexual violence to/differences from domestic violence dating violence and stalking.
   g) SAFE duties, responsibilities, and compensation.
   h) Self care for SAFEs

B. Didactic Training

1. The didactic training may be conducted by an experienced SAFE with the assistance of various members of the Sexual Assault Response Team (SART) or by participation in accredited SAFE/SANE courses.

2. SART System Overview – The trainee will be given an overview as to how the

SART system operates in the respective county. This can include, but is not limited to the roles and responsibilities of each SART agency, the activation of the SART, and how the medical-forensic examination fits into the SART process.

3. Medical-Legal Examination – The experienced SAFE will cover the acute forensic examination process with the trainee and will provide an explanation of the following components and how they relate to the acute medical-forensic examination:
   a) Victim-Centered Care – this section will include how to explain the examination process to a patient, patient rights, cultural and individual considerations, and referrals to community resources for follow-up care.
   b) Informed Consent
   c) Confidentiality
   d) Law Enforcement Reporting and Mandatory Reporting*
   e) Facilities – this section will include a tour of the facility or facilities where the forensic examination will take place, the equipment and supplies that the SAFE will use, and any other relevant nuances of performing a forensic examination in that facility (i.e. how a patient is registered or triaged).
   f) The Hawaii State Sexual Assault Evidence Collection Kit and the Hawaii State Medical-Legal Record and Sexual Assault Information Form5
   g) Drug Facilitated Sexual Assaults
   h) STI Evaluation and Care
   i) Pregnancy Evaluation and Care
   j) Discharge and Follow-Up

4. Examiner Court Appearances – It is recommended that the trainee will meet with a representative from the county Prosecutor's Office and the Public Defender's Office to understand the SAFE's role in the courtroom as either an expert or factual witness.

C. Preceptor Training

1. Non-traumatic genital assessment
   a) Identification of normal genital anatomy
   b) Identification of normal variation in genital anatomy
   c) Establish competent visualization techniques (use of speculum and change of position or use of specialization techniques)

2. Medical/forensic examination
   a) Performing a head-to-toe evaluation including a detailed anogenital assessment using a speculum, positioning, and other adjunctive techniques and equipment
      i. Before being qualified to perform an examination independently, the trainee will:
         (1) Observe a minimum of one (1) acute forensic examination.

(2) Perform a minimum of one (1) acute forensic examination while being observed by an experienced SAFE.
(3) This process may be expedited with the use of professional patients.

ii. The trainee must be approved by the director/coordinator of the program prior to performing an examination independently.

b) Identification and interpretation of findings
c) Use of evidence collection kit
d) Practice of photo documentation

3. Psychosocial assessment
   a) Crisis intervention
   b) Suicide and safety assessment and planning
   c) Referrals

D. Training Completion – SAFE training will be complete once the standards above are met and the director/coordinator of the program determines that the trainee can competently and independently perform an acute forensic examination.

E. On-Going Training

1. SAFEs are encouraged to attend trainings that will improve their ability to perform acute forensic examinations.

2. SAFEs are encouraged to attend peer review meetings.

Guideline

SUBJECT: **THE HAWAII STATE SEXUAL ASSAULT EVIDENCE COLLECITON KIT**

SECTION #: **3**

GUIDELINE #: **1**

DATE: **5/00, 2/03, 10/11, 2/20, 5/21**

General Statement: The Hawaii State Sexual Assault Evidence Collection Kit was designed to promote uniform evidence collection procedures, standardized medical protocols, and consistency in the investigation of sexual assault cases statewide. Members of the law enforcement, medical, social service, and legal communities in the State of Hawaii were convened to develop the protocols and standard evidence collection procedures embodied in the kit.

A Memorandum Agreement regarding the use of the Hawaii State Sexual Assault Evidence Collection Kit exists between the Department of the Attorney General, State of Hawaii; the Department of the Prosecuting Attorney for the City and County of Honolulu, County of Maui, County of Hawaii and County of Kauai; and the Honolulu, Maui County, Hawaii County and Kauai County Police Departments. All parties have agreed to use the evidence collection kit, its guidelines, and procedures for all examinations for evidence of a sexual assault or attempted sexual assault, and to make observations and perform tests as required by the procedures contained in the kit.

Purpose: To establish guidelines for the use of the Hawaii State Sexual Assault Evidence Collection Kit. To identify the contents found in the Hawaii State Sexual Assault Evidence Collection Kit and delineate expiration guidelines.

Procedure:

The Hawaii State Sexual Assault Evidence Collection Kit will be used in the collection of medical-legal evidence for cases involving minor and adult victims seen within 120 hours of a reported sexual assault.

The forensic examiner will follow the guidelines for the collection of evidence as outlined in the kit's instructional sheet.

Guideline

SUBJECT: **PROCEDURES FOR THE HAWAII STATE SEXUAL ASSAULT EVIDENCE COLLECTION KIT**

SECTION #: **3**

GUIDELINE #: **2**

DATE: **5/00, 2/03, 10/11, 9/19, 5/21**

General Statement: The Hawaii State Sexual Assault Evidence Collection Kit will be used in the collection of medical-legal evidence for cases seen within 120 hours of a reported sexual assault. Instructions on the use of the kit and the collection steps to be followed are found in the kit itself. While the protocol consists of 12 steps, the number of steps actually performed and the specimens collected will remain at the forensic examiner's discretion.
The forensic examiner is responsible for conducting the acute medical-forensic examination and for the collection and documentation of the medical-legal specimens.

Purpose: To promote uniform evidence collection procedures and consistency in the investigation of sexual assault cases statewide.

Procedure:

A sealed Hawaii State Sexual Assault Evidence Collection Kit will be transferred to the forensic examiner or authorized assistant prior to the commencement of the acute forensic examination. The kit will be checked to see that the kit's seal has not been tampered with or broken. The seal will be broken and the forensic examiner will follow the procedures located in the kit.

Note: All markings should be done in permanent black ink. When sealing evidence collection envelopes, moistener or evidence tape found in the examination room should be used.

Guideline

SUBJECT: **DRYING BOX**
SECTION #: **3**
GUIDELINE #: **3**
DATE: **5/00, 10/11, 9/19, 5/21**

General Statement: When indicated by patient history, specimens for DNA analysis will be collected as evidence in cases of sexual assault. The DNA drying box will be used in the preservation of the specimens.

Purpose: To establish guidelines for the proper preservation of DNA evidentiary specimens.

Procedure:

The drying box will be cleaned and used according to each county SAFE facility standards and instructions that prevents cross contamination of the samples.

If cross contamination occurs, the facility with work with the Honolulu SIS to determine if changes in the standards and instructions need to be revised.

Guideline

SUBJECT: **DRUG TESTING**
SECTION #: **3**
GUIDELINE #: **5**
DATE: **5/00, 2/20, 5/21**

General Statement: Drug testing will be available when a patient expresses concern of having been possibly drugged in connection with a reported sexual assault. Testing may be ordered as a part of the acute forensic examination when both the patient and the forensic examiner deem it warranted.

Drug testing should not be done upon the request of a parent of a minor patient for the purpose of determining drug use of the patient's own volition.

Purpose: To provide a mechanism for the collection and transfer of urine and/or blood specimens for the purpose of drug testing in a manner that protects the integrity of the specimens and the confidentiality of the patients.

Procedure:

1. CONSENT

    1. The forensic examiner will discuss the procedure with the patient and have the patient provide written consent.

2. SECURING OF THE SPECIMEN

    1. The forensic examiner or authorized assistant will obtain a urine and/or blood specimen.

    2. The forensic examiner or authorized assistant will secure the specimen in a tamper-proof urine cup and place a label with the patient's name on the cup. The forensic examiner or authorized assistant will initial and date the label.

3. DRUG TESTING REQUEST

    1. The forensic examiner will document the drug testing request on the "Medical-Legal Record And Sexual Assault Information Form."

    2. The forensic examiner will request the drug testing from an approved lab.
        a) The forensic examiner or authorized assistant will forward the urine/blood specimen to the lab, preserving chain of custody.
        b) The results of the drug test will be forwarded to the appropriate organization.

Guideline

SUBJECT: **PHOTOGRAPHY**
SECTION #: **3**
GUIDELINE #: **6**
DATE: **5/00, 10/11, 5/12, 9/19, 4/21**

General Statement: The photographing of injuries will be a part of the evidence collection process during the acute forensic examination for victims of sexual assault. Upon written consent of the patient, the forensic examiner will photograph areas of injury.

Purpose: To provide guidelines in photographing injuries for cases of sexual assault as a means of evidence documentation.

Procedure:

A. The forensic examiner or authorized assistant will obtain the patient's consent for photography. The victim has the right to refuse or deny consent for any particular part of the body.

B. A digital camera with the capability to store and archive digital media will be used to take the photographs. Note that personal cameras (including personal phone cameras) should not be used and may be subject to subpoena, or may be violations of legal restrictions, therefore, the camera used for photography should be an agency issued camera. The forensic examiner will:

1. Prior to photographing injuries, take the following photos:
   a. Examiner ID system label.
   b. Patient's face.
   c. When possible, overlapping photos of the body.
   d. Beginning bookend label.

2. Photograph each injury using victim centered techniques of injuries observed on the victim.
   a. Take a photograph of the injury and a general body part to identify where the injury is located on the victim's person.
   b. Photograph the injury with the scale in place.
   c. Photograph the injury again without the scale in place.

3. When photographs are complete, finish file with closure bookend label.

4. Complete documentation of the Photograph Inventory page of the patient's "Hawaii State Medical-Legal Record and Sexual Assault Information Form" according to local jurisdiction's protocols.

Guideline

SUBJECT: **ANO-GENITAL PHOTOGRAPHS**
SECTION #: **3**
GUIDELINE #: **7**
DATE: **5/00, 10/11, 2/20, 6/21**

General Statement: The forensic examiner may use a colposcope, a microscope which employs a binocular system with 5x to 30x magnification, or Secure Digital Forensic Imaging camera, or comparable camera system during the course of the forensic examination. The instrument, used to assist the forensic examiner in assessing trauma to the patient's ano-genital areas, is equipped with a camera to document the examination. The forensic examiner may also use the digital camera that is used to take injury photographs to take photographs of the patient's ano-genital areas.

Ano-genital photographs should be taken of all minors when indicated by the patient's sexual assault history, provided that the minor is cooperative and willing. Ano-genital photographs may be taken of adult patients at the discretion of the forensic examiner.

Purpose: To assist the forensic examiner in assessing trauma to the patient's ano-genital areas in cases of reported sexual assault. To provide guidelines for the preparation and use of the colposcope or digital camera as a means of documenting the examination.

Procedure:

A. CONSENT FOR ANO-GENITAL PHOTOGRAPHS

1. The forensic examiner or authorized assistant will obtain the written consent of the patient for ano-genital photographs.

B. CLEANING OF THE CAMERA

1. The forensic examiner or authorized assistant will clean the camera prior to the examination.

    a) Using antiseptic cleaning liquid, the forensic examiner or authorized assistant will spray and wipe all surfaces of the camera that are likely to be touched during the examination.

C. LOADING OF THE PHOTO IMAGING DEVICE

1. The forensic examiner or authorized assistant will load the photo imaging device according to the instructions specific to the organization's camera.

D. USE OF THE CAMERA

1. The forensic examiner will perform the ano-genital examination before any evidence is collected or a culture are taken and before a speculum is used.

2. The patient should be prepared for the examination, and shown the various positions used in the examination. With child patients, the forensic examiner may find it beneficial to employ strategies that heighten the child's sense of participation and control (e.g., examining a doll or stuffed animal together and letting the child look through the colposcope and take a picture).

3. **Examination positions:** The patient should be examined in both the supine and prone or lateral positions whenever possible.

   a) *Supine* positions include the *frog-leg* position in younger children and males, and the *lithotomy* position (feet in stirrups) in older children and adults.

   b) The ideal prone position is the *knee-chest* position, which allows thorough inspection of the posterior fourchette in pre-adolescent females and the anus in both males and females. Other positions sometimes used include the *supine knee-chest* position (for anal exams in infants) and the *lateral decubitus* position (for anal exams).

4. **Examination techniques:** The patient should be positioned as far down the table (i.e., close to the colposcope or digital camera) as possible for optimal focus.

   a) The patient should be photographed prior to any physical manipulation.

   b) Supine: The patient should be examined and photographed using both labial separation and labial traction. As most sex abuse-related injuries occur in the area of the posterior fourchette and posterior hymen, careful attention should be paid to these areas.

   c) Prone Knee-Chest: In order to examine and photograph the patient's hymenal area in this position, thumbs should be placed at the level of the posterior commissure (where the labia minora merge), and the gluteus muscles should be lifted upward along the curvature of the buttocks 2-4 inches until the posterior rim of the hymen is seen.

      1) This examination position may be extremely difficult to use in overweight patients and patients with posterior labial adhesions.

      2) It is important to examine the patient in this position if there are irregularities of the posterior hymen seen in the supine position.

      3) This is a good position to use to examine the anal area. When examined in the prone knee-chest position, gluteal separation is usually unnecessary.

5. The forensic examiner will indicate use of the colposcope or digital camera and document any findings on page 12 of the patient's "Medical-Legal Record and Sexual Assault Information Form."

E. POST EXAMINATION - REMOVING OF THE PHOTO IMAGING DEVICE AND STORAGE MEDIA

1. Once the examination has been completed, the forensic examiner or authorized assistant will remove the photo imaging device from the colposcope or SDFI digital camera and unload the photo storage media (if appropriate, depending on the model of the colposcope or digital camera).

2. The forensic examiner or authorized assistant will label (add Bar Code) and transfer the ano-genital imaging material to a secure depository in a manner that preserves the integrity of the chain of custody.

    a) In the event the ano-genital imaging material is to be included in the Hawaii Sexual Assault Evidence Collection Kit for transfer to law enforcement, the ano-genital imaging material should be identified with case id # and bar code as "other" evidence collected and its inclusion with the sealed kit should be specified on the "Evidence Report" form. (See Section 3, Guideline #8 – Chain Of Custody and Release Of Evidence To Law Enforcement)

F. CLEANING OF THE CAMERA

1. The forensic examiner or authorized assistant will clean the camera following its use during the examination.

    a) Using antiseptic cleaning liquid or antiseptic disposable cloth, the forensic examiner or authorized assistant will spray and wipe all surfaces of the camera that were touched during the examination.

Guideline

SUBJECT: **CHAIN OF CUSTODY AND RELEASE OF EVIDENCE TO LAW ENFORCEMENT**

SECTION #: **3**

GUIDELINE #: **8**

DATE: **5/00, 2/20, 6/21**

General Statement: A chain of custody for all evidentiary specimens collected during the course of the forensic examination will be maintained to preserve the integrity of the specimens. Evidence collected from a patient will be released to law enforcement with the written consent of the patient or parent/legal guardian of the minor patient or as required by law or court order.

Purpose: To establish an accurate and legally acceptable method for the collection, preservation, and transfer of evidentiary specimens collected at the time of the forensic examination.

Procedure:

A. The forensic examiner or authorized assistant will access the Hawaii State Sexual Assault Evidence Collection Kit and will check that the kit's seal has not been tampered with or broken. At the commencement of the forensic examination, the forensic examiner or authorized assistant will break the seal.

B. Upon completion of the forensic examination, the forensic examiner will complete all required documents and will transfer the documents via chain of custody to the appropriate entity.

C. Upon completion and sealing of the evidence collection kit, the kit will be transferred to the appropriate entity under chain of custody.

Guideline

SUBJECT: **PSYCHOLOGICAL REACTIONS IN THE ADULT PATIENT**
SECTION #: **4**
GUIDELINE #: **1**
DATE: **5/00, 10/11, 7/21**

General Statement: Patients who are victims of sexual assault often experience psychological trauma due to the psychological duress, intimidation, force or threat of force endured during the victimization. Psychological trauma may be experienced by the patient regardless of the method of assault, the type of sexual acts perpetrated, the presence or absence of physical injuries, the relationship of the offender, and whether the sexual assault was attempted or completed.

Purpose: To educate and provide health care providers with knowledge about the psychological reactions following sexual victimization.

PSYCHOLOGICAL REACTIONS

A. RAPE TRAUMA SYNDROME (Burgess and Holmstrom) - This syndrome refers to the phases and their associated symptoms that patients who are victims of sexual assault typically pass through. This is not an exhaustive list of symptoms.

1. The Shock Phase - Emotional and stress reactions indicative of this phase include:
    - numbness
    - shock and disbelief, dazed or bewildered presentation
    - diminished alertness, cognitive confusion
    - flat affect, psychological distancing, preoccupation
    - dulled sensory, affective, and memory functions
    - fearful and anxious presentation or outwardly calm and collected presentation

2. The Impact Phase - Psychological and behavioral symptoms of this phase may include:
    - denial
    - intrusive thoughts, impaired concentration
    - fearfulness and anxiety
    - lost sense of power and control, helplessness
    - depression
    - emotional ability, mood swings
    - guilt, self-blame, embarrassment
    - appetite disturbances
    - sleep pattern disturbances (vivid dreams, recurrent nightmares, insomnia, wakefulness)
    - flashbacks

- sexual dysfunction
- phobic reactions
- hyperalertness
- withdrawal from family and friends
- somatic symptoms

3. The Long-Term Reorganization and Integration Phase - During this phase, the individual works toward "putting life back together." The following may be experienced:
    - continued symptoms of phase two
    - changes in lifestyle
    - an altered view of the world and the people in it

    Individuals move into some sort of resolution of the event, which may be functional or dysfunctional. When resolution is dysfunctional, the individual remains fixated on the trauma and represses it. This may be indicated by:
    - distrust of others and impaired interpersonal relationships
    - low self-esteem
    - sexual dysfunction
    - depression
    - self-destructive behaviors, suicidal ideations and gestures
    - anxiety attacks
    - nightmares and difficulty sleeping
    - eating disorders
    - dissociation
    - substance abuse
    - prostitution

    When resolution is functional, the individual incorporates and integrates the experience and finds new ways to cope with the trauma. This may be indicated by:
    - a stronger sense of self
    - seeing self as a "survivor"
    - ability to cope with future crises
    - the desire to "give back"

B. Cultural differences, sexual orientation, gender identity, race, life-stage issues, mental or physical disabilities, and previous victimization may intensify the psychological trauma experienced by the patient.

Guideline

SUBJECT: **MEDICAL HISTORY INTERVIEW OF THE ADULT PATIENT**
SECTION #: **4**
GUIDELINE #: **2**
DATE: **5/00, 10/11, 7/21**

General Statement: The forensic medical examiner will conduct a medical history interview of the adult patient prior to the physical examination. Information about the sexual assault obtained during this interview enables the forensic medical examiner to conduct an appropriate medical examination and guides the collection of legal evidence. It is not an investigative interview and does not preclude nor duplicate a thorough and detailed investigative interview conducted by the police.

Purpose: To obtain the medical history of the adult patient which will assist in the medical examination, collection of forensic evidence, and medical diagnoses and treatment.

Procedure:

A. The medical history interview for the acute forensic examination will include completion of the first 5 pages of the patient's "Medical-Legal Record And Sexual Assault Information Form."

1. The courts have allowed testimony regarding details of the patient's statements obtained in the medical history interview; therefore, clear and legible documentation is essential.

B. A trauma-informed approach should be used and the following techniques should be considered by the forensic examiner when interviewing the patient:

1. If needed, whenever reasonably practical, using an official translator for those patients who require interpreter services.

2. Conducting the interview in a private place.

3. Sitting or standing at eye level with the patient.

4. Asking open-ended, non-leading questions and refraining from suggesting answers or assuming answers.

5. Avoiding any emotional reactions to the information given; maintaining a neutral, "tell me more" and "then what happened" approach.

6. Watching for signs of increasing anxiety; breaking from the interview if the patient is showing signs of heightened anxiety and is having difficulty tolerating the distress.

Guideline

SUBJECT: **THE ADULT FORENSIC EXAMINATION**
SECTION #: **4**
GUIDELINE #: **3**
DATE: **5/00, 2/03, 10/11, 9/21**

General Statement: The acute forensic examination will be conducted for adults seen within 120 hours of a reported sexual assault. The overall objectives of such an examination are: a) the collection of forensic evidence; b) the documentation of injuries; and c) the testing for and treatment of sexually transmitted infections (STIs), if indicated; using a trauma-informed approach. If STI testing and treatment are not done at the time of the acute forensic examination, the patient will be referred to community resources or to a private physician for such testing and treatment. While the finding of a STI may carry important evidence of sexual assault in the pediatric patient, the finding of a STI does not carry the same legal importance in a sexually active adult; the main goal of testing for STIs in this situation is the medical care of the patient.

The forensic examiner will use the Hawaii State Sexual Assault Evidence Collection Kit for the collection of forensic evidence. (See Section 3, Guideline #2 – Procedures for the Hawaii State Sexual Assault Evidence Collection Kit.) While the evidence collection protocol consists of 11 steps, the number of steps actually performed and the specimens collected will remain at the examiner's discretion.

It is important for the forensic examiner to understand sexual assault and its traumatic nature and to provide trauma-informed care. Patients may exhibit a wide range of emotions; the forensic examiner should view the patient's presentation as the individual's adaptation to a personal crisis. The forensic examiner's introduction of self and his/her role, the use of terminology that is clear and understandable, and explanation throughout the contact of what is being done and why it is being done will assist in building rapport and increasing the patient's comfort level. Patients should be provided information and the opportunity to participate in decision making regarding treatment and follow-up care.

Purpose: To delineate the objectives and outline the procedures to be followed when conducting the acute forensic examination in adult patients.

Procedure:

A. OBTAIN PATIENT CONSENT

The forensic examiner or authorized assistant will obtain the patient's signature on the appropriate consents. The consents may include the following:

1. Authorization for Collection, Release, and Storage of Sexual Assault Evidence Collection Kit (Step 1 form) (See Section 3, Guideline #2 - Procedures for the Hawaii State Sexual Assault Evidence Collection Kit).

2. Consent for Emergency Contraception (if applicable)

3. Consent for Antibiotics for Sexually Transmitted Diseases (if applicable)

B. OBTAIN PATIENT HEALTH HISTORY

1. The forensic examiner will obtain information on the patient's health history and will record this information on the patient's "Medical-Legal Record and Sexual Assault Information Form" (hereinafter referred to as the "Medical-Legal Form").

C. OBTAIN PATIENT HISTORY OF THE CURRENT INCIDENT

The history in a sexual assault examination should be viewed as a medical history and documented as such. It is not the forensic examiner's responsibility to document every detail of the history but rather to focus on those pieces of information that are pertinent to the presenting complaints and symptoms.

1. The forensic examiner will interview the patient to obtain the individual's medical history. If more than one perpetrator is involved, each perpetrator's actions should be documented as clearly as possible, and each perpetrator should be identified as simply as possible (e.g. man #1 - bald man). The acts described should be carefully recorded; this information is necessary to guide the medical examination and for interpretation of crime laboratory tests. The patient history must be accessed carefully; some patients may be reluctant to describe all acts committed, e.g., anal penetration.

D. PERFORM THE MENTAL STATUS EXAMINATION

The description of the patient's mental status should be based on the forensic examiner's observation of the patient.

1. The forensic examiner will document the patient's appearance, behavior, mood, and orientation on the patient's "Medical-Legal Form." To ascertain the patient's orientation, specific questions regarding orientation to person, place and time should be asked.

2. Any expressed concern of the patient should be documented in the patient's own words.

E. CONDUCT A GENERAL PHYSICAL EXAMINATION; COLLECT AND PRESERVE EVIDENCE - **Necessary cultures should be collected after the evidence has been secured.**

1. Collect all clothing worn during and immediately after the reported assault.

   a. The forensic examiner or authorized assistant will collect clothing that was worn at the time of the assault; if the patient is not wearing the clothing worn at the time of the assault, only those items in direct contact with the patient's genital area should be collected. Footwear should be collected only if it was worn during an assault that took place outdoors.

2. Conduct a general physical examination (head to toe) to look for injuries and other evidence of the reported assault.

   a. Physical Findings: The forensic examiner will conduct a physical examination and record the findings on the patient's "Medical-Legal Form." The diagrams should be used to record the location, size, and appearance of injuries. Signs of injury may include erythema, abrasions, contusions, lacerations, fractures, bleeding, bites, or burns.

   b. Photography: The forensic examiner will photograph all areas of injuries to the skin. (See Section 3, Guideline #6 – Photography.) The forensic examiner should document the location of the photographs on the Photograph Inventory page of the patient's "Medical-Legal Form."

   c. Alternate Light Source: The forensic examiner will collect dried and moist secretions, and stains from the body. The alternate light source should be used to scan the patient's skin for evidence of dried or moist secretions, stains, fluorescent fibers not visible to white light or subtle injury. (Dried semen typically has a shiny, mucoid appearance and tends to flake off the skin. Under an ultraviolet light, semen usually fluoresces in a blue-white or orange color, but these colors are not specific to semen.) It should be noted that fresh dried semen may not fluoresce. Therefore, each suspicious area should be swabbed regardless of whether it fluoresces.

      1) In a darkened room, the forensic examiner will scan the patient's entire body with an alternate light source (i.e., head first, then torso, back, arms and legs), and swab each suspicious stain or fluorescent area with a separate swab. Special attention should be given to the perioral area, the torso around the breasts, and the hands.

      2) The forensic examiner will use the appropriate diagram of the patient's

"Medical-Legal Form" to record the location, size, and appearance of any evidence of foreign materials, taking care to delineate the evidence of foreign materials from the documentation of the patient's injuries.

3. Examine the patient's mouth.

   a. The forensic examiner will examine the patient's oral cavity for injury and the area around the mouth for evidence of seminal fluid.

   b. The forensic examiner will collect oral swabs only if there is a history of oral-genital contact.

   c. The forensic examiner will document findings on the patient's "Medical-Legal Form."

4. Collect oral specimens for testing for sexually transmitted infections (STIs). (If applicable)

   a. The forensic examiner will collect oral specimens for STI testing if there is a history of oral-genital contact. The specimens will be collected and transferred in a manner that preserves chain of custody. (See Section 4, Guideline #4 – Sexually Transmitted Infections in the Adult Patient.)

   b. The forensic examiner will document the specimens collected on the patient's "Medical-Legal Form."

5. Obtain head hair.

   a. Head Hair Combing. The forensic examiner will have the patient run a comb through all areas of her/his hair to obtain any hairs possibly shed by the suspected perpetrator during the reported assault.

   b. Known Head Hair. This step should be done only when the identity of the perpetrator is not known. The forensic examiner will obtain cut patient head hairs for comparison with hairs found.

6. Collect fingernail swabs. (Should be collected only if the patient scratched the suspected perpetrator's skin or clothing.)

   a. Fingernail swabs may contain a variety of evidential materials including blood or tissue.

7. Examine the patient's external genitalia.

   The forensic examiner may want to consider examination of the area with the use of the colposcope or digital camera. Ano-genital photography enhances the forensic

examiner's ability to successfully identify and document potential findings on examination of the genitalia. (See Section 3, Guideline #7 – Ano-Genital Photographs.)

a. The forensic examiner will remove and unfold the paper towel from the Pubic Hair Combing envelope found in the evidence collection kit and place it under the patient's buttocks.

b. The forensic examiner will examine the patient's external genitalia for signs of injury.

   1) In female patients, the external genitalia includes the mons veneris, perineum, clitoris, labia majora, labia minora, urethral orifice, vulvar mucosa, perihymenal tissue, hymen (when present), vaginal introitus, posterior fourchette, and medial aspects of the thighs.

   2) In male patients, the external genitalia includes the penis and scrotum.

   3) Signs of injury may include erythema, abrasions, bruises, lacerations, tenderness, swelling, bleeding, or bites.

   4) The forensic examiner will document findings on the patient's "Medical-Legal Form." Findings should be recorded on the diagrams as they relate to their anatomic position and should be described with reference to the face of a clock (e.g., midline injuries at the entrance to the vagina over the posterior fourchette would be located at the 6 o'clock position).

c. The forensic examiner will examine the patient's external genitalia for dried and moist secretions.

   1) The forensic examiner will scan the area with an alternate light source and swab each suspicious stain or fluorescent area with a separate swab.

   2) The forensic examiner will use the diagram on the patient's "Medical- Legal Form" to record the location, size, and appearance of any evidence of foreign materials.

8. Obtain pubic hair.

   a. Pubic Hair Combing. The forensic examiner will comb the patient's pubic hair in downward strokes to obtain any pubic hairs possibly shed by the suspected perpetrator during the reported assault.

   b. Known Pubic Hair. The forensic examiner will obtain cut patient pubic hairs for comparison with hairs found.

c. If suspicious material is found on the patient's pubic hair, the forensic examiner will cut the matted hairs bearing the specimen.

9a. Female patients – Examine the patient's vagina and cervix.

A speculum moistened with water or water soluble lubricant should be used. Consideration of speculum size is important for the elderly, adolescents, and women who do not ordinarily have sexual relations with male partners.

Note: Foreign objects, such as tampons, recovered during the examination, should be placed in a leak-proof, screw top container available in the examination room. Foreign objects may also be dried in a DNA drying box and placed into an evidence collection bag (if available). A label with identifying information (name of patient, specimen collected, date and time of collection, examiner's name) should be affixed to the container or evidence collection bag. The container or evidence collection bag should be transferred with the Hawaii State Sexual Assault Collection Kit in accordance with proper procedures to preserve the chain of custody. (See Section 3, Guideline #8 – Chain of Custody and Release of Evidence to Law Enforcement.)

a. The forensic examiner will examine the vagina and cervix for injuries.

1) Signs of injury may include lacerations, abrasions, ecchymosis, or hematomas. A common post-coital finding is erythema of the posterior fourchette and superficial abrasion of the area.

2) The forensic examiner will document findings on the patient's "Medical-Legal Form."

9b. Female patients – Collect vaginal swabs. (Vaginal swabs should be collected only if vaginal assault occurred or was attempted.)

a. The vaginal swabs should be collected from the vaginal pool, not the cervix.

10. Male patients – Collect penile swabs. (Should be collected only if indicated by the history.)

a. The forensic examiner will examine the penis and scrotum for injuries.

1) If history indicates oral copulation or other such acts by the suspected perpetrator(s), the forensic examiner will collect a minimum of 2 penile swabs for saliva or foreign materials.

2) The forensic examiner will moisten both swabs with distilled water.

3) The forensic examiner will collect one swab from the urethral meatus and one from the glans and shaft.

4) The collected specimens will be preserved following Section 3, Guideline #2 – Procedures for the Hawai‘i State Sexual Assault Evidence Collection Kit.

11. Collect vaginal and/or endocervical or cervical, or penile specimens for testing for sexually transmitted infections (STIs). (If applicable)

    a. The forensic examiner will collect vaginal and/or endocervical or cervical or penile specimens for STI testing if indicated. The specimens will be collected and transferred in a manner that preserves chain of custody. (See Section 4, Guideline #4– Sexually Transmitted Infections in the Adult Patient.)

    b. The forensic examiner will document the specimens collected on the patient's "Medical-Legal Form."

12. A Note About Toluidine Blue.

    The forensic examiner may consider examination of the area with the use of Toluidine blue. Toluidine blue, a dye that preferentially binds to areas of tissue injury, can be a visual aid in the documentation of rectovaginal injuries. Its use can increase the forensic examiner's ability to identify traumatic lesions after a sexual assault. However, it should not be used in the perianal area due to difficulty in interpreting the findings. If the decision is made to use Toluidine blue, it should be done after all evidence has been collected from the rectovaginal area. Note: the patient should be warned that the dye may stain underwear.

    a. The area to be examined should be swabbed with Toluidine blue using a cotton-tipped applicator. (The Toluidine blue may be sprayed onto the area to be examined if a spray bottle is available.)

    b. The excess Toluidine blue should be removed using gauze that has been moistened with distilled water or saline or water soluble lubricant.

    c. The area should be examined using the digital camera or colposcope with a green filter in place before and after using the Toluidine blue.

    d. Findings should be documented on the patient's "Medical-Legal Form."

13. Examine the patient's anus and rectum.

    a. The forensic examiner will examine the patient's buttocks, perianal skin, and anal folds for signs of injury and foreign materials. Findings will be documented on the patient's "Medical-Legal Form."

    b. The forensic examiner will scan the area with an alternate light source and swab each suspicious area. The forensic examiner should use the diagram on the patient's "Medical-Legal Form" to record the location, size, and appearance of any evidence of foreign materials.

c. The forensic examiner will collect rectal swabs only if rectal assault occurred, was attempted, or if there are physical findings to suggest assault.

14. Collect rectal specimens for testing for sexually transmitted infections (STIs). (If applicable)

    a. The forensic examiner will collect rectal specimens for STI testing if indicated. The specimens will be collected and transferred in a manner that preserves chain of custody. (See Section 4, Guideline #4 – Sexually Transmitted Infections in the Adult Patient.)

    b. The forensic examiner will document the specimens collected on the patient's "Medical-Legal Form."

15. Obtain urine sample from patient.

    a. If not already done, a urine sample will be obtained from the patient.

    b. The urine may be tested for pregnancy, the presence of drugs, and the presence of spermatozoa in the rare situation where the forensic examiner is unable to collect vaginal swabs from the patient.

        1) When indicated, the forensic examiner will order a pregnancy test. The results will be documented on the patient's "Medical-Legal Form."

        2) When indicated, a urine sample will be sent for drug testing. The specimen will be collected and transferred in a manner that preserves chain of custody. (See Section 3, Guideline #5 – Drug Testing.) The forensic examiner will discuss the procedure with the patient and obtain the patient's written consent. The request for drug testing will be documented on the patient's "Medical-Legal Form."

16. Obtain patient's DNA sample.

    a. Buccal Swab. If an oral swab was obtained previously, swish and spit twice, then do the buccal swab.

        1) The buccal swab will be used to access a sample of the patient's DNA. The forensic examiner, with the assistance of an authorized assistant, will carefully swab the buccal area and gum line with the four swabs provided.

F. COMPLETE THE PATIENT'S "MEDICAL-LEGAL RECORD AND SEXUAL ASSAULT INFORMATION FORM" AND RECOMMEND TREATMENT PLAN

1. The forensic examiner will document the examination findings and will indicate whether a Hawaii State Sexual Assault Evidence Collection Kit was used on the patient's "Medical-Legal Form."

2. When indicated, the forensic examiner will discuss with the patient the risk of pregnancy and of contracting a sexually transmitted infection and will recommend a course of treatment and follow-up care. If STI testing and treatment were not done, the forensic examiner will provide the patient with referrals for such care. The forensic examiner will also discuss with the patient the benefits of counseling and provide referrals for such services when appropriate. The treatment plan and referrals provided should be documented on the patient's "Medical-Legal Form."

3. The forensic examiner will sign the patient's "Medical-Legal Form" upon completion of the examination. The date, time, and the forensic examiner's address and phone number should also be documented.

Guideline

SUBJECT: **SEXUALLY TRANSMITTED INFECTIONS IN THE ADULT PATIENT**

SECTION #: **4**

GUIDELINE #: **4**

DATE: **5/00, 10/11, 9/21**

General Statement: During the adult forensic examination, the forensic examiner may test for and treat sexually transmitted infections (STIs) when applicable. If STI testing and treatment are not done at the time of the acute forensic examination, the forensic examiner will provide the patient with community referrals or will refer the patient to a private physician for such care.

The Hawaii State Sexual Assault Evidence Collection Kit will be used in the collection of medical-legal evidence for cases seen within 120 hours of a reported sexual assault; necessary cultures for STI testing should be collected **after** the evidence has been secured. Among sexually active adults, the identification of sexually transmitted infections after a sexual assault is usually more important for the psychological and medical management of the patient than for legal purposes as the infection could have been acquired before the assault.

Purpose: To provide forensic examiners treating adult patients of sexual assault with recommendations obtained from the CDC Guidelines for Treatment of Sexually Transmitted Diseases.

Procedure:

A. The forensic examiner will assess the need of the patient and follow the guidelines below in the collection of STI cultures.

1. **GONORRHEA**

   a. Sites: Cultures should be taken from any site of penetration or attempted penetration.

   b. Incubation period: 3-7 days.

   c. Method: Only standard culture systems for the isolation of *N. gonorrhoeae* should be used. Specimens should be collected on a BD culturette with Amies or charcoal swab. The specimens should be labeled with the specimen site, collection date and time, patient information label, and forensic examiner or authorized assistant's initials. The specimen should be placed into a biohazard bag until it is transferred to laboratory personnel.

      Cervical:

      - Do not use lubricant during the procedure.

- Wipe the cervix clean of vaginal secretion and mucus.
- Rotate a sterile swab, and obtain exudates from the endocervical glands,
- If no exudate is seen, insert a sterile swab into the endocervical canal, and rotate the swab.

Vaginal:

- Insert a sterile swab into the vagina.
- Collect discharge or vaginal secretions from the mucosa high in the vaginal canal.

Alternative Method GC DNA (Urine):

- Spermicidal agents and feminine powder sprays can interfere. Do not use prior to specimen collection.
- **Urine Female: Clean catch method should be advised.** Collect the first 15-50 or more mL of the **first** part of the voided urine (i.e., not midstream). Void into a sterile cup. Urine sample **cannot** be shared for urinalysis or other urine tests.
- **Urine Male:** Collect 15-50 or more mL of urine. Midstream collection is acceptable. Specimen can be shared for urinalysis or other urine tests. Submit the **entire** urine cup or note the total volume of the entire voided urine on the aliquot tube.

Alternative Method GC DNA (Swab):

- Spermicidal agents and feminine powder sprays can interfere. Do not use prior to specimen collection.
- Collect sample with sterile cervical or urethral swab. **Do not use other types of swabs.** Moderately mucoid contamination and moderately bloody swabs may cause false negative results.

d. Treatment: Prophylactic treatment is recommended after a sexual assault.

Ceftriaxone 500 mg IM in a single dose

Note: Gonococcal infections in women are of special concern because of the possibility of ascending infection.

2. **CHLAMYDIA**

a. Sites: Cultures should be taken from the anus in both men and women and from the cervix in women when a history of penetration of those sites is obtained. A urethral swab in men should be taken only if discharge is present.

b. Incubation period: Variable, but usually at least 1 week.

c. Method: If chlamydia cultures are not available, nonculture tests (particularly nucleic acid amplification tests) are acceptable substitutes. If a nonculture test is used, a positive test result should be verified with a second test based on a different diagnostic principle. EIA and DFA are not acceptable alternatives because false- negative test results occur more often with these nonculture tests, and false-positive test results may occur.

C.trachomatis is an obligate intracellular parasite. Specimens are best collected with a **dacron swab** so as not to disrupt the cell membranes. Avoid cotton-tipped wooden swabs as they have formalin in them, which may kill chlamydia. Pharyngeal specimens are not recommended because of the low yield.

The chylamydia tube should be labeled with the specimen site, date, time and the forensic examiner or authorized assistant's initials, and should be placed in a biohazard bag. The biohazard bag should be placed into a cooling device until transfer to laboratory personnel.

Alternative Method Chlamydia DNA (Urine):

- Spermicidal agents and feminine powder sprays can interfere. Do not use prior to specimen collection.
- **Urine Female: Clean catch method should be advised.** Collect the first 15-50 or more mL of the **first** part of the voided urine (i.e., not midstream). Void into a sterile cup. Urine sample **cannot** be shared for urinalysis or other urine tests.
- **Urine Male:** Collect 15-50 or more mL of urine. Midstream collection is acceptable. Specimen can be shared for urinalysis or other urine tests. Submit the **entire** urine cup or note the total volume of the entire voided urine on the aliquot tube.

Alternative Method GC DNA (Swab):

- Spermicidal agents and feminine powder sprays can interfere. Do not use prior to specimen collection.
- Collect sample with sterile cervical or urethral swab. **Do not use other types of swabs.** Moderately mucoid contamination and moderately bloody swabs may cause false negative results.

d. Treatment: Prophylactic treatment is recommended.

Doxycycline 100 mg orally twice a day for 7 days

Note: Chlamydial infections in women are of special concern because of the

possibility of ascending infection.

3. **TRICHOMONAS**

   a. Sites: A vaginal swab should be taken.

   b. Incubation period: Not applicable.

   c. Method: A vaginitis-swab should be used. The vaginal wall is rubbed with the tip of the swab and sent to the lab for microscopic examination.

   d. Treatment: Prophylactic treatment is recommended.

Metronidazole 500 mg twice a day for 7 days

4. **SYPHILIS**

   a. Sites and Method: Blood work for nontreponemal serologic studies (RPR,VDRL) should be done if syphilis is suspected based on the patient's physical examination or history. Syphilis serology should also be considered if the patient has a history of another STI. Specific treponemal tests (FTA-ABS, MHA-TP) should be performed to confirm a positive nontreponemal test. (Follow up serologic assays are required at 3-6 months after the sexual assault.)

   b. Incubation period: Initial RPR, VDRL results with an average of 24 hours. The specific treponemal tests, 10-90 days with an average of 3 weeks.

   c. Treatment: Parental penicillin G is the preferred drug for treatment of all stages of syphilis. The preparation(s) used, the dosage, and length of treatment depend on the stage and clinical manifestation of the disease.

5. **HERPES SIMPLEX VIRUS (HSV) 1 and 2**

   a. Sites: Vesicles or pustules in the genital area.

   b. Incubation period: 2-20 days.

   c. Method: Lesions should be scraped with a dacron swab and transported to the lab in an appropriate medium for the culture and staining. If there is to be a delay (>1 hour) in transport, the specimen should be stored at 4 degrees C.

   d. Treatment: Primary genital herpes infection is usually painful, and once a culture is obtained, treatment can be considered.

Acyclovir 400 mg orally 3 times a day for 7-10 days,

OR

Acyclovir 200 mg orally 5 times a day for 7-10 days,

OR

Famcyclovir 250 mg orally 3 times a day for 7-10 days,

OR

Valacyclovir 1 g orally twice a day for 7-10 days.

Note: Treatment may be extended if healing is incomplete after 10 days of therapy.

Recurrent genital herpes can be treated with:

Acyclovir 400 mg orally 3 times a day for 5 days,

OR

Acyclovir 200 mg orally 5 times a day for 5 days,

OR

Acyclovir 800 mg orally twice a day for 5 days,

OR

Famcyclovir 125 mg orally twice a day for 5 days,

OR

Valacyclovir 500 mg orally twice a day for 5 days.

Note: Crusted lesions are less likely to yield a positive culture.
Both HSV-1 and HSV-2 can cause all of the clinical herpes infections.
Differential diagnosis of genital ulcers includes:

Other viral infections	Trauma
Behcet's Syndrome	Drug reactions
Lichen Sclerosis	Chancroid Syphilis

6. **HUMAN IMMUNODEFICIENCY VIRUS (HIV)**

   a. Sites and Method: If the patient is to be tested, testing should be done as soon as possible following the sexual assault, and then repeated at least one more time, 1-3 months later. At the time of the forensic examination, the patient should be counseled on the importance of HIV testing where applicable, and should be provided referrals for such testing.

   b. Incubation period: Serum antibody usually develops within 4-12 weeks of infection.

Note: Serologic testing for HIV should be considered when:

- there is a likelihood of infection in the suspected perpetrator;
- the patient has a history of high risk behaviors (e.g. prostitution, drug abuse);
- there is a clear history of genital or oral penetration or ejaculation;
- the patient has another STI;
- there is evidence of body fluid such as semen, blood, or saliva upon examination;
- the suspected perpetrator is unknown or there are multiple perpetrators.

c. Treatment: Prophylaxis: Two medications

Isentress – 400 mg tablets, 1 orally twice per day x 28 days

Truvada – 200/300 tablets, 1 orally daily x 28 days

HIV follow-up will be arranged by the medical provider.

B. If STI cultures are indicated, the forensic examiner will obtain and transfer the specimens in a manner that preserves chain of custody.

C. The forensic examiner will document the testing done on the patient's "Medical-Legal Record and Sexual Assault Information Form."

D. The forensic examiner will inform the patient of the symptoms of STIs and the need for immediate examination by their medical provider if symptoms occur. The forensic examiner should also counsel the patient regarding abstinence from sexual intercourse until STI prophylactic treatment is completed.

E. The patient should be notified of any positive test results as soon as the information is available.

F. The results of the laboratory analysis on specimens obtained during the acute forensic examination will be forwarded to law enforcement when applicable.

Guideline

SUBJECT: **PRESCRIBING PROPHYLACTIC BIRTH CONTROL TO THE ADULT PATIENT**

SECTION #: **4**

GUIDELINE #: **5**

DATE: **5/00, 10/11, 9/21**

General Statement: Emergency treatment is available to reduce the risk of pregnancy from a sexual assault.

Option 1: Levonorgestrel ("Plan B"), which contains the hormones estrogen and progesterone, may be prescribed for this use. When taken within 72 hours of a sexual assault, the likelihood of pregnancy is considered to be very low.

Option 2: Ulipristal ("Ella"), which contains the hormone progesterone, may be prescribed for this use. When taken within 120 hours of a sexual assault, the likelihood of pregnancy is considered to be very low.

Levonorgestrel or Ulipristal may be prescribed during the provision of medical-legal services at the discretion of the physician and only with informed patient consent.

Purpose: To establish guidelines for prescribing Levonorgestrel or Ulipristal to the adult patient as a part of medical-legal services.

Procedure:

A. The patient's written consent must be obtained.

B. The patient's medical history will be obtained and a physical examination will be performed prior to prescribing the Levonorgestrel or Ulipristal.

C. All pertinent information about the treatment and possible side effects will be presented to the patient prior to treatment prescription.

Guideline

SUBJECT: **REPORTING CASES OF VULUNERABLE ADULT ABUSE AND NEGLECT**

SECTION #: **4**

GUIDELINE #: **6**

DATE: **5/00, 10/11, 10/21**

General Statement: Pursuant to the Hawaii Revised Statutes, Chapter 346, any licensed or registered professional of the healing arts and any health-related occupation who examines, treats or provides other professional or specialized services to dependent adults is mandated to report all suspected cases of vulnerable adult abuse to the Department of Human Services-Dependent Adult Protective Services (DHS-DAPS). Employees or officers of any public or private agency or institution providing social, medical, hospital or mental health services, and employees or officers of any law enforcement agency including the courts, police departments, correctional institutions, and parole or probation offices are also mandated to report cases of vulnerable adult abuse.

Purpose: To provide criteria for identifying vulnerable adult abuse and to delineate the legal reporting requirements when treating an adult who is or is suspected to be the victim of vulnerable adult abuse. To establish guidelines and roles/responsibilities for those involved in the care and support of such patients.

Definitions:

A. Vulnerable adult abuse includes any of the following, separately or in combination as defined in Hawaii Revised Statutes 346-222:

1. Physical abuse:

a) "The nonaccidental infliction of physical or bodily injury, pain, or impairment, including but not limited to hitting, slapping, causing burns or bruises, poisoning, or improper physical restraint; or

b) "Causing physical injuries that are not justifiably explained or where the history given for an injury is at variance with the degree or type of injury." HRS § 346-222.

2. Psychological abuse:

a) The "infliction of mental or emotional distress by use of threats, insults, harassment, humiliation, provocation, intimidation, or other means that profoundly confuse or frighten a vulnerable adult" Id.

3. Sexual abuse:

   a) The nonconsensual sexual contact or conduct caused by another person, including but not limited to: sexual assault, molestation, sexual fondling, incest, or prostitution; or pornographic photographing, filming, or depiction. Id.

4. Financial exploitation:

   a) The wrongful taking, withholding, appropriation, or use of a vulnerable adult's money, real property, or personal property, including but not limited to: the breach of a fiduciary duty; the unauthorized taking of personal assets; the misappropriation or misuse of moneys belonging to the vulnerable adult from a personal or joint account; or the failure to effectively use a vulnerable adult's income and assets for the necessities required for the vulnerable adult's support and maintenance, by a person with a duty to expend income and assets on behalf of the vulnerable adult for such purposes. Id.

5. Caregiver neglect:

   a) The failure of a caregiver to exercise that degree of care for a vulnerable adult that a reasonable person with the responsibility of a caregiver would exercise within the scope of the caregiver's assumed, legal or contractual duties, including but not limited to the failure to: assist with personal hygiene; protect the vulnerable adult from abandonment; provide, in a timely manner, necessary food, shelter, or clothing; provide, in a timely manner, necessary health care, access to health care, prescribed medication, psychological care, physical care, or supervision; protect the vulnerable adult from dangerous, harmful, or detrimental drugs; protect the vulnerable adult from health and safety hazards; or protect the vulnerable adult from abuse by third parties. Id.

6. Self-neglect:

   a) A vulnerable adult's inability or failure, due to physical or mental impairment, or both, to perform tasks essential to caring for oneself, including but not limited to: obtaining essential food, clothing, shelter, and medical care; obtaining goods and services reasonably necessary to maintain minimum standards or physical health, mental health, emotional well-being, and general safety; or management of one's financial assets and obligations; and
   b) The vulnerable adult appears to lack sufficient understanding or capacity to make or communicate responsible decisions and appears to be exposed to a situation or condition that poses an immediate risk of death or serious physical harm. Id.

B. Dependent adults are persons over the age of 18, who because of mental, developmental, or physical impairment, is unable to communicate or make responsible decisions to manage the person's own care or resources; carry out or arrange for essential activities of daily living; or protect oneself from abuse, as previously defined. Id.

Procedure:

A. The forensic examiner or authorized assistant will report to the DHS-DAPS when the forensic examiner or authorized assistant:

1. Has observed or has knowledge of an incident that reasonably appears to be physical abuse, neglect, isolation, fiduciary abuse or abandonment;

2. Is told by a dependent adult that he or she has experienced behavior constituting physical abuse, neglect, isolation, fiduciary abuse or abandonment;

3. Reasonably suspects abuse or neglect.

B. The forensic examiner or authorized assistant will call the DHS-DAPS Hotline to report the situation as soon as the forensic examiner or authorized assistant becomes aware of the harmful situation. Whenever possible, the dependent adult should be informed of the need to notify the DHS-DAPS prior to the report being made.

1. The forensic examiner or authorized assistant will include the following in the oral report:
   a) name of the dependent adult;
   b) address of the dependent adult;
   c) name of the person/care facility/care organization alleged to be responsible for the abuse;
   d) nature and extent of the injury or harm to the dependent adult;
   e) any other information that might be helpful in establishing the cause of the abuse or harm.

2. A follow-up written report should be sent to the DHS-DAPS by the forensic examiner or authorized assistant. The written report should be reflective of the information provided in the oral report.

C. Following the report to the DHS-DAPS, medical-legal services will be provided as usual unless otherwise directed by the DHS-DAPS.

D. The forensic examiner or authorized assistant will clearly document the report to DHS-APS and any follow-up action in the patient's chart.

Guideline

SUBJECT: **REPORTING CASES OF SUSPICIOUS WOUNDS**
SECTION #: **4**
GUIDELINE #: **7**
DATE: **5/00, 10/11, 10/21**

General Statement: Pursuant to Hawaii Revised Statutes, Chapter 453-14, it is the duty of every physician, surgeon, hospital, and clinic to report suspicious wounds to the police.

Purpose: To provide criteria for identifying suspicious wounds and to delineate the legal reporting requirements when treating patients with such wounds. To establish guidelines and roles/responsibilities for those involved in the care and support of such patients.

Procedure:

A. Situations in which patients present with knife, bullet and/or gunshot wounds, powder burns, or any injury that would seriously maim, produce death or render unconsciousness caused by the use of violence, or sustained in a suspicious or unusual manner, must be reported to the police.

1. The attending physician or designee is responsible for reporting to the police.

a) The reporter should give the patient's name, description of the nature, type, and extent of the injury, and other pertinent information which may be useful to the police.

b) Should the investigating officer need additional information, the attending physician may be asked to complete the Police Department Physician's Report form. The patient must consent to the release of the information on the form by signing the form before the information is released.

B. Once the patient is medically stable, the acute forensic examination can take place.

C. If domestic violence is suspected, the situation should be addressed with the patient.

1. The patient should be placed in a safe, private room. Anyone accompanying the patient should be asked to remain in the waiting area.

2. The patient's immediate physical and emotional needs should be assessed.

3. The patient should be interviewed in a supportive, nonjudgmental manner. If the patient reveals domestic violence, the message that he/she is not alone and does not deserve to be abused should be conveyed. The patient should be informed of help that is available.

    a) The patient should be informed of community resources and shelters. If the patient does not want to meet with a domestic violence counselor at that time, the patient should be provided with referrals that he/she may be able to utilize at a later time.

4. The patient should be assisted with developing a safety plan if he/she chooses to return home.

D. The report to the police, provision of information to the patient, and the plan of action should be clearly documented in the patient's chart.

Guideline

SUBJECT: **RESPONDING TO CASES OF DOMESTIC VIOLENCE**
SECTION #: **4**
GUIDELINE #: **8**
DATE: **5/00, 10/11, 10/21**

General Statement: Domestic violence may come to the attention of the forensic examiner or authorized assistant when a patient seeking medical-legal services discloses that the perpetrator of the reported sexual assault is someone with whom he/she has or had an intimate relationship. Or, domestic violence may be disclosed or suspected during the provision of medical-legal services, with the reported perpetrator of domestic violence being someone other than the individual who committed the sexual assault.

Incidents of domestic violence must be reported to the police department if the patient is injured in a manner that falls within the definition of "suspicious wounds." (See Section 4, Guideline #7-Reporting Cases of Suspicious Wounds.) Incidents of domestic violence that fall outside of the suspicious wounds reporting mandate should only be reported to the police with the consent of the patient.

Purpose: To provide criteria for identifying domestic violence and to establish guidelines and roles/responsibilities for those involved in the care of patients who are victims of such violence.

Definition: Domestic violence refers to the victimization of a person with whom the abuser has or had an intimate relationship. Domestic violence may take the form of physical, sexual, and/or psychological/emotional abuse, is generally repeated, and often escalates within the relationship.

Assaultive or abusive conduct includes, but is not limited to, murder; manslaughter; mayhem; aggravated mayhem; torture; assault with intent to commit mayhem; rape, sodomy, or oral copulation; administering controlled substances or anesthetic to aid in commission of a felony; battery; sexual battery; incest; throwing any vitriol, corrosive acid or caustic chemical with intent to injure or disfigure; assault with a stun gun or laser; assault with a deadly weapon, firearm, assault weapon or machine gun or by means likely to produce great bodily injury; spousal rape; procuring any female to have sex with another man; abuse of spouse or cohabitant; oral copulation; or genital or anal penetration by a foreign object.

Procedure:

A. The forensic examiner or authorized assistant who suspects domestic violence, or to whom domestic violence is disclosed, will address the situation with the patient in a supportive, nonjudgmental manner either prior to or following the provision of the acute forensic examination. The forensic examiner or authorized assistant will:

1. Place the patient in a safe, private room. Anyone accompanying the patient

should be asked to remain in the waiting area.

2. Assess the patient's immediate physical and emotional needs.

3. Convey the message that he/she is not alone, does not deserve to be abused, and that help is available.

4. Discuss the option of reporting the abuse to the police. If the injury is not classified as a "suspicious wound" (see Section 4, Guideline #7 – Reporting Cases of Suspicious Wounds), a police report will not be made without the consent of the patient.

5. Inform the patient of community resources and shelters. If the patient does not want to meet with a domestic violence counselor at that time, provide the patient with referrals that he/she may be able to utilize at a later time.

6. Assist the patient with developing a safety plan if he/she chooses to return home.

B. The forensic examiner or authorized assistant will document the above provision of information and plan of action in the patient's chart.

Guideline

SUBJECT: **PSYCHOLOGICAL REACTIONS AND BEHAVIORAL INDICATORS IN THE PEDIATRIC PATIENT**

SECTION #: **5**

GUIDELINE #: **1**

DATE: **5/00, 10/11, 1/22**

General Statement: The sexual assault of a child presents in a variety of ways. It may entail a single incident, or may involve multiple victimizations over a long period of time. It may be intrafamilial abuse involving family members, child molestation by nonfamily members, forcible child sexual assault such as the abduction and sexual penetration of a minor, or child sexual exploitation such as pornography, prostitution, and sex-rings.

Coercive techniques are often used by the perpetrator to involve the child in sexual activity and secure compliance. The coercion may take the form of psychological pressure, exertion of adult authority, gift giving, misrepresentation of guidance and love ("Because I love you I need to teach you"), or force and threats. The child may cooperate because of fear, unmet needs for attention and love, a sense of loyalty to the adult and the desire to please, or because of confusion about what is happening and what to do.

The sexual contact typically begins with fondling and may gradually proceed to masturbation, digital penetration, oral-genital contact, vaginal, or anal penetration. The perpetrator is usually known to the victim, often times sharing a close relationship.

Purpose: To educate and provide health care providers with knowledge about the range of psychological reactions and behavioral symptoms following the sexual victimization of a child, to ensure trauma-informed care.

PSYCHOLOGICAL REACTIONS

A. The following are common feelings and concerns experienced by child victims of sexual assault regardless of the identity and relationship of the perpetrator:

- Anxiety/Fear - A child might be anxious and afraid of re-abuse or retribution (the child may have been threatened harm if he/she tells), of the response of parents and significant others (anger, disbelief, blame), of disruption of the family, and of the future fate of the perpetrator (children often care for the perpetrator and are caught in a double bind).

- Guilt/Shame - Guilt may stem from the child's belief that he/she did something wrong as well as from not having been able to prevent or stop the abuse, from complying with rather than resisting the abuse, from feeling physical pleasure from the touching, or from breaking a promise of secrecy by disclosing. Shame may result from the child's belief that he/she is a bad person for having been touched sexually.

- Anger - Violation of trust, fear, physical trauma, and a sense of loss all contribute to feelings of anger in the child. The manner in which the anger presents varies among children and may be either internalized or externalized.

- Sadness - In the aftermath of the abuse, a child feels an enormous sense of loss (i.e., loss of sense of control, sense of safety and security, trust in others, etc.) and resultant sadness.

Additional reactions more characteristic of child victims of sexual assault over a period of time by a family member include:

- Low self-esteem
- Inability to trust
- Blurred role boundaries, role confusion, lack of boundaries
- Pseudomaturity with failure to accomplish developmental tasks
- Developmental delays

B. Cultural differences, life-stage developmental issues, mental or physical disabilities, and previous victimization may intensify the psychological trauma experienced by the child.

C. The medical examination can trigger feelings of powerlessness or lead the child to re-experience a sense of violation and associated shame. Family disruption and/or removal from the home, seeing the perpetrator, confronting the abuse, parental rejection and lack of support from family, and appearing in court are other variables that may result in or intensify reactions in the child.

INDICATORS OF CHILD SEXUAL ABUSE

A. The following are possible indicators of child sexual abuse; however, as some may not be symptomatic of abuse when taken separately, it is important that they be examined in the context of other behaviors or situational factors.

1. Disclosure – The single most important indicator of sexual abuse is disclosure by the child. The disclosure may be direct or indirect, and may be incomplete as the child may first "test the water." While a delay in disclosure by children is common, fabrication of these accounts is rare; disclosures should be taken seriously.

2. Physical Symptoms:

- Itching, irritation, or unexplained injuries to the genital and/or rectal area (bruises, tears, lacerations, swelling, bleeding, etc.)
- Genital discharge or infection
- Sexually transmitted diseases
- Complaints of pain (throat, genital, anal, upon urination/defecation)
- Stomachaches, headaches, or other physical symptoms

3. Behavioral Indicators in Young Children:

- Enuresis
- Fecal soiling
- Appetite disturbance (overeating, undereating)
- Sleep disturbance (nightmares, difficulty falling asleep, fretful sleep, oversleeping)
- Fears, phobias, or avoidance behavior
- Pseudomaturity or regressive behavior
- Difficulty concentrating; increased irritability
- Unexplained or abnormal behavior
- Changes in school performance
- Sexual behaviors (detailed or age-inappropriate understanding of sexual behavior, excessive curiosity about or focus on sexual matters or genitalia, compulsive masturbation, inappropriate or unusual sexual behavior with peers or sexualized play)

4. Behavioral Indicators in Older Children and Adolescents:

- Withdrawal, nonparticipation in social activities
- Depression
- Crying without provocation
- Overly compliant behavior
- Avoidance of home life
- Poor hygiene or excessive bathing
- Self-consciousness of body beyond that expected for age
- Fear of offender gender
- School problems, changes in school performance
- Unusually seductive behavior or prostitution
- Dressing promiscuously or wearing over-sized, baggy clothing
- Runaway, aggressive, oppositional defiance, or delinquent behavior
- Alcohol or drug abuse
- Pyromania
- Suicidal ideations or attempts
- Self-mutilation

Guideline

SUBJECT: **MEDICAL HISTORY INTERVIEW OF THE PEDIATRIC PATIENT**
SECTION #: **5**
GUIDELINE #: **2**
DATE: **5/00, 10/11, 1/22**

General Statement: The forensic examiner will conduct a medical history interview of the pediatric patient prior to the physical examination. Information about the sexual assault obtained during this interview enables the forensic examiner to conduct an appropriate medical examination and guides the collection of legal evidence. It is not an investigative interview and does not preclude nor duplicate a thorough and detailed forensic interview conducted by trained police and/or a child welfare services worker.

The importance of the medical history interview in the acute forensic examination, especially for the child patient, cannot be overemphasized. The history of sexual assault has both criminal and protective ramifications. The courts have allowed testimony regarding details of the patient's statements obtained in the medical history interview; therefore, clear documentation is essential.

Purpose: To define the parameters of the medical history interview of the pediatric patient and to provide interviewing guidelines.

Procedure:

A. The medical history interview for the acute forensic examination includes completion of the "Medical-Legal Record and Sexual Assault Information Form."

B. The forensic examiner should keep in mind that the minor faces a detailed forensic interview and should ask only what is necessaryto guide the acute forensic examination and testing for sexually transmitted infections.

C. Caretaker (historian) Interview

1. The interview should be conducted in a private place with minimal or no interruptions.

2. The caretaker(s) should be interviewed without the minor present.

D. Minor Interview

1. The interview should be conducted in a private place with minimal or no interruptions.

2. Whenever possible, the minor should be interviewed without the parent or family present. If a family member is present, they should be positioned in the room to avoid any eye contact with the minor. This will decrease any non-verbal communication

cues. If a family member is present, they should be instructed to allow the minor to answer questions.

3. A parent who is suspected of perpetrating the abuse shall not be allowed in the examination room during the interview or examination.

E. The forensic examiner should do the following when interviewing the minor.

1. Take time to establish rapport by discussing common, nonsexual topics to allow the child to become more comfortable with the situation and to determine the child's general level of functioning. Convey a relaxed, calm attitude.

2. Sit or stand at eye level with the minor.

3. Ask open-ended, non-leading questions.

4. Do not suggest or assume answers.

   a) Avoid projecting your own feelings or perceptions about the situation onto the child.
   b) Do not assume the child is experiencing guilt or anger as neither may be present.
   c) Do not assume the child found the sexual contact unpleasant.

5. Avoid any emotional reactions to the information given; a neutral "tell me more" and "then what happened" approach should be maintained.

6. Watch for signs of increasing anxiety; break from the interview if the child is showing signs of heightened anxiety. Do not press for answers when a child is showing signs of stress.

7. Ask the questions in a manner that is appropriate to the minor's age and level of understanding.

   a) The child's terminology for body parts should be used rather than medical terminology.
   b) The forensic examiner should consider the developmental capabilities of the minor. For example, a preschool age child will be able to remember best via events that have occurred but will not have a clear understanding of the order and timing of events.

8. Do not ask the minor why he/she did not tell anyone sooner.

9. Information may be gathered from the minor and/or from a parent or other historian who may be able to provide additional information about the alleged sexual assault. The pediatric version of the "Medical-Legal Record and Sexual Assault Information Form" has been designed to accommodate information provided by both the minor and the historian.

F. During, or at the conclusion of the interview and examination, the forensic examiner may need to discuss the following with the minor.

1. The presence or absence of physical injury.

2. Provide reassurance of normal findings and follow-up for any medical care.

3. Fear of consequences or punishment because of disclosure or the belief that he/she is to blame for what happened.

4. Concerns about further sexual victimization or potential family separation.

G. During, or at the conclusion of the interview and examination of the minor, the forensic examiner may need to discuss the following with the parent or family member.

1. The presence or absence of physical injury.

2. Provide reassurance of normal findings and follow-up for any medical care.

3. Feelings of failure and guilt for not having prevented the sexual assault from occurring.

4. The possible emotional and psychological impact of the sexual assault on the child.

Guideline

SUBJECT: **THE PEDIATRIC FORENSIC EXAMINATION**
SECTION #: **5**
GUIDELINE #: **3**
DATE: **5/00, 10/11, 2/22**

General Statement: The acute forensic examination will be conducted for minors seen within 120 hours of a reported sexual assault. (The pediatric sex abuse medical evaluation is performed post 120 hours of a reported sexual assault and is conducted to assess the health and well-being of the sexually abused child.) The overall objectives of the acute forensic examination are: a) the collection of forensic evidence; b) the documentation of injuries; and c) the testing for and treatment of sexually transmitted infections (STIs), if indicated. If STI testing and treatment are not done at the time of the acute forensic examination, the patient will be referred to community resources or to a private physician for such testing and treatment. (Note: The finding of a STI carries important evidence of sexual assault in the pediatric patient; see Section 5, Guideline #4 – Sexually Transmitted Infections in the Pediatric Patient.)

Patients may exhibit a wide range of emotions; the forensic examiner should view the minor's presentation as the individual's adaptation to a personal crisis. The forensic examiner's introduction of self and his/her role, the use of terminology that is clear and understandable, and explanation throughout the contact of what is being done and why will assist in building rapport and increasing the minor's comfort level. Minors and their parents/legal guardians should be provided information and the opportunity to participate in decision making regarding treatment and follow-up care.

The role of the forensic examiner in the pediatric forensic examination is the reporting of findings. The forensic examiner may use the Hawaii State Sexual Assault Evidence Collection Kit for the collection of forensic evidence. (See Section 3, Guideline #2 – Procedures for the Hawaii State Sexual Assault Evidence Collection Kit.) While the evidence collection protocol consists of numerous steps, the number of steps actually performed and the specimens collected will remain at the examiner's discretion.

There are 2 versions of the "Medical-Legal Record and Sexual Assault Information Form"; a pediatric version and a version for the adolescent/adult patient. The pediatric version of this form will typically be used for patients 13 years of age and younger; the adolescent/adult version will typically be used for patients 14 years of age and older. However, it will be left to the discretion of the forensic examiner to determine the version best suited for the minor being examined based on the minor's developmental stage. **If the pediatric version of the form is used, the guidelines and procedures outlined in this policy should be followed; if the adolescent/adult version of the form is used, the guidelines and procedures outlined in Section 4, Guideline #3 – "The Adult Forensic Examination" should be followed.**

Purpose: To delineate the objectives and outline the procedures to be followed when conducting the acute forensic examination in pediatric patients.

Procedure:

A. OBTAIN PATIENT CONSENT

The forensic examiner or authorized assistant will obtain signature on the appropriate consents. The consents may include the following:

1. Consent for Genital or Pelvic Examination

2. Consent for Ano-Genital Photographs

3. Consent for Emergency Contraception (if applicable)

4. Authorization for Collection, Release, and Storage of Evidence and Information (Step 1 Form See Section 3, Guideline #2 - Procedures for the Hawaii State Sexual Assault Evidence Collection Kit, Step 1.)

B. OBTAIN HEALTH HISTORY

The forensic examiner will obtain information on the patient's past health history and will record this information on the patient's "Medical-Legal Record and Sexual Assault Information Form" (hereinafter "Medical-Legal Form").

C. OBTAIN PATIENT HISTORY

The history in a sexual assault evaluation is viewed as a medical history and is documented as such. The importance of the medical history in the pediatric examination cannot be overemphasized as it can have both criminal and protective ramifications. However, the medical history is **not** an investigative interview.

The courts have allowed testimony regarding details of the child's statements obtained in the medical history; therefore, clear documentation is essential.

1. The forensic examiner will interview the minor and/or accompanying adult to obtain the individual's medical history and will complete the patient's "Medical-Legal Form." The forensic examiner should specify what parts of the history were obtained from the minor and what parts were obtained from the accompanying adult.

2. If more than one perpetrator is involved, each perpetrator's actions should be documented as clearly as possible, and each perpetrator should be identified as simply as possible (e.g. man #1 - bald man). The acts described should be carefully recorded; this information is necessary to guide the medical examination and for interpretation of crime laboratory tests. The patient history must be accessed carefully; some patients may be reluctant to describe all acts committed,

particularly anal penetration.

D. OBTAIN INFORMATION ON SYMPTOMS EXPERIENCED BY THE MINOR

1. The forensic examiner will obtain information on physical and behavioral/emotional symptoms being experienced by the minor and will document this on the patient's "Medical-Legal Form." The forensic examiner will differentiate information obtained from the minor from information obtained from the accompanying adult.

E. PERFORM THE MENTAL STATUS EXAMINATION

The description of the patient's mental status should be based on the forensic examiner's observation of the patient.

1. The forensic examiner will document the patient's appearance, behavior, mood, and orientation on the patient's "Medical-Legal Form." To ascertain the patient's orientation, specific questions regarding orientation to person, place and time should be asked.

2. Any expressed concern of the patient should be documented in the patient's own words.

F. CONDUCT A GENERAL PHYSICAL EXAMINATION; COLLECT AND PRESERVE EVIDENCE - **Necessary cultures should be collected after the evidence has been secured.**

1. Collect all clothing worn during and immediately after the reported assault.

   a. The forensic examiner or authorized assistant will collect clothing that was worn at the time of the assault; if the patient is not wearing the clothing worn at the time of the assault, only those items in direct contact with the patient's genital area should be collected. Footwear should be collected only if it was worn during an assault that took place outdoors. (See Section 3, Guideline #2 – Procedures for the Hawaii State Sexual Assault Evidence Collection Kit.)

2. Conduct a general physical examination (head to toe) to look for injuries and other evidence of the reported assault.

   a. The forensic examiner will conduct a physical examination and record the findings on the appropriate diagram of the patient's "Medical-Legal Form." The diagrams should be used to record the location, size, and appearance of injuries. Signs of injury may include erythema, abrasions, contusions, lacerations, fractures, bleeding, bites, or burns. Specific physical signs to further assess in the minor include height and weight and Tanner Stages.

   b. Photography: The forensic examiner will photograph all areas of injuries to the

skin. (See Section 3, Guideline #6 – Photography.) The forensic examiner should document the location of the photographs on the patient's "Medical-Legal Form."

c. Alternative Light Source: The forensic examiner will collect dried and moist secretions, and stains from the body. The Alternative Light Source should be used to scan the patient's skin for evidence of dried or moist secretions, stains, fluorescent fibers not visible to white light, or subtle injury. (Dried semen typically has a shiny, mucoid appearance and tends to flake off the skin. Under an ultraviolet light, semen usually fluoresces in a blue-white or orange color, but these colors are not specific to semen.) It should be noted that fresh dried semen may not fluoresce. Therefore, each suspicious area should be swabbed regardless of whether it fluoresces.

1) In a darkened room, the forensic examiner will scan the patient's entire body with an Alternative Light Source (i.e., head first, then torso, back, arms and legs), and swab each suspicious stain or fluorescent area with a separate swab. Special attention should be given to the perioral area, the torso around the breasts (for female patients), and the hands.

2) The forensic examiner will use the appropriate diagrams of the patient's "Medical-Legal Form" to record the location, size, and appearance of any evidence of foreign materials, taking care to delineate the evidence of foreign materials from the documentation of the patient's injuries.

3. Examine the patient's mouth.

a. The forensic examiner will examine the patient's oral cavity for injury and the area around the mouth for evidence of seminal fluid.

b. The forensic examiner will collect oral swabs only if there is a history of oral-genital contact.

c. The forensic examiner will document findings on the patient's "Medical-Legal Form."

4. Collect oral specimens for testing for sexually transmitted infections (STIs). (If applicable)

a. The forensic examiner will collect oral specimens for STI testing if indicated. The specimens will be collected and transferred in a manner that preserves chain of custody. (See Section 5, Guideline #4 – Sexually Transmitted Infections in the Pediatric Patient.)

b. The forensic examiner will document the specimens collected on the patient's "Medical-Legal Form."

5. Obtain head hair.

   a. Head Hair Combing - The forensic examiner will comb or have the patient run a comb through all areas of her hair to obtain any head hairs possibly shed by the suspected perpetrator during the reported assault.

   b. Known Head Hair – This step should be done only when the identity of the perpetrator is not known. The forensic examiner will obtain cut patient head hairs for comparison with hairs found.

6. Collect fingernail swabbings. (Should be collected only if the patient scratched the suspected perpetrator's skin or clothing.)

   a. Fingernail swabbings may contain a variety of evidential materials including blood or tissue.

7. Examine the patient's external genitalia.

   The minor should be examined in both the supine, frog-legged and the prone knee/chest positions whenever possible. Examination in the knee/chest position allows a more detailed inspection of the posterior hymen, fossa navicularis and posterior fourchette – primary areas of injury in sexual abuse. Hymenal tissue falls anteriorly secondary to gravity, allowing a clear view of the rim of the hymen and the amount of hymenal tissue present. The knee/chest position also allows for better visualization of the anal area. All patients should be examined in the knee/chest position as well as the supine position, especially when the hymen appears abnormal in the supine position and when there is a history of anal penetration.

   Ano-Genital Photographs:

   The use of a digital camera enhances the forensic examiner's ability to identify and document potential findings on examination of the genitalia. **Ano-genital photographs should be taken of all minor patients, provided that the minor is cooperative and willing.** (See Section 3, Guideline #7 – Ano-Genital Photographs.)

   Supine Position

   a. The forensic examiner or authorized assistant will remove and unfold the paper towel from the Pubic Hair Combing envelope found in the evidence collection kit and place it under the patient's buttocks, as applicable.

   b. The forensic examiner will examine the patient's external genitalia for signs of injury.

      1) In female patients, the external genitalia includes the mons veneris,

perineum, clitoris, labia majora, labia minora, urethral orifice, vulvar mucosa, perihymenal tissue, hymen, vaginal introitus, posterior fourchette, and medial aspects of the thighs.

2) In male patients, the external genitalia include the penis and scrotum.

3) Signs of injury may include erythema, abrasions, bruises, lacerations, tenderness, swelling, bleeding, or bites. A common post-coital finding is erythema of the posterior fourchette and superficial abrasion of the area.

4) The forensic examiner will document findings on the patient's "Medical-Legal Form." Findings should be recorded on the diagrams as they relate to their anatomic position and should be described with reference to the face of a clock (e.g., midline injuries at the entrance to the vagina over the posterior fourchette would be located at the 6 o'clock position).

c. The forensic examiner will examine the patient's external genitalia for dried and moist secretions.

1) The forensic examiner will scan the area with an Alternative Light Source and swab each suspicious stain or fluorescent area with a separate swab.

2) The forensic examiner will use the appropriate diagram of the patient's "Medical- Legal Form" to record the location, size, and appearance of any evidence of foreign materials.

8. Obtain pubic hair.

a. Pubic Hair Combing – This will be done if the patient was disrobed during the reported assault. The forensic examiner will comb the patient's pubic hair in downward strokes to obtain any pubic hairs possibly shed by the suspected perpetrator during the reported assault.

b. Known Pubic Hair – The forensic examiner will obtain cut patient pubic hairs for comparison with hairs found.

c. If suspicious material is found on the patient's pubic hair, the forensic examiner will cut the matted hairs bearing the specimen.

9a. Female patients – Examine the patient's external genitalia

a. The forensic examiner will examine external genitalia for injuries.

1) Signs of injury may include lacerations, abrasions, ecchymosis, or hematomas.

2) The forensic examiner will document findings on the patient's "Medical-Legal Form."

10. Male patients – Collect penile swabs. (Should be collected only if indicated by the history.)

    a. The forensic examiner will examine the penis and scrotum for injuries.

        1) If history indicates oral copulation or other such acts by the suspected perpetrator(s), the forensic examiner will collect a minimum of 2 penile swabs for saliva or foreign materials.

        2) The forensic examiner will moisten both swabs with distilled water.

        3) The forensic examiner will collect one swab from the urethral meatus and one swab from the glans shaft.

        4) The collected specimens will be preserved following Section 3, Guideline #2 – Procedures for the Hawaii State Sexual Assault Evidence Collection Kit.

11. Collect urine or penile specimens for testing for sexually transmitted infections (STIs), if applicable.

    a. The forensic examiner will collect urine or penile specimens for STI testing, if applicable. The specimens will be collected and transferred in a manner that preserves chain of custody. (See Section 5, Guideline #4– Sexually Transmitted Infections in the Pediatric Patient.)

    b. The forensic examiner will document the specimens collected on the patient's "Medical-Legal Form."

12. A Note About Toluidine Blue:

    The forensic examiner may consider examination of the area with the use of toluidine blue. Toluidine blue, a dye that preferentially binds to areas of tissue injury, can be a visual aid in the documentation of rectovaginal injuries. Its use can increase the forensic examiner's ability to identify traumatic lesions after a sexual assault. However, it should not be used in the perianal area due to difficulty in interpreting the findings. If the decision is made to use toluidine blue, it should be done after all evidence has been collected from the rectovaginal area. Note: the patient should be warned that the dye may stain underwear.

    a. The area to be examined should be swabbed with toluidine blue using a cotton-tipped applicator. (The toluidine blue may be sprayed onto the area to be examined if a spray bottle is available.)

    b. The excess toluidine blue should be removed using gauze that has been moistened with distilled water or saline.

c. Findings should be photographed and documented on the patient's "Medical-Legal Form."

13. Examine the patient's anus and rectum.

Reminder: The prone knee/chest position allows easier and more complete examination of the perianal area. Alternative positions include lateral and supine knee/chest positions.

a. The forensic examiner will examine the patient's buttocks, perianal skin, and anal folds for signs of injury and foreign materials. Findings will be documented on the patient's "Medical-Legal Record Form."

b. The forensic examiner will scan the area with an Alternate Light Source and swab each suspicious area. The forensic examiner should use the appropriate diagram on the patient's "Medical-Legal Form" to record the location, size, and appearance of any evidence of foreign materials.

c. The forensic examiner will collect rectal swabs only if rectal assault occurred or was attempted, or if there are physical findings to suggest assault.

14. Collect rectal specimens for testing for sexually transmitted infections (STIs), if applicable.

a. The forensic examiner will collect rectal specimens for STI testing, if indicated. The specimens will be collected and transferred in a manner that preserves chain of custody. (See Section 5, Guideline #4 – Sexually Transmitted Infections in the Pediatric Patient.)

b. The forensic examiner will document the specimens collected on the patient's "Medical-Legal Form."

15. Obtain urine sample from patient.

a. If not already done, a urine sample will be obtained from the patient.

b. The urine may be tested for pregnancy, the presence of drugs, and the presence of spermatozoa in the rare situation where the forensic examiner is unable to collect vaginal swabs from the patient.

1) When indicated, the forensic examiner will order a pregnancy test. The results will be documented on the patient's "Medical-Legal Form."

2) When indicated, a urine sample will be sent for drug testing. The specimen will be collected and transferred in a manner that preserves chain of custody. (See Section 3, Guideline #5 – Drug Testing.) The forensic examiner will discuss the procedure with the patient and obtain written consent. The request for drug testing will be documented on the

patient's "Medical-Legal Form."

16. Obtain patient's DNA sample

a. Buccal Swab. If an oral swab was obtained previously, swish and spit twice, then do the bucal swab.

1) The buccal swab will be used to access a sample of the patient's DNA. The forensic examiner, with the assistance of an authorized assistant, will carefully swab the buccal area and gum line with the four swabs provided.

G. COMPLETE THE PATIENT'S "MEDICAL-LEGAL RECORD AND SEXUAL ASSAULT INFORMATION FORM" AND RECOMMEND TREATMENT PLAN

1. The forensic examiner will document the examination findings and will indicate whether a Hawaii State Sexual Assault Evidence Collection Kit was used on the patient's "Medical-Legal Form."

2. When indicated, the forensic examiner will discuss with the minor and/or the minor's parent or legal guardian the risk of pregnancy and of contracting a sexually transmitted infection, and will recommend a course of treatment and follow-up care. If STI testing and treatment were not done, the forensic examiner will provide the patient with referrals for such care. The forensic examiner will also discuss with the minor and/or the minor's parent or legal guardian the benefits of counseling and provide referrals for such services when appropriate. The treatment plan and referrals provided should be documented on the patient's "Medical-Legal Form."

3. The forensic examiner will sign the patient's "Medical-Legal Form" upon completion of the examination. The date, time, and the forensic examiner's address and phone number should also be documented.

Guideline

SUBJECT: **SEXUALLY TRANSMITTED INFECTIONS IN THE PEDIATRIC PATIENT**

SECTION #: **5**

GUIDELINE #: **4**

DATE: **5/00, 10/11, 5/22**

General Statement: During the pediatric forensic examination, the forensic examiner may test for and treat sexually transmitted infections (STIs) when applicable. If STI testing and treatment are not done at the time of the acute forensic examination, the forensic examiner will provide the patient with community referrals or will refer the patient to a private physician for such care.

The Hawaii State Sexual Assault Evidence Collection Kit will be used in the collection of medical-legal evidence for cases seen **within 120 hours of a reported sexual assault**; the collection kit should not be used for minors seen through the Sex Abuse Clinic post-120 hours of the reported sexual assault. During the acute forensic examination, necessary cultures should be collected **after** the evidence has been secured.

The decision to culture for STIs in the prepubertal child is at the forensic examiner's discretion. A variety of factors should be considered including: a) the possibility of oral, genital, or rectal contact; b) the local incidence of STIs; c) whether the suspected perpetrator is known to have a STI or is at high risk for a STI; d) the presence of STIs in other household members; e) whether the child is symptomatic; and f) physical characteristics including both weight and stage of pubertal development of the child. Only tests that have been proven to be highly specific (i.e., a low incidence of false positives) should be used.

Purpose: To provide forensic examiners treating pediatric patients of sexual assault with recommendations obtained from the CDC Guidelines for Treatment of Sexually Transmitted Diseases.

Procedure:

A. The forensic examiner will assess the need of the patient and follow the guidelines below in the collection of STI cultures.

Note: The hymen in prepubertal girls is extremely sensitive. When obtaining a vaginal culture, the tip of the swab should be inserted while traction is being applied to the labia in order to avoid touching the hymen. A small dacron-tipped swab can be used in lieu of a cotton-tipped swab for patient comfort.

In boys, a small dacron-tipped or cotton swab moistened with bacteriostatic water should be used in culturing the urethra. The swab should be rubbed on the edge of the urethral meatus. Deep insertion of the swab is not necessary.

1. GONORRHEA

a. Sites: First choice is urine. If necessary, cultures/DNA swab should be taken from the pharynx and anus in both boys and girls, and from the urethra or urethral meatus in boys.

b. Incubation Period: 3-7 days.

c. Methods:

GC DNA (Urine) (first choice):

- Patient should not urinate up to 2 hours prior to collection. Spermicidal agents and feminine powder sprays can interfere. Do not use prior to specimen collection.
- **Urine Female:** Collect the first 15-50 or more mL of the **first** part of the voided urine (i.e., not midstream). Void into a sterile cup. Urine sample **cannot** be shared for urinalysis or other urine tests.
- **Urine Male:** Collect 15-50 or more mL of urine. Midstream collection is acceptable. Specimen can be shared for urinalysis or other urine tests. Submit the entire urine cup or note the total volume of the entire voided urine on the aliquot tube.

Cervical (usually done under anesthesia)

Alternative Method GC culture (Swab):

- Do not use lubricant during the procedure.
- Wipe the cervix clean of vaginal secretion and mucus.
- Rotate a sterile swab, and obtain exudates from the endocervical glands.
- If no exudate is seen, insert a sterile swab into the endocervical canal, and rotate the swab.

Alternative Method GC DNA (Swab):

- Spermicidal agents and feminine powder sprays can interfere. Do not use prior to specimen collection.
- Collect sample with cervical or urethral swab with M4RT, M4, M5, or Universal Transport Media (UTM) media. ThinPrep vials are acceptable if a PAP smear is also ordered. **Do not use other types of swabs.** Moderately mucoid contamination and moderately bloody swabs may cause false negative results.

Vaginal (usually done under anesthesia):

- Insert a sterile swab into the vagina.
- Collect discharge or vaginal secretions from the mucosa high in the vaginal canal.

d. Treatment: Once a positive culture is confirmed, treatment should be instituted:

<45 kg:

Ceftriaxone 25-50 mg per kg IM, in a single dose, not to exceed 250 mg.

≥45 kg:

Ceftriaxone 500 mg IM in a single dose.

Note: Gonococcal infections in females are of special concern because of the possibility of ascending infection.

e. Points to Remember:
   - In boys, a urethral discharge is an adequate substitute for an intraurethral swab specimen when a discharge is present.
   - Gonorrhea in children >1 year of age is considered definite evidence of sexual abuse.
   - Up to 45% of children with gonorrhea may be asymptomatic.

2. CHLAMYDIA

a. Sites: First choice is urine. If necessary, cultures should be taken from the anus in both boys and girls. A urethral or urethral meatus swab in boys should be taken only if discharge is present.

b. Incubation Period: Variable, but usually at least 1 week.

c. Methods:

Urine Method Chlamydia DNA:

- Spermicidal agents and feminine powder sprays can interfere. Do not use prior to specimen collection.
- **Urine Female:** Collect the first 15-50 or more mL of the **first** part of the voided urine (i.e., not midstream). Void into a sterile cup. Urine sample **cannot** be shared for urinalysis or other urine tests.
- **Urine Male:** Collect 15-50 or more mL of urine. Midstream collection is acceptable. Specimen can be shared for urinalysis or other urine tests. Submit the **entire** urine cup or note the total volume of the entire voided urine on the aliquot tube.

Alternative Method GC DNA (Swab):

- Collect sample with cervical or urethral swab with M4RT, M4, M5, or Universal Transport Media (UTM) media. ThinPrep vials are acceptable if a PAP smear is also ordered. **Do not use other types of swabs.** Moderately mucoid contamination and moderately bloody swabs may cause false negative results.
- Specimens are best collected with a **dacron swab** so as not to disrupt the cell membranes. Avoid cotton-tipped wooden swabs as they have formalin in them, which may kill Chlamydia. Pharyngeal specimens are not recommended because of the low yield.

d. Treatment: Once a positive culture is confirmed, treatment should be instituted:

<45 kg:

Erythromycin base 50 mg/kg/day orally divided into 4 doses daily for 14 days.

Note: Erythromycin is effective 80% of the time. A follow-up culture should be done after completion of the treatment. A second course of therapy may be required.

≥45 kg:

Doxycycline 100 mg orally twice a day for 7 days (first choice).

OR

Azithromycin 1 g orally in a single dose.

Note: Chlamydial infections in females are of special concern because of the possibility of ascending infection.

e. Points to Remember:
   - *C. trachomatis* acquired at birth can persist for up to 3 years in the genital, pharyngeal, and anal areas. When a positive culture is obtained on a child <3 years of age suspected of having been sexually abused, greater concern exists if asymptomatic maternal infection has been excluded and urethral infection of the suspected perpetrator can be demonstrated by culture.
   - Anal or genital chlamydial infection in a child >3 years of age is confirming evidence of sexual abuse.

3. TRICHOMONAS

a. Sites: A vaginal swab should be taken for microscopic wet mount examination or NAAT/PCR test.
b. Incubation Period: 4-28 days with an average of 1 week.
c. Methods: A cotton-tipped or dacron swab can be used. The vaginal wall should be rubbed with the tip of the swab and examined with a drop of normal saline under the microscope. A positive wet mount for *T. vaginalis* is of forensic importance in a girl who has no history of prior sexual activity.
d. Treatment: Once *T. vaginalis* is found on culture, treatment should be instituted:

   <45 kg:

   Consult with Pediatric Infection Specialist.

   ≥45 kg (female):

   Metronidazole 500 mg orally twice per day x 7 days.

   OR

   ≥45 kg (male or female):

   Tinidazole 2 g orally in a single dose.

e. Points to Remember:
   - There must be high suspicion of trichomonas before obtaining a culture. (e.g., unexplained discharge and vulva irritation.)
   - Perinatally acquired *T. vaginalis* can persist in the vagina for 3-6 weeks after birth, and persist after that in the urinary tract.
   - Isolation of *T. vaginalis* after the first year of life is highly suspicious of abuse.
   - Isolation of *T. vaginalis* suggests recent abuse because the organism does not usually survive for long in the alkaline pH of the prepubertal vagina.

4. SYPHILIS

a. Sites and Method: Blood work for nontreponemal serologic studies (RPR,VDRL) should be done if syphilis is suspected based on the patient's physical examination or history. Syphilis serology should also be considered if the patient has a history of another STI. Specific treponemal tests (FTA-ABS, MHA-TP) should be performed to confirm a positive nontreponemal test. (Follow-up serologic assays are required at 3-6 months after the sexual assault.)

b. Incubation period: 10-90 days with an average of 3 weeks.

c. Treatment: Parental penicillin G is the preferred drug for treatment of all stages of syphilis. The preparation(s) used, the dosage, and length of treatment depends on the stage and clinical manifestation of the disease.

d. Points to Remember:

- In children, syphilis undergoes a primary (painless chancre with nonsuppurative regional adenopathy) and secondary (nonpruritic, maculopapular rash that is generalized and involves the palms and soles) stage.
- When an infant <1 month of age is diagnosed with syphilis, every effort should be made to review maternal serology and records to assess whether the child has congenital or acquired syphilis.
- **When congenitally acquired syphilis is ruled out, the finding of syphilis makes the diagnosis of sexual abuse a certainty.**
- Follow up serologic assays are required 3-6 months after the sexual assault.

5. HERPES SIMPLEX VIRUS (HSV) 1 and 2

a. Sites: Vesicles or pustules in the genital area.

b. Incubation period: 2-20 days.

c. Method: Lesions should be scraped with a dacron swab and transported to the lab in an appropriate medium for the culture and staining. If there is to be a delay (>1 hour) in transport, the specimen should be stored at 4 degrees C.

d. Treatment: Primary genital herpes infection is usually painful, and once a culture is obtained, treatment can be considered.

<45 kg:

Consult with Pediatric Infection Specialist – dosing depends on weight, age, clinical manifestation.

≥45 kg:

Acyclovir 400 mg orally 3 times a day for 7-10 days.

Recurrent genital herpes can be treated if > 45 kg with:

Acyclovir 400 mg orally 3 times a day for 5 days.

Note: Treatment may be extended if healing is incomplete after 10 days of therapy.

e. Points to Remember:
- Routine cultures for HSV in asymptomatic children are not recommended.
- Crusted lesions are less likely to yield a positive culture.
- If a child with a suspected HSV infection gives a history revealing oral or anal assault, cultures should be obtained from these sites as well.
- Serology should be considered if there is a high suspicion of acquisition of new HSV infection. Rising herpes antibody titer will indicate recent (vs congenitally acquired) infection.
- HSV has been shown to be transmitted in utero and at birth. **However, any child with genital HSV infection should be examined carefully for evidence of sexual abuse.**
- Both HSV-1 and HSV-2 can cause all of the clinical herpes infections.
- Primary genital herpes has been reported in children with no history of sexual assault following oral HSV infection, suggesting that autoinoculation may occur.
- Differential diagnosis of genital ulcers includes:

Other viral infections	Trauma
Behcet's Syndrome	Drug reactions
Lichen Sclerosis	Chancroid
Syphilis	

6. HUMAN IMMUNODEFICIENCY VIRUS (HIV)

a. Sites and Method: If the patient is to be tested, testing should be done as soon as possible following the sexual assault, and then repeated at least one more time, 1-3 months later. At the time of the forensic examination, the patient's parent/legal guardian should be counseled on the importance of HIV testing where applicable, and should be provided referrals for such testing.

b. Incubation period: Serum antibody usually develops within 4-12 weeks of infection.

c. Points to Remember:
- Serologic testing for HIV should be considered when:
  - there is a likelihood of infection in the suspected perpetrator;
  - the patient has a history of high risk behaviors (e.g. prostitution, drug abuse);
  - there is a clear history of genital or oral penetration or ejaculation;
  - the patient has signs or symptoms of AIDS;
  - the patient has another STD;
  - there is evidence of body fluid such as semen, blood, or saliva upon examination;
  - the suspected perpetrator is unknown or there are multiple perpetrators.
- **If not perinatally acquired or acquired by transfusion, HIV infection is considered diagnostic of sexual abuse.**

B. If STI cultures are indicated, the forensic examiner will obtain and transfer the specimens in a manner that preserves chain of custody.

C. The forensic examiner will document the testing done on the patient's "Medical- Legal Record And Sexual Assault Information Form."

D. The forensic examiner will inform the patient's parent/legal guardian of the symptoms of STIs, the need for immediate examination if symptoms occur, and the need for a repeat examination 2-4 weeks after the assault unless prophylactic treatment has been provided.

E. The patient should be notified of any positive test results as soon as the information is available.

F. The results of the laboratory analysis on specimens obtained during the acute forensic examination will be provided to law enforcement when applicable.

Guideline

SUBJECT: **PRESCRIBING PROPHYLACTIC BIRTH CONTROL TO THE PEDIATRIC PATIENT**

SECTION #: **5**

GUIDELINE #: **5**

DATE: **5/00, 10/11, 3/22**

General Statement: Emergency treatment is available to reduce the risk of pregnancy from a sexual assault.

Option 1: Levonorgestrel ("Plan B"), which contains the hormones estrogen and progesterone, may be prescribed for this use. When taken within 72 hours of a sexual assault, the likelihood of pregnancy is considered to be very low.

Option 2: Ulipristal ("Ella"), which contains the hormone progesterone, may be prescribed for this use. When taken within 120 hours of a sexual assault, the likelihood of pregnancy is considered to be very low.

Levonorgestrel or Ulipristal may be prescribed during the provision of medical-legal services at the discretion of the physician and only with informed patient consent.

Purpose: To establish guidelines for prescribing Levonorgestrel or Ulipristal to the pediatric patient as a part of medical-legal services.

Procedure:

A. The patient's written consent must be obtained.

B. The patient's medical history will be obtained and a physical examination will be performed prior to prescribing the Levonorgestrel or Ulipristal.

C. All pertinent information about the treatment and possible side effects will be presented to the patient prior to treatment prescription.

Guideline

SUBJECT: **REPORTING CASES OF CHILD ABUSE AND NEGLECT**
SECTION #: **5**
GUIDELINE #: **6**
DATE: **5/00, 10/11, 3/22**

General Statement: Pursuant to the Hawaii Revised Statutes, Chapter 350, any licensed or registered health care professional who examines, attends, treats or provides other professional specialized services is mandated to report all suspected cases of child abuse and neglect by any person who, or legal entity which, is in any manner or degree related to the child, is residing with the child, or is otherwise responsible for the child's care to the Department of Human Services, Child Welfare Services (DHS-CWS). Employees or officers of any public or private agency or institution, or other individuals providing social, medical, hospital or mental health services are also mandated to report cases of child abuse and neglect.

Purpose: To provide criteria for identifying child abuse and/or neglect and to delineate the legal reporting requirements when treating a minor patient who is or is suspected to be the victim of child abuse and/or neglect. To establish guidelines and roles/responsibilities for those involved in the care and support of such patients.

Definitions:

A. Child abuse is defined as acts or omissions including, but not limited to:

1. Evidence of physical injury to the child;
2. Sexual contact or conduct;
3. Injury to the psychological capacity of the child;
4. Lack of timely provision of adequate food, clothing, shelter, psychological care, physical care, medical care or supervision to the child;
5. The provision of dangerous, harmful, or detrimental drugs to the child.

B. Sexual assault includes, but is not limited to:

1. Molestation/sexual fondling, or sexual penetration;
2. Prostitution, obscene or pornographic photographing, filming or depiction of the minor;
3. Other forms of sexual exploitation.

Procedure:

A. The forensic examiner or authorized assistant who suspects or receives a disclosure of abuse or neglect of a minor by a parent or other family member, person residing in the child's home, or of abuse occurring in facilities licensed by the DHS (foster and group homes, day care centers, babysitters) must report the situation to the DHS-CWS Intake

Unit. Whenever possible, the forensic examiner or authorized assistant should inform the individual of the need to notify the DHS-CWS prior to making the reports.

1. The forensic examiner or authorized assistant will complete the "Mandated Reporter Checklist for Suspected Child Abuse and Neglect" form. The forensic examiner or authorized assistant will also include the following information in the report if known:

    a) reported perpetrator's demographics such as name, age, address (Note: The reported perpetrator's full legal name should be accessed as well as any alias names.);

    b) reported perpetrator's access to other children and the demographics of such children.

2. The forensic examiner or authorized assistant will call the DHS-CWS Intake Unit to report the situation. The information provided in the oral report should be reflective of what is documented on the "Mandated Reporter Checklist for Suspected Child Abuse and Neglect" form.

3. The forensic examiner or authorized assistant will mail or fax the completed "Mandated Reporter Checklist for Suspected Child Abuse and Neglect" form within 5 days of the oral report to the DHS-CWS Intake Unit.

B. Following the report to the DHS-CWS, medical-legal services will be provided as usual unless otherwise directed by the DHS-CWS.

1. If the DHS-CWS accepts the case for investigation and takes the minor into its custody, consent for medical-legal services will be provided by the DHS-CWS. If the parent retains custody of the minor, the parent must provide the consent for medical-legal services.

2. The DHS-CWS may assess that protective intervention is not warranted based on the information given and may decline the case for investigation at the time. If further information reflective of harm or risk of harm becomes known to the forensic examiner or authorized assistant, the DHS-CWS should be contacted again.

C. The forensic examiner or authorized assistant will clearly document the report to the DHS-CWS, disposition rendered, and any follow-up action in the patient's chart.

D. If evidence is collected during the provision of medical-legal services and the "Authorization for Collection, Release, and Storage of Sexual Assault Evidence Collection Kit" form has been signed by the party who holds consenting authority, the minor's Hawaii State Sexual Assault Evidence Collection Kit, clothing (if applicable), and "Medical-Legal Record and Sexual Assault Information Form" will be released to law enforcement.

Guideline

SUBJECT: **MEDICAL FOLLOW-UP**
SECTION #: **6**
GUIDELINE #: **1**
DATE: **5/00, 10/11, 3/22**

General Statement: All individuals receiving medical-legal services will receive recommendations for follow-up medical and emotional care and discharge information at the conclusion of the acute forensic examination.

Purpose: To promote continued care for the patient following the acute forensic examination.

Procedure:

A. During the acute forensic examination, the forensic examiner will discuss with the patient the risk of pregnancy and of contracting sexually transmitted diseases when applicable.

B. The forensic examiner, at the conclusion of the acute forensic examination, will recommend a course of treatment (when applicable) and follow-up medical care.

1. The patient will be referred back to the patient's primary care provider, or in the absence of a physician, the patient will be provided with referrals for such follow-up medical care in the community.

C. The forensic examiner or authorized assistant will also address the patient's emotional needs and will provide referrals for counseling services in the community.

D. The forensic examiner will document the treatment plan and referrals provided on the patient's "Medical-Legal Record and Sexual Assault Information Form."

E. Prior to the patient's discharge, the patient will be provided with instructions regarding any medications prescribed. The forensic examiner will answer any remaining questions that the patient may have.

SECTION 7: APPENDICES

1. Hawaii Revised Statutes
2. Hawaii State Medical-Legal Record and Sexual Assault Information Form (Adolescent and Adult)
3. Hawaii State Medical-Legal Record and Sexual Assault Information Form (Pediatric)
4. Hawaii State Sexual Assault Evidence Collection Kit Instructions
5. Evidence Report
6. Step 1 Form Authorization for Collection, Release, and Storage of Sexual Assault Evidence Collection Kit
7. Sexual Assault Victim Rights Notification Form

§346-222 Definitions. For the purposes of this part:

"Abuse" means any of the following, separately or in combination:

(1) Physical abuse;
(2) Psychological abuse;
(3) Sexual abuse;
(4) Financial exploitation;
(5) Caregiver neglect; or
(6) Self-neglect;

each as further defined in this chapter. Abuse does not include, and a determination of abuse shall not be based solely on, physical, psychological, or financial conditions that result when a vulnerable adult seeks, or when a caregiver provides or permits to be provided, treatment with the express consent of the vulnerable adult or in accordance with the vulnerable adult's religious or spiritual practices.

"Capacity" means the ability to understand and appreciate the nature and consequences of making decisions concerning one's person or to communicate these decisions.

"Caregiver" means any person who has knowingly and willingly assumed, on a part-time or full-time basis, the care, supervision, or physical control of, or who has a legal or contractual duty to care for the health, safety, and welfare of a vulnerable adult.

"Caregiver neglect" means the failure of a caregiver to exercise that degree of care for a vulnerable adult that a reasonable person with the responsibility of a caregiver would exercise within the scope of the caregiver's assumed, legal or contractual duties, including but not limited to the failure to:

(1) Assist with personal hygiene;
(2) Protect the vulnerable adult from abandonment;
(3) Provide, in a timely manner, necessary food, shelter, or clothing;
(4) Provide, in a timely manner, necessary health care, access to health care, prescribed medication, psychological care, physical care, or supervision;
(5) Protect the vulnerable adult from dangerous, harmful, or detrimental drugs, as defined in section 712-1240; provided that this paragraph shall not apply to drugs that are provided to the vulnerable adult pursuant to the direction or prescription of a practitioner, as defined in section 712-1240;
(6) Protect the vulnerable adult from health and safety hazards; or
(7) Protect the vulnerable adult from abuse by third parties.

"Court" means the family court.

"Department" means the department of human services and its authorized representatives.

"Director" means the director of human services.

"Emergency medical treatment" means any service necessary to maintain a person's physical health and without which there is a reasonable belief that the person will suffer irreparable harm or death.

"Financial exploitation" means the wrongful taking, withholding, appropriation, or use of a vulnerable adult's money, real property, or personal property, including but not limited to:

(1) The breach of a fiduciary duty, such as the misuse of a power of attorney or the misuse of guardianship privileges, resulting in the unauthorized appropriation, sale, or transfer of property;
(2) The unauthorized taking of personal assets;
(3) The misappropriation or misuse of moneys belonging to the vulnerable adult from a personal or joint account; or
(4) The failure to effectively use a vulnerable adult's income and assets for the necessities required for the vulnerable adult's support and maintenance, by a person with a duty to expend income and assets on behalf of the vulnerable adult for such purposes.

Financial exploitation may be accomplished through coercion, manipulation, threats, intimidation, misrepresentation, or exertion of undue influence.

"Party" means those persons, care organizations, or care facilities entitled to notice of proceedings under sections 346-237 and 346-238, including any state department or agency that is providing services and treatment to a vulnerable adult in accordance with a protective services plan.

"Physical abuse" means:

(1) The nonaccidental infliction of physical or bodily injury, pain, or impairment, including but not limited to hitting, slapping, causing burns or bruises, poisoning, or improper physical restraint; or
(2) Causing physical injuries that are not justifiably explained or where the history given for an injury is at variance with the degree or type of injury.

"Protective services plan" means a specific written plan, prepared by the department, that sets forth the specific services and treatment to be provided to a vulnerable adult.

"Psychological abuse" means the infliction of mental or emotional distress by use of threats, insults, harassment, humiliation, provocation, intimidation, or other means that

profoundly confuse or frighten a vulnerable adult.

"Self-neglect" means:

(1) A vulnerable adult's inability or failure, due to physical or mental impairment, or both, to perform tasks essential to caring for oneself, including but not limited to:

(A) Obtaining essential food, clothing, shelter, and medical care;

(B) Obtaining goods and services reasonably necessary to maintain minimum standards of physical health, mental health, emotional well-being, and general safety; or

(C) Management of one's financial assets and obligations to accomplish the activities in subparagraphs (A) and (B); and

(2) The vulnerable adult appears to lack sufficient understanding or capacity to make or communicate responsible decisions and appears to be exposed to a situation or condition that poses an immediate risk of death or serious physical harm.

"Sexual abuse" means nonconsensual sexual contact or conduct caused by another person, including but not limited to:

(1) Sexual assault, molestation, sexual fondling, incest, or prostitution; or

(2) Pornographic photographing, filming, or depiction.

"Vulnerable adult" means a person eighteen years of age or older who, because of mental, developmental, or physical impairment, is unable to:

(1) Communicate or make responsible decisions to manage the person's own care or resources;

(2) Carry out or arrange for essential activities of daily living; or

(3) Protect oneself from abuse, as defined in this part.

[L 1989, c 381, pt of §1; am L 1990, c 144, §1 and c 234, §1; am L 2008, c 154, §4]

Previous Chapter 346 Next

§346-224 Reports. (a) The following persons who, in the performance of their professional or official duties, know or have reason to believe that a vulnerable adult has incurred abuse or is in danger of abuse if immediate action is not taken shall promptly report the matter orally to the department:

(1) Any licensed or registered professional of the healing arts and any health-related occupation who examines, treats, or provides other professional or specialized services to a vulnerable adult, including physicians, physicians in training, psychologists, dentists, nurses, osteopathic physicians and surgeons, optometrists, chiropractors, podiatrists, pharmacists, and other health-related professionals;

(2) Employees or officers of any public or private agency or institution providing social, medical, hospital, or mental health services, including financial assistance;

(3) Employees or officers of any law enforcement agency, including the courts, police departments, correctional institutions, and parole or probation offices;

(4) Employees or officers of any adult residential care home, adult day care center, or similar institution;

(5) Medical examiners or coroners; and

(6) Social workers licensed pursuant to chapter 467E and non-licensed persons employed in a social worker position pursuant to section 467E-6(2).

(b) The initial oral report required by subsection (a) shall be followed as soon as possible by a written report to the department; provided that if a police department is the initiating agency, a written report shall not be required unless the police department declines to take further action and the department informs the police department that the department intends to investigate the oral report of abuse. A written report shall contain:

(1) The name and address of the vulnerable adult, if known;

(2) The name and address of the party who is alleged to have committed or been responsible for the abuse, if known;

(3) The nature and extent of the vulnerable adult's injury or harm; and

(4) Any other information the reporter believes may be helpful in establishing the cause of the abuse.

(c) This section shall not prohibit any person from reporting an incident that the person has reason to believe involves abuse that came to the person's attention in a private

or nonprofessional capacity.

(d) Any person not enumerated in subsection (a) who has reason to believe that a vulnerable adult has incurred abuse or is in danger of abuse if immediate action is not taken may report the matter orally to the department.

(e) Any person who knowingly fails to report as required by this section or who wilfully prevents another person from reporting pursuant to this section shall be guilty of a petty misdemeanor.

(f) The department shall maintain a central registry of reported cases.

(g) Nothing in this section shall require a member of the clergy to report communications that are protected under rule 506 of the Hawaii rules of evidence. [L 1989, c 381, pt of §1; am L 1990, c 144, §1 and c 234, §2; am L 2008, c 154, §6; am L 2015, c 35, §9]

Law Journals and Reviews

Elder Abuse and Laws to Protect Older Persons in Hawaii. 15 HBJ, no. 13, at 93 (2013).

Holding Hawai‘i Nursing Facilities Accountable for the Inadequate Pain Management of Elderly Residents. 27 UH L. Rev. 233 (2004).

Previous Chapter 346 Next

§346-231 Order for immediate protection. (a) If the department believes that a person is a vulnerable adult and it appears probable that the vulnerable adult has incurred abuse or is in danger of abuse if immediate action is not taken and the vulnerable adult consents, or if the vulnerable adult does not consent and there is probable cause to believe that the vulnerable adult lacks the capacity to make decisions concerning the vulnerable adult's person, the department may seek an order for immediate protection in accordance with this section.

(b) A finding of probable cause may be based in whole or in part upon hearsay evidence when direct testimony is unavailable or when it is demonstrably inconvenient to summon witnesses who will be able to testify to facts from personal knowledge.

(c) Upon finding that the person is a vulnerable adult and that there is probable cause to believe that the vulnerable adult has incurred abuse or is in danger of abuse if immediate action is not taken and the vulnerable adult consents, or if the vulnerable adult does not consent and there is probable cause to believe that the vulnerable adult lacks the capacity to make decisions concerning the vulnerable adult's person, the court shall issue an order for immediate protection. This order may include:

(1) An authorization for the department to transport the person to an appropriate medical or care facility;
(2) An authorization for medical examinations;
(3) An authorization for emergency medical treatment; and
(4) Any other matters as may prevent immediate abuse, pending a hearing under section 346-232.

(d) The court may also make orders as may be appropriate to third persons, including temporary restraining orders, enjoining them from:

(1) Removing the vulnerable adult from the care or custody of another;
(2) Actions that would result in abuse of the vulnerable adult;
(3) Living at the vulnerable adult's residence;
(4) Contacting the vulnerable adult in person or by telephone;
(5) Selling, removing, or otherwise disposing of the vulnerable adult's personal property;
(6) Withdrawing funds from any bank, savings and loan association, credit union, or other financial institution, or from a stock account in which the vulnerable adult has an interest;
(7) Negotiating any instruments payable to the vulnerable

adult;

(8) Selling, mortgaging, or otherwise encumbering any interest that the vulnerable adult has in real property;

(9) Exercising any powers on behalf of the vulnerable adult by representatives of the department, any court-appointed guardian or guardian ad litem, or any official acting on the vulnerable adult's behalf; and

(10) Engaging in any other specified act that, based upon the facts alleged, would constitute harm or present a danger of immediate harm to the vulnerable adult or would cause the loss of the vulnerable adult's property.

(e) Court orders under section 346-232 and this section may be obtained upon oral or written application by the department, without notice and without a hearing. Any oral application shall be reduced to writing within twenty-four hours. The court may issue its order orally; provided that it shall reduce the order to writing as soon as possible thereafter and in any case not later than twenty-four hours after the court received the written application. Certified copies of the application and order shall be personally served upon the vulnerable adult and any other person or entity affected by the order together with the notice of the order to show cause hearing in section 346-232.

(f) If a written order for immediate protection is issued, the department shall file a petition invoking the jurisdiction of the court under this part within twenty-four hours. [L 1989, c 381, pt of §1; am L 1990, c 144, §1 and c 234, §4; am L 2008, c 154, §13; am L 2016, c 22, §1]

Case Notes

This section did not provide a jurisdictional basis for an order to void a will in another action sought by a party other than the department of human services where this chapter makes clear that this statute is for the benefit of the department and does not create a right to proceed for private litigants. 110 H. 8, 129 P.3d 511 (2006).

§350-1 Definitions. For the purposes of this chapter, unless the context specifically indicates otherwise:

"Child" means a person who is born alive and is less than eighteen years of age.

"Child abuse or neglect" means:

(1) The acts or omissions of any person who, or legal entity which, is in any manner or degree related to the child, is residing with the child, or is otherwise responsible for the child's care, that have resulted in the physical or psychological health or welfare of the child, who is under the age of eighteen, to be harmed, or to be subject to any reasonably foreseeable, substantial risk of being harmed. The acts or omissions are indicated for the purposes of reports by circumstances that include but are not limited to:

(A) When the child exhibits evidence of:

(i) Substantial or multiple skin bruising or any other internal bleeding;

(ii) Any injury to skin causing substantial bleeding;

(iii) Malnutrition;

(iv) Failure to thrive;

(v) Burn or burns;

(vi) Poisoning;

(vii) Fracture of any bone;

(viii) Subdural hematoma;

(ix) Soft tissue swelling;

(x) Extreme pain;

(xi) Extreme mental distress;

(xii) Gross degradation; or

(xiii) Death; and

such injury is not justifiably explained, or when the history given concerning such condition or death is at variance with the degree or type of such condition or death, or circumstances indicate that such condition or death may not be the product of an accidental occurrence;

(B) When the child has been the victim of sexual contact or conduct, including but not limited to sexual assault as defined in the Penal Code, molestation, sexual fondling, incest, or prostitution; obscene or pornographic photographing, filming, or depiction; or other similar forms of sexual exploitation, including but not limited to acts that constitute an offense pursuant to section 712-1202(1)(b);

(C) When there exists injury to the psychological capacity of a child as is evidenced by an observable and substantial impairment in the child's ability to function;

(D) When the child is not provided in a timely manner with adequate food, clothing, shelter, psychological care, physical care, medical care, or supervision;

(E) When the child is provided with dangerous, harmful, or detrimental drugs as defined by section 712-1240; provided that this subparagraph shall not apply when such drugs are provided to the child pursuant to the direction or prescription of a practitioner, as defined in section 712-1240; or

(F) When the child has been the victim of labor trafficking under chapter 707; or

(2) The acts or omissions of any person that have resulted in sex trafficking or severe forms of trafficking in persons; provided that no finding by the department pursuant to this chapter shall be used as conclusive evidence that a person has committed an offense under part VIII of chapter 707 or section 712-1202.

"Department" means the department of human services.

"Electronic medium" means any recording, synthetic media, magnetic disc memory, magnetic tape memory, compact disk, digital video disk, thumb drive, or any other data recording hardware or media used with a computer.

"Report" means the initial oral statement and, if required by section 350-1.1(c), the subsequent written account concerning the facts and circumstances which cause a person to have reason to believe that child abuse or neglect has occurred or that there exists a substantial risk that child abuse or neglect may occur in the reasonably foreseeable future.

"Severe forms of trafficking in persons" has the same meaning as provided in title 22 United States Code Annotated section 7102(9).

"Sex trafficking" has the same meaning as provided in title 22 United States Code Annotated section 7102(10). [L 1982, c 77, §1; am L 1983, c 171, §5; am L 1987, c 204, §3 and c 339, §4; am L 1988, c 141, §29; am L 2013, c 246, §3; am L 2017, c 16, §2; am L 2020, c 35, §2]

Revision Note

Pursuant to §23G-15, in:

(1) Paragraphs (1) to (4) of the definition of "child abuse

or neglect", "or" deleted; and

(2) The definition of "report", section "350-1.1(c)" substituted for "350-1.1(d)".

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§350-1.1 Reports. (a) Notwithstanding any other state law concerning confidentiality to the contrary, the following persons who, in their professional or official capacity, have reason to believe that child abuse or neglect has occurred or that there exists a substantial risk that child abuse or neglect may occur in the reasonably foreseeable future, shall immediately report the matter orally to the department or to the police department:

(1) Any licensed or registered professional of the healing arts or any health-related occupation who examines, attends, treats, or provides other professional or specialized services, including but not limited to physicians, including physicians in training, psychologists, dentists, nurses, osteopathic physicians and surgeons, optometrists, chiropractors, podiatrists, pharmacists, and other health-related professionals;

(2) Employees or officers of any public or private school;

(3) Employees or officers of any public or private agency or institution, or other individuals, providing social, medical, hospital, or mental health services, including financial assistance;

(4) Employees or officers of any law enforcement agency, including but not limited to the courts, police departments, department of public safety, correctional institutions, and parole or probation offices;

(5) Individual providers of child care, or employees or officers of any licensed or registered child care facility, foster home, or similar institution;

(6) Medical examiners or coroners;

(7) Employees of any public or private agency providing recreational or sports activities;

(8) Commercial film and photographic print or image processors;

(9) Commercial computer technicians; and

(10) Members of the clergy or custodians of records therefor; provided that a member of the clergy shall not be required to report information gained solely during a penitential communication. When a clergy member receives reportable information from any other source, the clergy member shall comply with the reporting requirements of this section, regardless of whether the clergy member received the same information during a penitential communication. For purposes of this paragraph, "penitential

communication" means a communication, including a sacramental confession, that is intended to be kept confidential and is made to a member of the clergy who, in the course of the discipline or practice of the applicable religious organization, is authorized or accustomed to hear those communications, and under the discipline, tenets, customs, or practices of the applicable religious organization, has a duty to keep those communications secret.

(b) Whenever a person designated in subsection (a) is a member of the staff of any public or private school, agency, or institution, that staff member shall immediately report the known or suspected child abuse or neglect directly to the department or to the police department and also shall immediately notify the person in charge or a designated delegate of the report made in accordance with this chapter.

(c) The initial oral report shall be followed as soon as possible by a report in writing to the department; provided that:

(1) If a police department or the department of public safety is the initiating agency, a written report shall be filed with the department for cases that the police or the department of public safety takes further action on or for active cases in the department under this chapter;

(2) All written reports shall contain the name and address of the child and the child's parents or other persons responsible for the child's care, if known, the child's age, the nature and extent of the child's injuries, and any other information that the reporter believes might be helpful or relevant to the investigation of the child abuse or neglect; and

(3) This subsection shall not be construed to serve as a cause of action against the department, the police, or the department of public safety.

(d) Any person subject to subsection (a), upon demand of the department or any police department, shall provide all information related to the alleged incident of child abuse or neglect, including but not limited to medical records and medical reports and any image, film, video, or other electronic medium, that was not included in the written report submitted pursuant to subsection (c).

(e) The director may adopt, amend, or repeal rules, subject to chapter 91, to further define or clarify the specific forms of child abuse or neglect enumerated in section 350-1 for use in implementing this chapter; provided that rules adopted under this subsection shall be limited to such further or clarifying definitions. [L 1967, c 261, §2; HRS §350-1; am L

1970, c 21, §1 and c 105, §5; am L 1975, c 147, §1; am L 1977, c 81, §2; am L 1979, c 171, §1; am L 1981, c 59, §1; ren and am L 1982, c 77, §2; am L 1985, c 17, §1 and c 208, §3; am L 1987, c 204, §4 and c 339, §4; am L 1988, c 323, §2; am L 1998, c 134, §4; am L 1999, c 271, §4; am L 2000, c 248, §1; am L 2006, c 159, §1 and c 193, §2; am L 2020, c 35, §3]

Cross References

Child abuse, see chapter 707, part VI.

Case Notes

Cited: 711 F. Supp. 2d 1195 (2010).

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§350-1.2 Nonreporting; penalty. Any person subject to section 350-1.1(a) who knowingly prevents another person from reporting, or who knowingly fails to provide information as required by section 350-1.1(c) or (d), shall be guilty of a petty misdemeanor. [L 1985, c 17, §3; am L 1987, c 204, §5 and c 339, §4]

Case Notes

Cited: 711 F. Supp. 2d 1195 (2010).

Previous Chapter 35 Next

[§350-1.3] Any person may report. Any person, not otherwise required to report pursuant to section 350-1.1, who becomes aware of facts or circumstances which cause that person to have reason to believe that child abuse or neglect has occurred or that there exists a substantial risk that child abuse or neglect may occur in the reasonably foreseeable future, may immediately report the matter orally to the department or to the police department. [L 1987, c 204, §1]

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§350-1.4 Confidentiality. (a) All reports to the department concerning child abuse or neglect made pursuant to this chapter, as well as all records of such reports, are confidential. The director may adopt rules, pursuant to chapter 91, to provide for the confidentiality of reports and records and for the authorized disclosure of reports and records. Any person who intentionally makes an unauthorized disclosure of a report or record of a report made to the department shall be guilty of a misdemeanor.

(b) Every reasonable good faith effort shall be made by the department to maintain the confidentiality of the name of a reporter who requests that the reporter's name be confidential.

(c) Notwithstanding subsection (a) and section 346-10, the director may adopt rules pursuant to chapter 91 to provide for the release of information required by federal statute or regulation. [L 1987, c 204, §2; am L 1999, c 34, §2]

Previous Chapter 35 Next

§350-2 Action on reporting. (a) Upon receiving a report concerning child abuse or neglect, the department shall proceed pursuant to chapter 587A and the department's rules.

(b) The department shall inform the appropriate police department of all reports received by the department regarding a case of child abuse or neglect, including reports received under section 350-1.1; provided that the name of the person who reported the case of child abuse or neglect shall be released to the police department pursuant only to court order or the person's consent.

(c) The department shall inform the appropriate police department or office of the prosecuting attorney of the relevant information concerning a case of child abuse or neglect when the information is required by the police department or the office of the prosecuting attorney for the investigation or prosecution of that case; provided that the name of the person who reported the case of child abuse or neglect shall be released to the police department or the office of the prosecuting attorney pursuant only to court order or the person's consent.

(d) The department shall maintain a central registry of reported child abuse or neglect cases and shall promptly expunge the reports in cases if:

(1) The report is determined not confirmed by the department, an administrative hearing officer, or a Hawaii state court on appeal; or

(2) The petition arising from the report has been dismissed by order of the family court after an adjudicatory hearing on the merits pursuant to chapter 587A.

Records and information contained in a report that is expunged may be retained by the department solely for future risk and safety assessment purposes.

(e) For a confirmed case of child abuse or neglect that occurred at a licensed or registered child care facility as defined in section 346-151, the department is authorized to disclose that the report of child abuse or neglect was confirmed to any parent or guardian of a child who was enrolled at the licensed or registered child care facility as defined in section 346-151.

(f) For a confirmed case of child abuse or neglect that occurred at a child care facility as defined in section 346-151 that is operating in accordance with an exclusion or exemption pursuant to section 346-152 and upon receipt of consent, the department is authorized to disclose the report of child abuse or neglect was confirmed to any parent or guardian of a child who was enrolled at the child care facility.

(g) For a confirmed case of child abuse or neglect that results in a child's death or near fatality, the department is authorized to disclose to the public:

(1) The cause of and circumstances regarding the fatality or near fatality;

(2) The age and gender of the child;

(3) Information describing any previous reports and results of child abuse or neglect investigations that are pertinent to the child abuse or neglect that led to the fatality or near fatality; and

(4) The action taken by the department on behalf of the child that is pertinent to the child abuse or neglect that led to the fatality or near fatality.

(h) The department shall adopt rules as may be necessary in carrying out this section. [L 1967, c 261, §3; HRS §350-2; am L 1970, c 105, §5; am L 1987, c 204, §6 and c 339, §4; am L 1991, c 123, §1; am L 1998, c 134, §5; am L 1999, c 271, §5; am L 2010, c 135, §7; am L 2017, c 16, §3; am L 2018, c 176, §1; am L 2019, c 85, §1]

Cross References

Rulemaking, see chapter 91.
Vexatious litigants, see chapter 634J.

Case Notes

Cited: 711 F. Supp. 2d 1195 (2010).

§350-3 Immunity from liability. (a) Anyone participating in good faith in the making of a report pursuant to this chapter shall have immunity from any liability, civil or criminal, that might be otherwise incurred or imposed by or as a result of the making of such report, including persons who otherwise provide information or assistance, including medical evaluations or consultation, in connection with a report, investigation, or legal intervention pursuant to a good faith report of child abuse or neglect. Any such participant shall have the same immunity with respect to participation in any judicial proceeding resulting from such report.

(b) Any individual who assumes a duty or responsibility pursuant to section 350-2 or chapter 587A shall have immunity from civil liability for acts or omissions performed within the scope of the individual's duty or responsibility. Nothing in this section shall limit the liability of the department, any other state agency, or any private organization for the conduct of individuals provided immunity herein. [L 1967, c 261, §4; HRS §350-3; am L 1986, c 229, §1; am L 1987, c 204, §7 and c 339, §4; am L 2010, c 135, §7; am L 2021, c 26, §2]

Case Notes

Cited: 711 F. Supp. 2d 1195 (2010).

Previous Chapter 35 Next

§350-5 Admissibility of evidence. The physician-patient privilege, the psychologist-client privilege, the spousal privilege, and the victim-counselor privilege shall not be grounds for excluding evidence in any judicial proceeding resulting from a report of child abuse or neglect pursuant to this chapter. [L 1967, c 261, §6; HRS §350-5; am L 1987, c 204, §8; am L 1992, c 217, §3]

Cross References

Physician-patient privilege, see §626-1, rule 504.
Psychologist-client privilege, see §626-1, rule 504.1.
Spousal privilege, see §626-1, rule 505.
Victim-counselor privilege, see §626-1, rule 505.5.

Previous Chapter 35 Next

§453-14 Duty of physician, osteopathic physician, surgeon, hospital, clinic, etc., to report wounds. (a) Every physician, osteopathic physician, physician assistant, and surgeon attending or treating a case of knife wound, bullet wound, gunshot wound, powder burn, or any injury that would seriously maim, produce death, or has rendered the injured person unconscious, caused by the use of violence or sustained in a suspicious or unusual manner or in motor vehicle collisions resulting in serious injury or death, or, whenever the case is treated in a hospital, clinic, or other institution, the manager, superintendent, or person in charge thereof, shall report the case or provide requested information to the chief of police of the county within which the person was attended or treated, giving the name of the injured person, description of the nature, type, and extent of the injury, together with other pertinent information that may be of use to the chief of police. As used herein, the term "chief of police" means the chief of police of each county and any of the chief's authorized subordinates.

(b) This section shall not apply to wounds, burns, or injuries received by a member of the armed forces of the United States or of the State while engaged in the actual performance of duty.

(c) Any person who fails to make the report called for herein within twenty-four hours after the attendance or treatment shall be fined not less than $50 nor more than $500.

[L 1933-34, c 27, §§1, 2; RL 1935, §1202; am L 1943, c 23, §1; RL 1945, §2513; am L 1955, c 110, §1; RL 1955, §64-13; HRS §453-14; am L 1983, c 92, §1(10); am L 2005, c 39, §1; am L 2008, c 5, §16; am L 2009, c 151, §19]

Cross References

Report of child abuse, see chapter 350.

Previous Chapter 453 Next

BAR CODE # _____ **POLICE REPORT #** _____

HAWAII STATE
MEDICAL-LEGAL RECORD AND SEXUAL ASSAULT INFORMATION FORM

ADOLESCENT AND ADULT

Date: _____ Patient Name: _____

Gender Identity reported by patient: ☐ M ☐ F ☐ Transgender (MTF) ☐ Transgender (FTM) ☐ Other: _____

Time In: _____ AM / PM

Time Out: _____ AM / PM DOB: _____

Age: _____ Ethnicity: _____

Accompanied patient to exam site/relationship: _____

Present during the exam/relationship: _____

Height: _____ Temp: _____ Resp: _____

Weight: _____ Pulse: _____ B/P: _____ Glasses/Contacts: _____ Yes _____ No

Victim Rights Notification Form Provided : ☐ _____ Signature of person completing the above information

THIS PORTION TO BE COMPLETED BY EXAMINER IN ATTENDANCE

HEALTH HISTORY

1A. **PAST HISTORY**

Major Illnesses / Disabilities: _____

Drug Allergies: _____

Medications: _____

Pre-existing physical injuries: _____

Pertinent medical history of anal-genital injuries, surgeries, diagnostic procedures, or medical treatment:

_____

History of Hepatitis B Vaccination: _____ Yes _____ No _____ Unknown

FEMALES: Age of Menarche: _____

Menstrual History: Regular / Irregular: _____ Cycle: _____ (days) LMP: _____

Last Pelvic Exam: _____ Gravidity: _____ Parity: _____

Hysterectomy: _____ Tubal Ligation: _____

Current Contraception: _____

1B. **PATIENT HISTORY**

Is the patient able to answer question(s) pertaining to the assault? _____ Yes _____ No

If no, explain: _____

_____

Name of person providing history: _____

Relationship to Patient: _____

Sexual penetration/contact within past 120 hours, other than this assault: Yes ____ No ____ Unable to discuss ____

Condom used: ____ Yes ____ No

Date / Time / Location of assault: _____

_____ Less than 120 hours since assault took place _____ Over 120 hours since assault took place

BAR CODE # _____ **POLICE REPORT #** _____

Number of perpetrator(s): _____

Name(s) and age(s) of perpetrator(s) if known: _____

Relationship of perpetrator(s) to patient: _____

2. Since assault, check (√) if patient has:

_____ Drank / Eaten	_____ Brushed Teeth	_____ Defecated
_____ Changed Clothes	_____ Used Mouthwash	_____ Douched
_____ Been Swimming	_____ Vomited	_____ Removed / inserted tampon, sponge, diaphragm (circle)
_____ Bathed / Showered	_____ Urinated	

3. SUMMARY OF PRESENTING COMPLAINTS, SYMPTOMS AND HISTORY:

COMPLAINTS / HISTORY (Incident)

SUMMARY OF PRESENTING COMPLAINTS, SYMPTOMS AND HISTORY: (Continued)

BAR CODE # _____ **POLICE REPORT #** _____

4. ACTS DESCRIBED:

___ Unable to obtain detailed history because of:

___ developmental age ___ altered mental status

Describe:	Described by: P = Patient / H = Historian				
	Yes	No	Attempted	Unknown	N/A
Penetration of genital opening by:					
Penis:					
Finger:					
Foreign object:					
Describe object:					
Penetration of anus by:					
Penis:					
Finger:					
Foreign object:					
Describe object:					
Oral contact of genitals:					
Of patient's genitals by perpetrator:					
Of perpetrator's genitals by patient:					
Oral contact of anus:					
Of patient's anus by perpetrator:					
Of perpetrator's anus by patient:					
Physical contact: genitals, anus, breasts, buttocks, and/or other (circle)					
If other, specify location:					
Of patient by perpetrator:					
Of perpetrator by patient:					
Of perpetrator by perpetrator:					
Ejaculation:					
Inside of body orifice:					
Outside of body orifice:					
Specify location:					
Kissing / licking:					
Specify location:					

5. METHODS EMPLOYED BY PERPETRATOR:

	Described by: P = Patient / H = Historian		
	Yes	**No**	**Unknown**
Weapons used:			
Type of weapon:			
Physical blows:			
Specify location:			
Specify what was used:			
Strangulation: **If "Yes" complete Appendix A – Strangulation Supplemental**			
Grabbing / grasping / holding (circle):			
Specify location:			
Physical restraints:			
Specify location:			
Specify what was used:			
Bites / suction:			
Specify location:			
Threat(s) of harm:			
To whom:			
Type of threat(s):			
Other: (Describe)			
DID PERPETRATOR:			
Claim vasectomy / sterile:			
Use a condom:			
Use a lubricant:			
Clean self after assault:			
Describe what was used:			

6. MENTAL STATUS EXAMINATION

1. GENERAL DESCRIPTION

a) Appearance (example: clean, well-groomed, dirty, disheveled):

b) Behavior (example: cooperative, combative, sleepy):

c) Mood (example: quiet, depressed, angry):

d) Orientation (to person, place, time):

2. PATIENT CONCERNS

a) Medical:

b) Non-Medical:

SYMPTOMS:

Described by P = Patient / H = Historian
DNI = Did Not Inquire

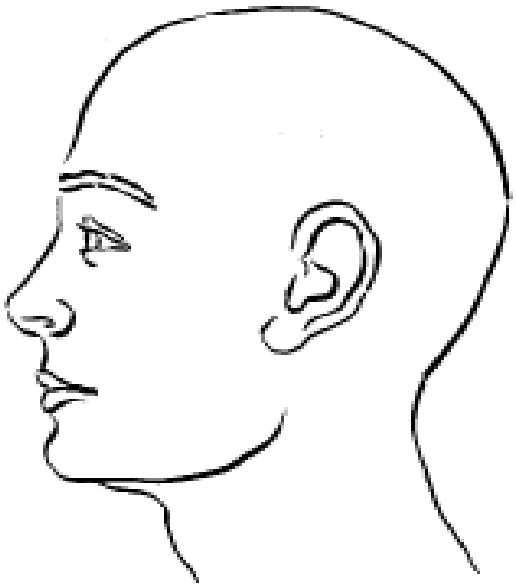
	Yes	No	DNI
Abdominal / pelvic pain			
Genital discomfort / pain			
Dysuria			
Enuresis (day or night)			
Encopresis (incontinent of stool)			
Vaginal / Penile itching			
Vaginal / Penile discharge			
Describe color, odor and amount:			

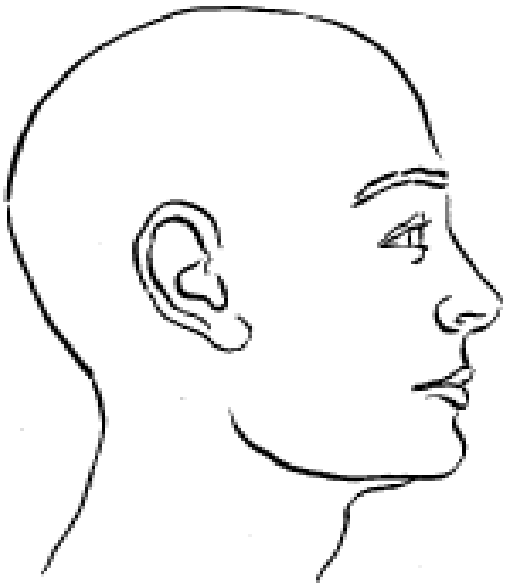
	Yes	No	DNI
Vaginal / Penile bleeding			
Anal / rectal pain			
Anal / rectal bleeding			
Anal / rectal discharge			
Constipation			
Loss of consciousness			
Vomiting			
Physical injuries, pain or tenderness			
Describe:			

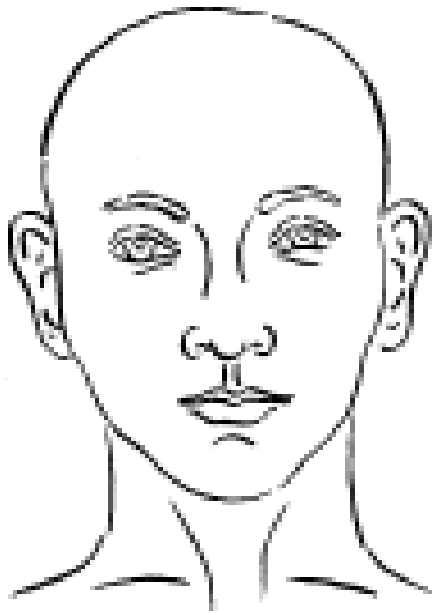
7. PHYSICAL FINDINGS OF FACE AND MOUTH: (Document location and include all signs of tenderness and trauma)

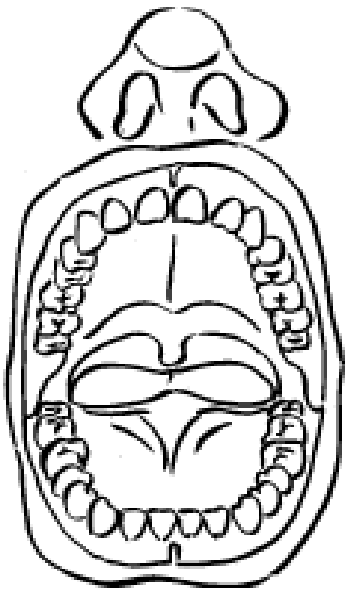
A = Abrasion
B = Bite
BR = Bruise
BU = Burn
E = Erythema
FM = Foreign Material
L = Laceration
P = Petechiae
R = Rash
S = Scar
SW = Swelling / Edema
T = Tenderness
OI = Other Injury (Describe)

Photos ___ Yes ___ No







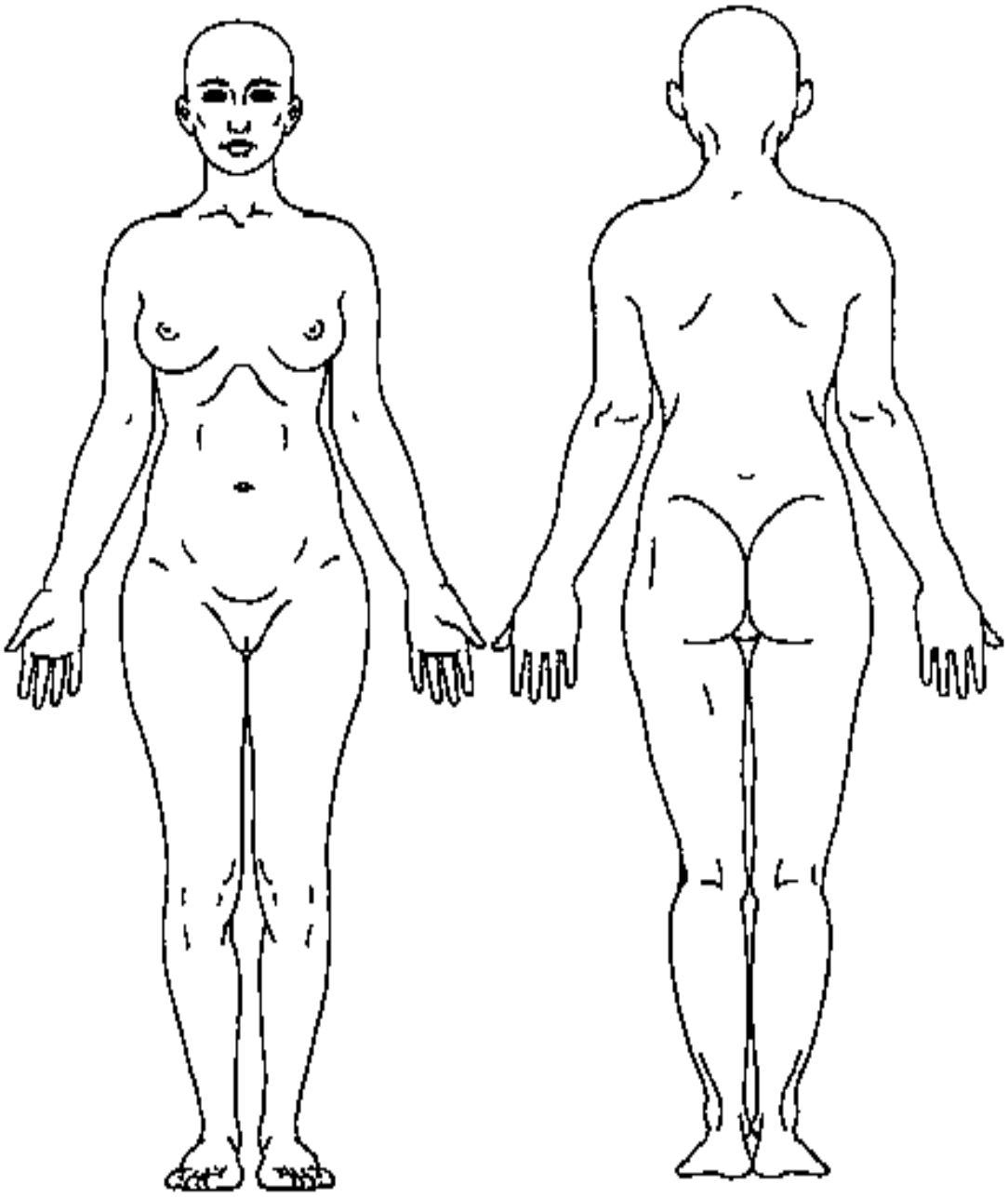


POLICE REPORT # _____

PHYSICAL FINDINGS OF FEMALE: (Document location and include all signs of tenderness and trauma)

A = Abrasion
B = Bite
BR = Bruise
BU = Burn
E = Erythema
FM = Foreign Material
L = Laceration
P = Petechiae
R = Rash
S = Scar
SW = Swelling / Edema
T = Tenderness
OI = Other Injury (Describe)

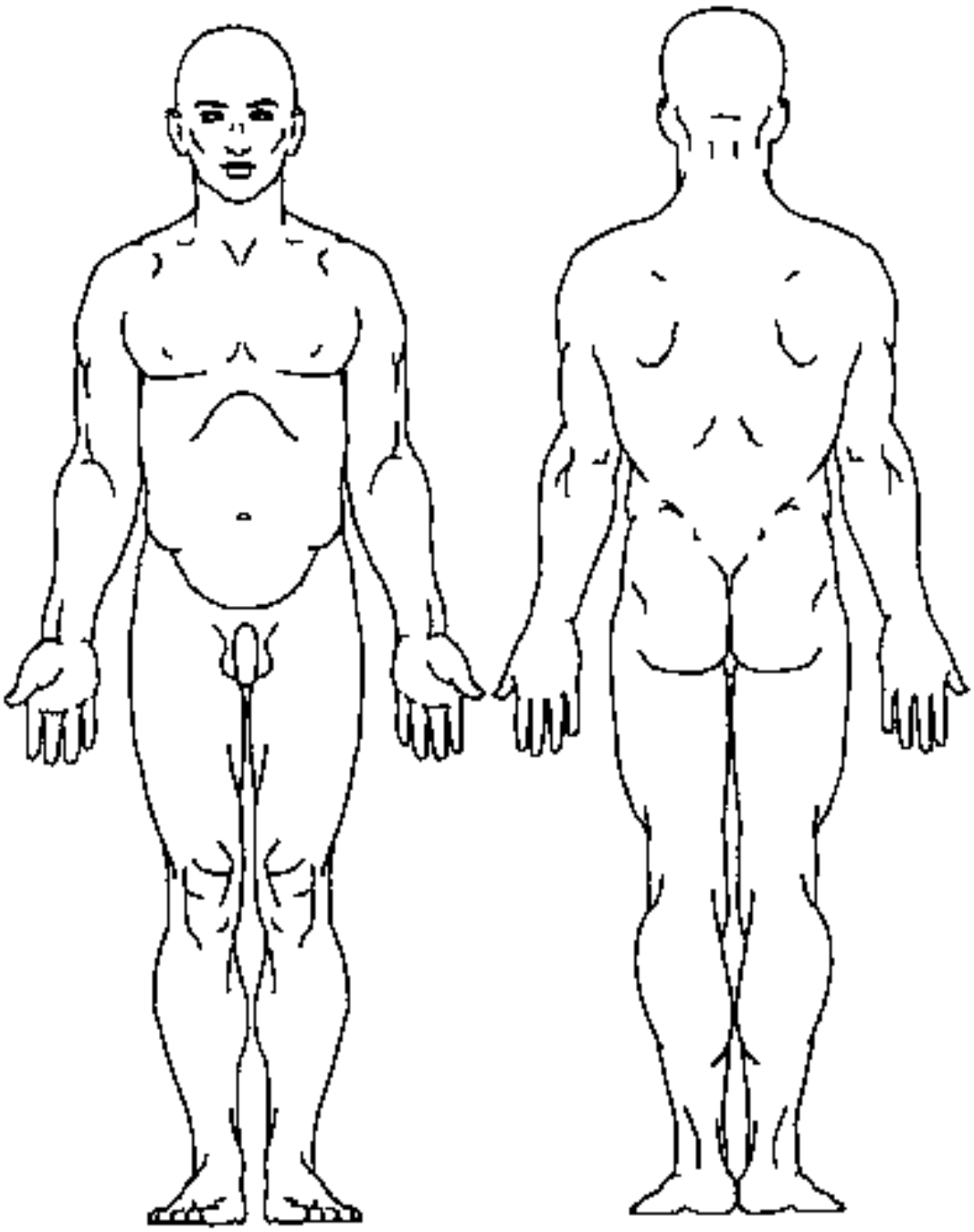
Body Photos ____ Yes ____ No



PHYSICAL FINDINGS OF MALE: (Document location and include all signs of tenderness and trauma)

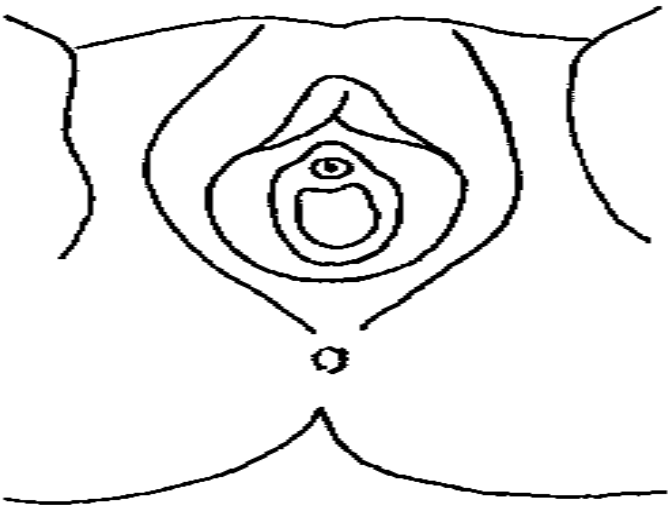
A = Abrasion
B = Bite
BR = Bruise
BU = Burn
E = Erythema
FM = Foreign Material
L = Laceration
P = Petechiae
R = Rash
S = Scar
SW = Swelling / Edema
T = Tenderness
OI = Other Injury (Describe)

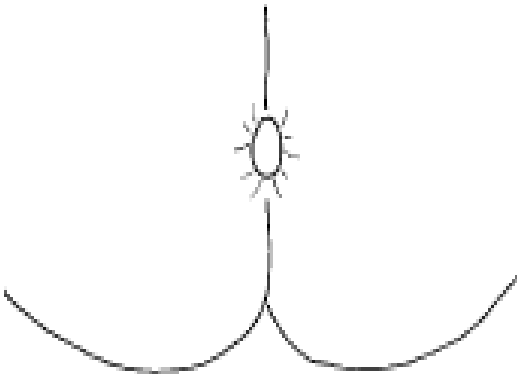
Body Photos ____ Yes ____ No

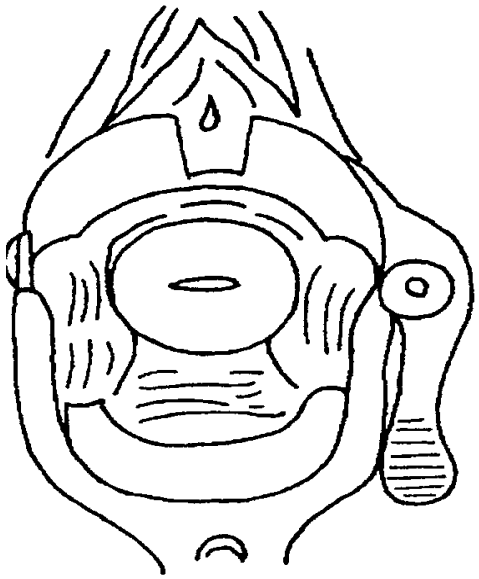


8. PHYSICAL EXAMINATION OF FEMALE – Include all signs of tenderness, trauma, discharge and scars. Illustrate signs of trauma and document sites of fluorescence.

Was Speculum used: ____ Yes ____ No







Genital/ Anogenital Photographs ____ Yes ____ No

Genital/ Anogenital Photographs with Toluidine Blue ____ Yes ____ No

Additional Comments: _____

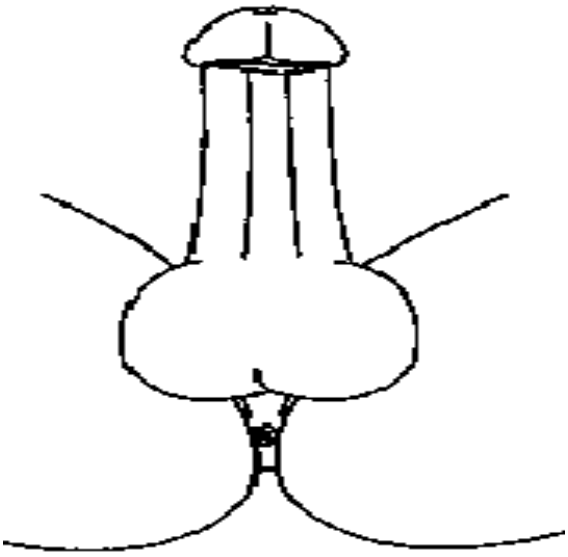
Fluorescence

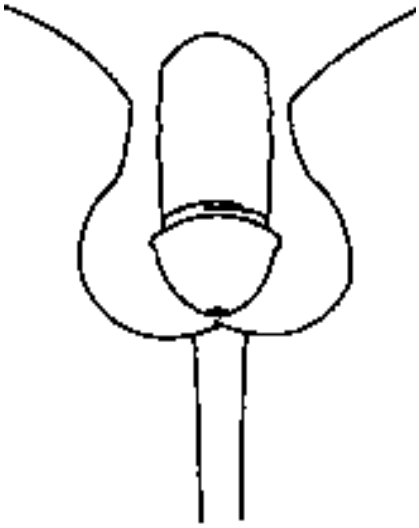
Alternate Light Source ____ Yes ____ No

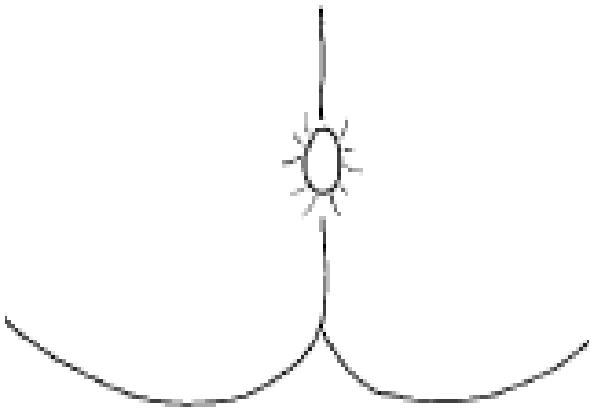
Was fluorescence observed ____ Yes ____ No

List sites: _____

PHYSICAL EXAMINATION OF MALE – Include all signs of tenderness, trauma, discharge and scars. Illustrate signs of trauma and document sites of fluorescence.







Genital/ Anogenital Photographs _____ Yes _____ No

Genital/ Anogenital Photographs with Toluidine Blue _____ Yes _____ No

Additional Comments: _____

Fluorescence

Alternate Light Source _____ Yes _____ No

Was fluorescence observed _____ Yes _____ No

List sites: _____

Photograph Inventory (optional):

Identification of areas photographed (e.g., right cheek, right thigh, left arm, vulva, vagina, hymen, etc.)

9. ANAL-GENITAL CHART:

FEMALE / MALE GENERAL

Tanner Stage											
Female:						**Male:**					
Breast	1	2	3	4	5	Genitals	1	2	3	4	5
Pubic Hair N/A	1	2	3	4	5	Pubic Hair N/A	1	2	3	4	5

	WNL	ABN	Not Examined	Describe
Inguinal adenopathy				
Medial aspect of thighs				
Perineum				
Vulvovaginal discharge				
Urethral discharge				
Anal discharge				

FEMALE	WNL	ABN	Not Examined	Describe
Labia majora				
Clitoris				
Labia minora				
Periurethral tissue/urethral meatus				
Hymen				
Posterior fourchette				
Fossa navicularis				
Vagina				
Cervix				
Other (describe):				

Genital exam position used: (check all that apply):
____ Supine Lithotomy ____ Supine Frog-legged ____ Supine Knee Chest ____ Prone Knee Chest

MALE	WNL	ABN	Not Examined	Describe
Penis Circumcised ___ Yes ___ No				
Urethral Meatus (e.g., discharge, redness)				
Scrotum				
Testes				
Other (describe):				
FEMALE / MALE ANUS	WNL	ABN	Not Examined	Describe
Buttocks				
Perianal skin				
Anal verge / folds / rugae				
Anal tone (e.g., spasm,laxity)				
Rectal ampulla				
Other (describe):				

Genital Exam done with: _____ Direct Visualization _____ Digital Imaging System

Method of exam for anal tone: _____ Observation _____ Digital Exam

Anal exam position used: _____ Supine _____ Prone _____ Lateral recumbent

10. EXAMINATION FINDINGS:

Physical examination reveals:

_____ Physical Findings _____ No Physical Findings

SUMMARY OF PHYSICAL FINDINGS:

____ Oral Trauma ____ Genital Trauma ____ Anal Trauma ____ Other Physical Trauma

_____

_____

_____

_____

_____

PHOTOGRAPHY:

_____ Yes _____ No

HAWAII STATE SEXUAL ASSAULT EVIDENCE COLLECTION KIT USED:

_____ Yes _____ No

FOLLOW – UP:

Check (√) if applicable:

_____ Return for follow-up exam with private health provider or gynecologist
When: _____

_____ Referral for further STI testing if not treated

_____ Follow-up by Department of Human Services – Child Welfare Services (DHS-CWS)

_____ Referral for counseling given

_____ Other: _____

_____ Examiner's Time In: _____ AM / PM
Examiner's Signature

_____ Examiner's Time Out: _____ AM / PM
Examiner's Name (Please Print)

Address and phone number where you can be reached:

Address: _____ Phone: _____

_____

ATTACHMENT A

ATTACHMENT USED: Yes _____ No _____

LABORATORY SPECIMENS

Check (√) if Done:

___Urine Test for Pregnancy: ____ Positive ____ Negative ____ Pending

___ Gonorrhea: ____ Endocervical ____ Vaginal ____ Rectal ____ Penile ____ Oral ____ Urine

___ Chlamydia: ____ Endocervical ____ Vaginal ____ Rectal ____ Penile ____ Urine

___ Herpes: Specify Site: _____

___ Complete Urinalysis

___ Drug Screening

___ HIV Protocol (only to be offered to 13 yrs old and older for exposure within 72 hours)

___ Other: (Specify) _____

WET MOUNT

Wet Mount slide prepared: _____ Yes _____ No

Slide interpreted by examiner: _____ Yes _____ No

Motile sperm observed: _____ Yes _____ No

Non-motile sperm observed: _____ Yes _____ No

Monilia observed _____ Yes _____ No

Trichomonas observed: _____ Yes _____ No

POLICE REPORT # _____

ATTACHMENT B

ATTACHMENT USED: Yes _____ No _____

		Medication Administered / Dispensed By: (Initials)	Info Given for Medication By: (Initials)

PLAN

1. Pregnancy prophylaxis (Emergency Contraception) – **FEMALES**

a) _____ Ulipristal (Ella) 30mg p.o. single dose (Examiner has informed patient of possible risks and side effects of such Rx if pregnancy were to occur) _____ _____

b) _____ Levonorgestrel (Plan B One-Step) 1.5mg p.o. single dose (Examiner has informed patient of possible risks and side effects of such Rx if pregnancy were to occur) _____ _____

c) _____ Not given (patient declined)

_____ Not given (contraindicated)

Reason: _____

2. Sexually transmitted disease prophylaxis / treatment **- ADULTS**

a) Recommended Regimen

_____ Ceftriaxone 500 mg. i.m. single dose _____ _____

PLUS

_____ Metronidazole 500 mg p.o. BID x 7 days _____ _____

PLUS

_____ Doxycycline 100 mg p.o. BID X 7 days (contraindicated in pregnant women) _____ _____

OR

_____ Azithromycin 1 gm p.o. single dose _____ _____

b) Alternative Regimen

_____ Ceftriaxone 500 mg i.m. single dose _____ _____

PLUS

_____ Erythromycin Base 500 mg p.o. QID X 7 days _____ _____

PLUS

_____ Metronidazole 500 mg p.o. BID X 7 days _____ _____

c) _____ Not given (await culture results)

_____ Not given (patient declined)

_____ Not given (other) specify _____

POLICE REPORT # _____

3. HIV Prophylaxis - **ADULTS**

a) _____ Truvada 200 / 300 mg / 1 p.o. everyday #5 _____ _____

_____ Isentress 400 mg / 1 p.o. twice a day # 10 _____ _____

b) _____ Not given (patient declined)

_____ Not given (other) specify _____

4. Hepatitis B Vaccination

a) _____ Given _____ _____

b) Not given (already vaccinated)

Not given (contraindicated)

Not given (patient declined)

_____ Not given (other) specify _____

5. Comfort Medication

a) _____ Acetaminophen 325 mg tablets
Take _____mg p.o. _____ _____

b) _____ Ibuprofen 200 mg tablets
Take _____mg p.o. _____ _____

6. Other: _____

Reason: _____

_____ _____

Administered / Dispensed / Prescribed By (Signature) Date

_____

Print Name

Bar Code # _____ **Police Report #** _____

APPENDIX A: NON-FATAL STRANGULATION / SUFFOCATION SUPPLEMENTAL FORM

Patient Name: _____

Strangulation / Suffocation is a serious event that can occur in the context of sexual assaults. Many times strangulation / suffocation presents **NO VISIBLE INJURIES**. It is important to ask about strangulation / suffocation in all sex assault cases, and document positive disclosure or any signs and symptoms.

NOTE:

- Strangulation is impeding the normal breathing or circulation of the blood by applying pressure on the throat or the neck with any part of the body or ligature;
- Suffocation is impeding normal breathing by blocking the nose and mouth; or applying pressure to the chest.

Was the patient strangled? ☐ No ☐ Yes

How many times did strangulation occur? _____

Why/how did the strangulation stop?_____

How did strangulation occur? (Check all that apply)

☐ Right hand ☐ Left hand ☐ Both hands ☐ Unknown ☐ Chokehold maneuver

☐ Other (describe) _____

What is the measurement of the patient's neck circumference? _____

Describe mannequin demonstration (where applicable)

_____

_____

Was the patient suffocated? ☐ No ☐ Yes

How many times did suffocation occur? _____

Why/how did the suffocation stop?

_____

Pressure on: Nose and Mouth? ☐ No ☐ Yes Chest? ☐ No ☐ Yes (describe)_____

_____

_____

Was the patient shaken during the incident?

☐ No ☐ Yes (describe) _____

Was the patient's head pounded against any object during the incident?

☐ No ☐ Yes (describe) _____

Was the assailant wearing any jewelry on hands or wrists?

☐ Unknown ☐ No ☐ Yes (describe) _____

Describe what the pressure felt like during strangulation and/or suffocation:

_____

_____

What was the patient thinking during the strangulation and/or suffocation?

_____

_____

What did the assailant say before, during, or after the strangulation and/or suffocation?

_____

_____

What was the assailant's demeanor during strangulation and/or suffocation?_____

Signs/Symptoms of Strangulation and/or Suffocation
The following signs/symptoms should be asked about, assessed for and documented in writing, with body mapping, and by photo-imaging (if applicable). **Check ALL that apply.**

Head/Scalp

☐ Petechiae on scalp
☐ Pulled hair
☐ Contusions / bump
☐ Cuts / abrasions
☐ Other _____
☐ Nausea
☐ Vomiting

Face

☐ Red, flushed
☐ Petechiae (Red Spots)
☐ Scratch marks
☐ Cuts / abrasions
☐ Other _____

Eyes & Eyelids

☐ Bloody red eyeball
☐ Petechiae eyeball
  ☐ *Right*
  ☐ *Left*
☐ Petechiae eyelid
  ☐ *Right*
  ☐ *Left*
☐ Ptosis
  ☐ *Right*
  ☐ *Left*
☐ Other _____

Nose

☐ Bloody nose
☐ Broken nose
☐ Petechiae
☐ Cuts / abrasions
☐ Other _____

Ears

☐ Petechiae
  ☐ *Right*
  ☐ *Left*
☐ Bleeding from ear
  ☐ *Right*
  ☐ *Left*
☐ Auditory changes
☐ Cuts / abrasions
☐ Other _____

Mouth

☐ Swollen tongue
☐ Swollen lips
☐ Cut / abrasions
☐ Petechiae
☐ Bruising
☐ Other _____

Neck/Under Chin

☐ Redness
☐ Scratch marks
☐ Cuts / abrasions
☐ Bruises
☐ Neck pain _____ (Pain scale 0–10)
☐ Swelling
☐ Ligature marks
☐ Subcutaneous emphysema
☐ Fingernail impressions
☐ Other _____

Shoulders

☐ Redness
☐ Scratch marks
☐ Bruise(s)
☐ Cuts / abrasions
☐ Other _____

Chest

☐ Redness
☐ Scratch marks
☐ Cuts / abrasions
☐ Bruises
☐ Subcutaneous emphysema
☐ Other _____

Behavioral

☐ Agitation
☐ Combative
☐ Anxiety
☐ Memory disruption
☐ Confusion
☐ Other _____

Neurological

☐ Loss of consciousness
☐ Involuntary urination
☐ Involuntary defecation
☐ Seizures
☐ Headache ____ (Pain scale 0–10)
☐ Dizziness
☐ Faintness
☐ Tinnitus
☐ Visual changes
☐ "Saw Stars" or Spots
☐ Other _____

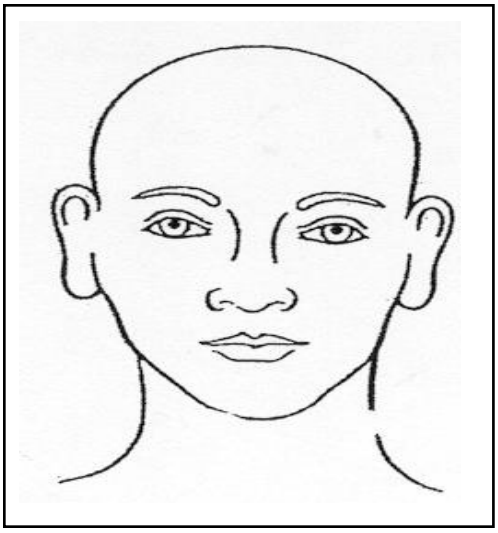
Throat/Voice

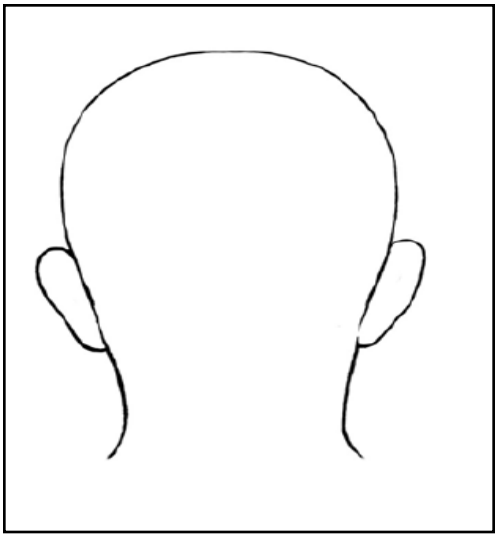
☐ Dysphagia
☐ Odynophagia (painful swallowing)
☐ Dysphasia
☐ Aphasia
☐ Drooling or inability to swallow
☐ Throat pain____ (Pain scale 0–10)
☐ Raspy voice/ hoarseness
☐ Coughing
☐ Change in voice pitch
☐ Other _____

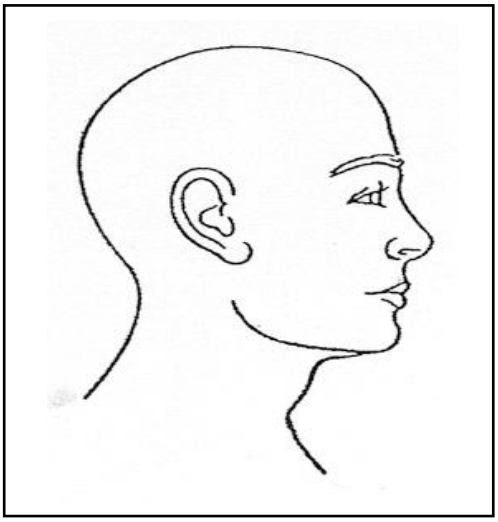
Respiratory

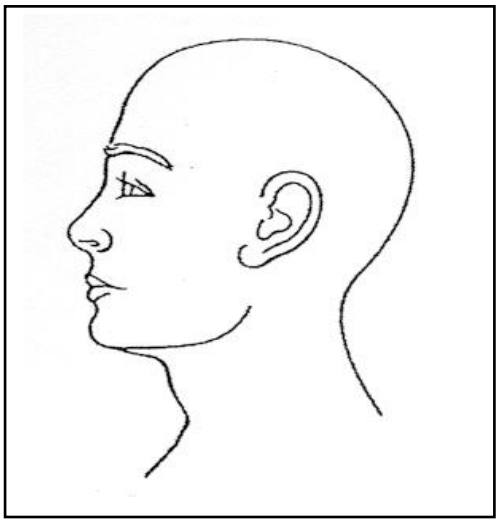
☐ Stridor
☐ Hoarseness
☐ Trouble catching breath
☐ Hyperventiliation
☐ Respiratory Distress
☐ Hemoptysis
☐ Other _____

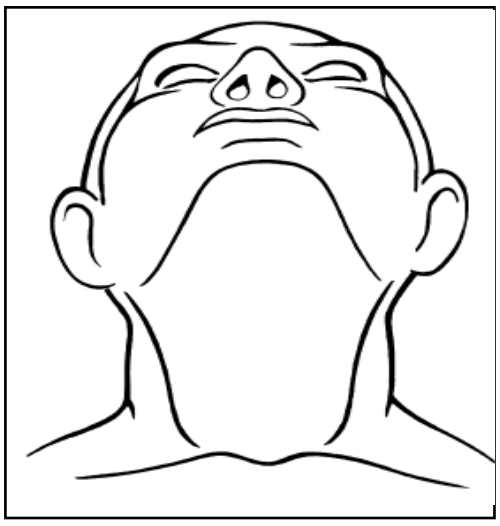
Please indicate all injuries checked above on the body maps below.

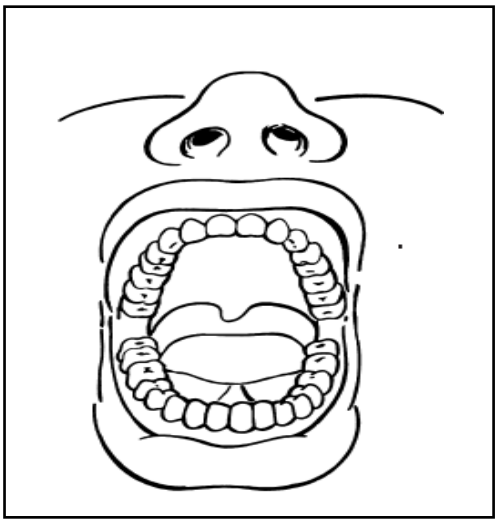




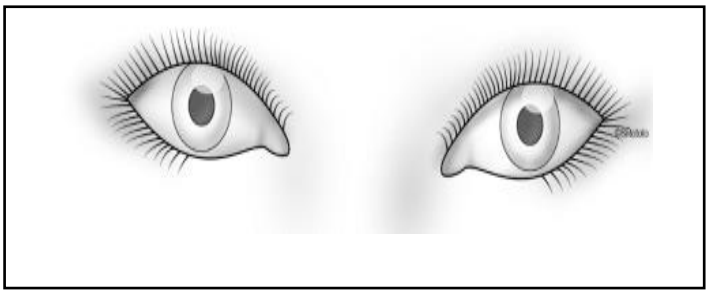


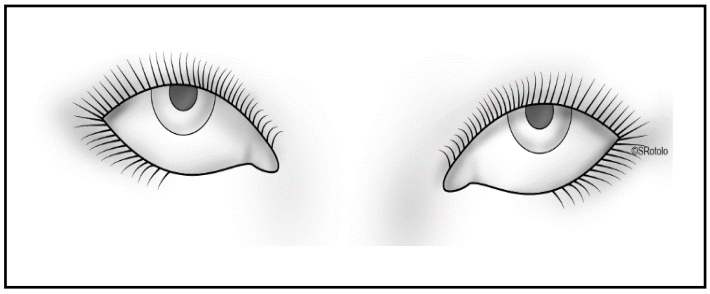


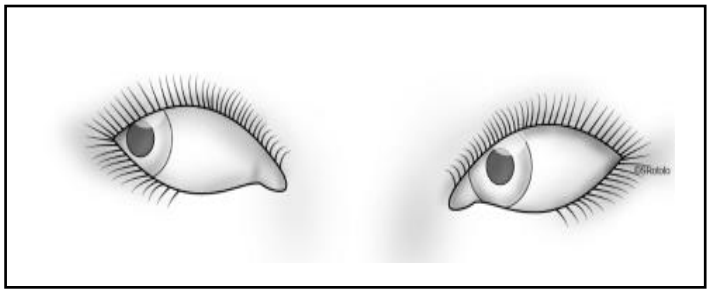


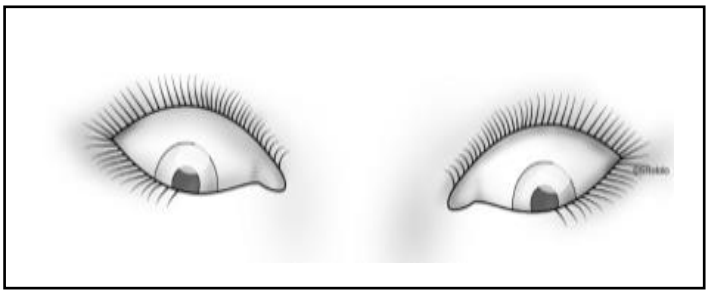


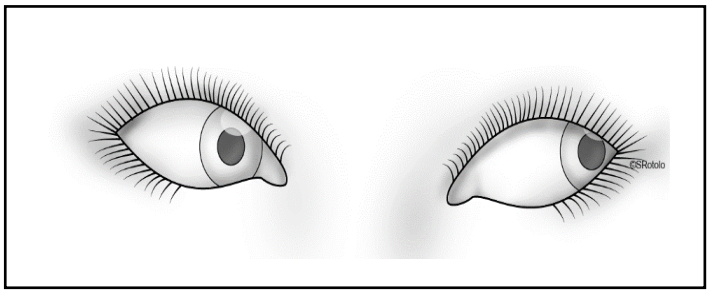
Please indicate all injuries checked above on the body maps below











Notes

BAR CODE # _____ **POLICE REPORT #** _____

HAWAII STATE
MEDICAL-LEGAL RECORD AND SEXUAL ASSAULT INFORMATION FORM

PEDIATRIC

Date: _____ Patient Name: _____

Time In: _____ AM / PM Nickname: _____ Age: _____

Time Out: _____ AM / PM Gender Identity reported by patient: ☐ M ☐ F ☐ Transgender (MTF) ☐ Transgender (FTM) ☐ Other: _____

DOB: _____ Ethnicity: _____

Accompanied patient to exam site/relationship: _____

Present during the exam/relationship: _____

Height: _____ Temp: _____ Resp: _____
Weight: _____ Pulse: _____ B/P: _____ Glasses/Contacts: _____ Yes _____ No

Victim Rights Notification Form Provided: ☐ _____
Signature of person completing the above information

THIS PORTION TO BE COMPLETED BY EXAMINER IN ATTENDANCE

HEALTH HISTORY

1A. **PAST HISTORY**

Major Illnesses / Disabilities: _____

Drug Allergies: _____

Medications: _____

Pre-existing physical injuries: _____

Pertinent medical history of anal-genital injuries, surgeries, diagnostic procedures, or medical treatment:

_____

History of Hepatitis B Vaccination: _____ Yes _____ No _____ Unknown

FEMALES: IF HISTORY OF MENARCHE, USE ADULT / ADOLESCENT FORM

1B. **PATIENT HISTORY**

Is the patient able to answer question(s) pertaining to the assault? _____ Yes _____ No
If no, explain: _____

_____

Name of person providing history: _____

Relationship to Patient: _____

Sexual penetration/contact within the past 120 hours, other than this assault: ____ Yes ____ No ____ Unable to discuss

Date / Time / Location of assault: _____

_____ Less than 120 hours since assault took place _____ Over 120 hours since assault took place

Number of perpetrator(s): _____

Name(s) and age(s) of perpetrator(s) if known: _____

Relationship of perpetrator(s) to patient: _____

BAR CODE # _____ **POLICE REPORT #** _____

2. Since assault, check (√) if patient has:

_____ Drank / Eaten	_____ Brushed Teeth	_____ Defecated
_____ Changed Clothes	_____ Used Mouthwash	_____ Douched
_____ Been Swimming	_____ Vomited	_____ Removed / inserted tampon, sponge, diaphragm (circle)
_____ Bathed / Showered	_____ Urinated	

3. SUMMARY OF PRESENTING COMPLAINTS, SYMPTOMS AND HISTORY:

COMPLAINTS / HISTORY (Incident)

SUMMARY OF PRESENTING COMPLAINTS, SYMPTOMS AND HISTORY: (Continued)

BAR CODE # _____ **POLICE REPORT #** _____

4. ACTS DESCRIBED:

Unable to obtain detailed history because of:

___ developmental age ___ altered mental status

Describe:	Described by: P = Patient / H = Historian				
	Yes	No	Attempted	Unknown	N/A
Penetration of genital opening by:					
Penis:					
Finger:					
Foreign object:					
Describe object:					
Penetration of anus by:					
Penis:					
Finger:					
Foreign object:					
Describe object:					
Oral contact of genitals:					
Of patient's genitals by perpetrator:					
Of perpetrator's genitals by patient:					
Oral contact of anus:					
Of patient's anus by perpetrator:					
Of perpetrator's anus by patient:					
Physical Contact: genitals, anus, breasts, buttocks, and/or other (circle)					
If other, specify location:					
Of patient by perpetrator:					
Of perpetrator by patient:					
Of perpetrator by perpetrator:					
Ejaculation:					
Inside of body orifice:					
Outside of body orifice:					
Specify location:					
Kissing / licking:					
Specify location:					

BAR CODE # _____ **POLICE REPORT #** _____

5. METHODS EMPLOYED BY PERPETRATOR:

	Described by: P = Patient / H = Historian		
	Yes	No	Unknown
Weapons used:			
Type of weapon:			
Physical blows:			
Specify location:			
Specify what was used:			
Strangulation: If "Yes" complete Appendix A – Strangulation Supplemental			
Grabbing / grasping / holding (circle):			
Specify location:			
Physical restraints:			
Specify location:			
Specify what was used:			
Bites / suction:			
Specify location:			
Threat(s) of harm:			
To whom:			
Type of threat(s):			
Other: (Describe)			
DID PERPETRATOR:			
Claim vasectomy / sterile:			
Use a condom:			
Use a lubricant:			
Clean self after assault:			
Describe what was used:			

6. MENTAL STATUS EXAMINATION

1. GENERAL DESCRIPTION

a) Appearance (example: clean, well-groomed, dirty, disheveled):

b) Behavior (example: cooperative, combative, sleepy):

c) Mood (example: quiet, depressed, angry):

d) Orientation (to person, place, time):

2. PATIENT CONCERNS

a) Medical:

b) Non-Medical:

SYMPTOMS:

Described by P = Patient / H = Historian
DNI = Did Not Inquire

	Yes	No	DNI
Abdominal / pelvic pain			
Genital discomfort / pain			
Dysuria			
Enuresis (day or night)			
Encopresis (incontinent of stool)			
Vaginal / Penile itching			
Vaginal / Penile discharge			
Describe color, odor and amount:			

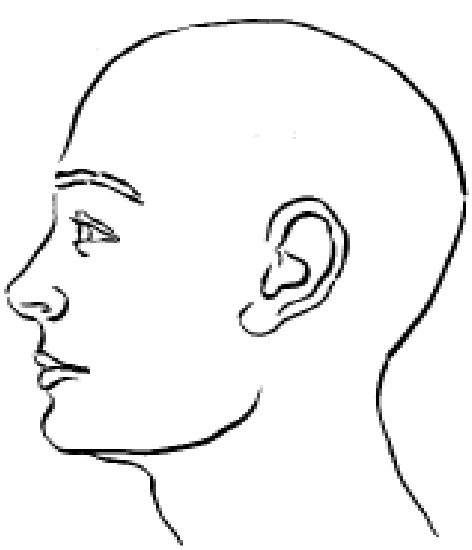
	Yes	No	DNI
Vaginal / Penile bleeding			
Anal / rectal pain			
Anal / rectal bleeding			
Anal / rectal discharge			
Constipation			
Loss of consciousness			
Vomiting			
Physical injuries, pain or tenderness			
Describe:			

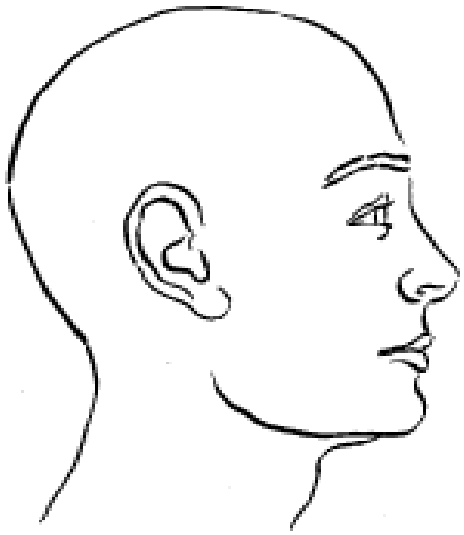
BAR CODE # _____ **POLICE REPORT #** _____

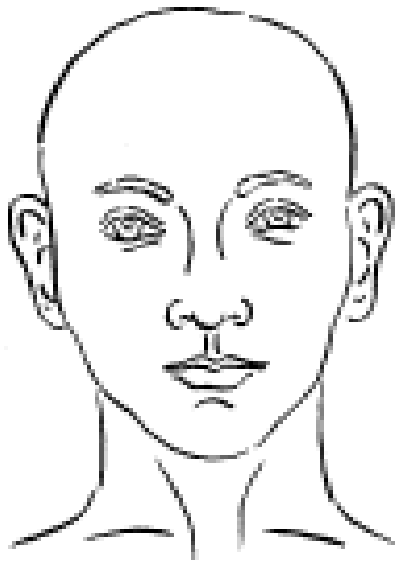
7. PHYSICAL FINDINGS OF FACE AND MOUTH: (Document location and include all signs of tenderness and trauma)

A = Abrasion
B = Bite
BR = Bruise
BU = Burn
E = Erythema
FM = Foreign Material
L = Laceration
P = Petechiae
R = Rash
S = Scar
SW = Swelling / Edema
T = Tenderness
OI = Other Injury (Describe)

Body Photos ___ Yes ___ No





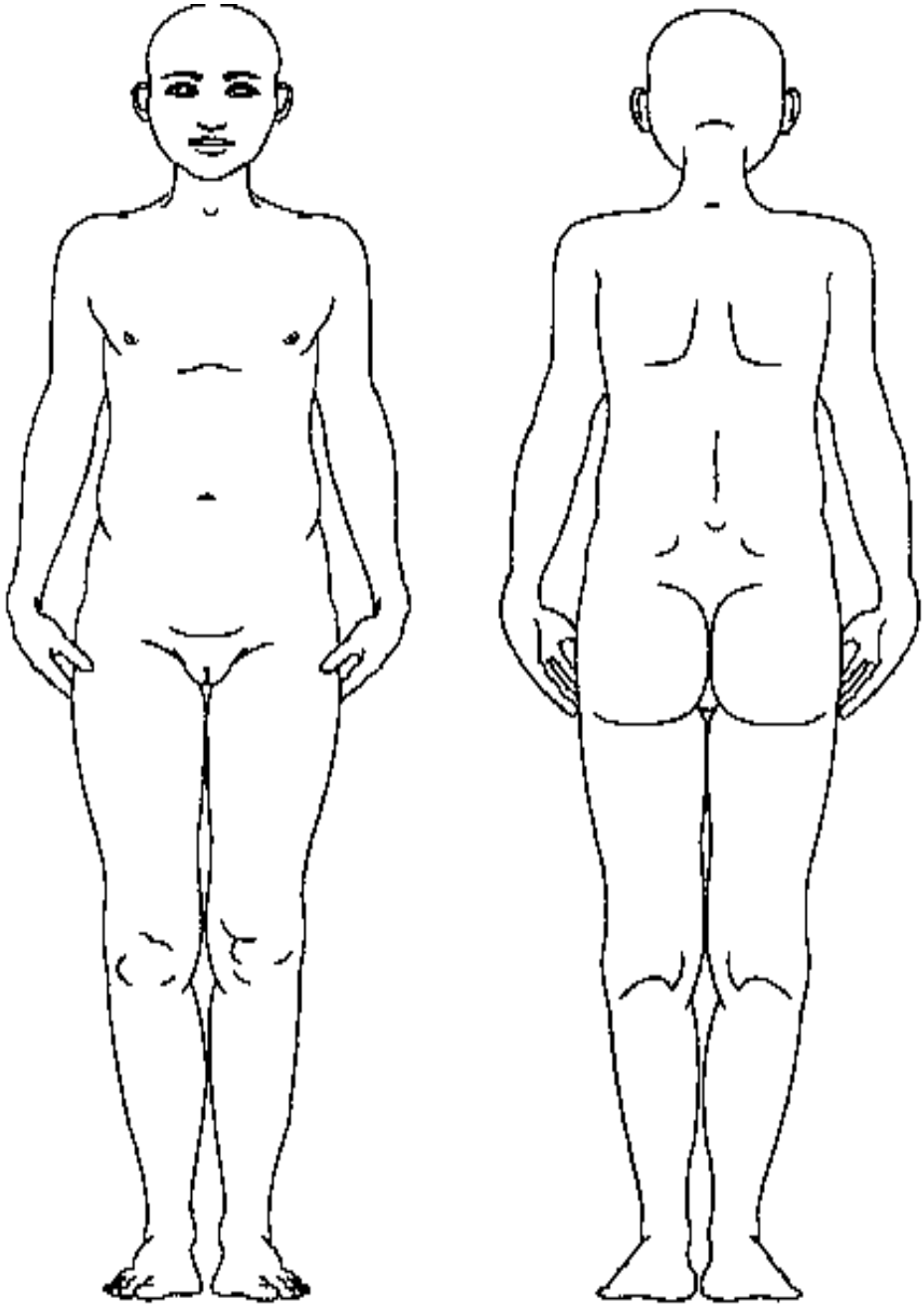


POLICE REPORT # _____

PHYSICAL FINDINGS OF FEMALE: (Document location and include all signs of tenderness and trauma)

A = Abrasion
B = Bite
BR = Bruise
BU = Burn
E = Erythema
FM = Foreign Material
L = Laceration
P = Petechiae
R = Rash
S = Scar
SW = Swelling / Edema
T = Tenderness
OI = Other Injury (Describe)

Body Photos ___ Yes ___ No

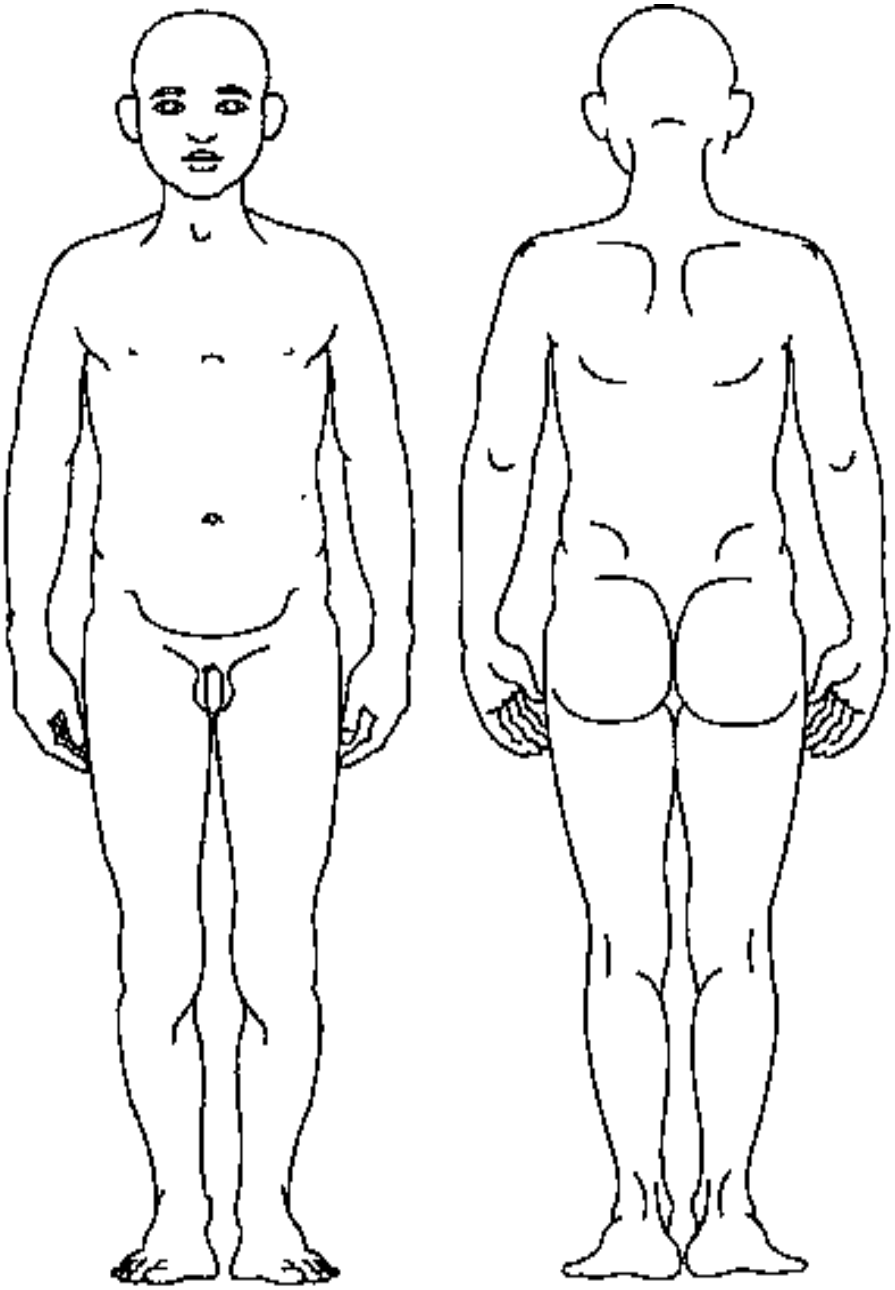


POLICE REPORT # _____

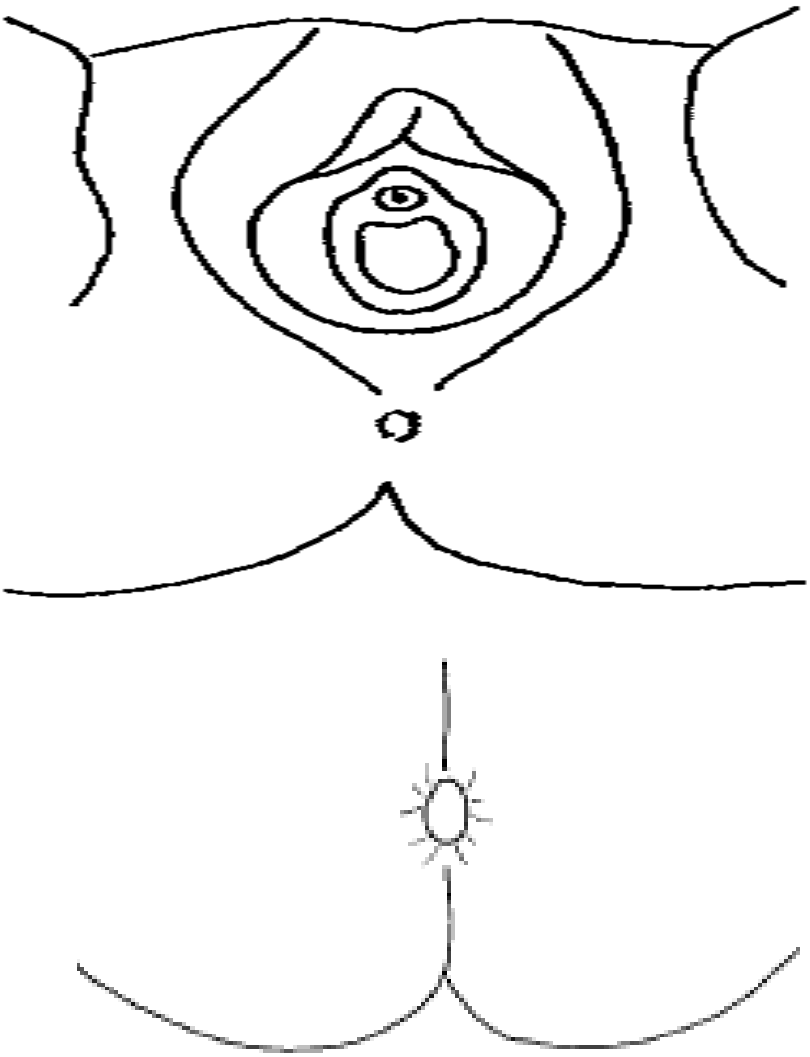
PHYSICAL FINDINGS OF MALE: (Document location and include all signs of tenderness and trauma)

A = Abrasion
B = Bite
BR = Bruise
BU = Burn
E = Erythema
FM = Foreign Material
L = Laceration
P = Petechiae
R = Rash
S = Scar
SW = Swelling / Edema
T = Tenderness
OI = Other Injury (Describe)

Body Photos ___ Yes ___ No



8. PHYSICAL EXAMINATION OF FEMALE – Include all signs of tenderness, trauma, discharge and scars. Illustrate signs of trauma and document sites of fluorescence.



Genital/ Anogenital Photographs _____ Yes _____ No

If yes, complete documentation on page 12

Genital/ Anogenital Photographs with Toluidine Blue _____ Yes _____ No

Additional Comments: _____

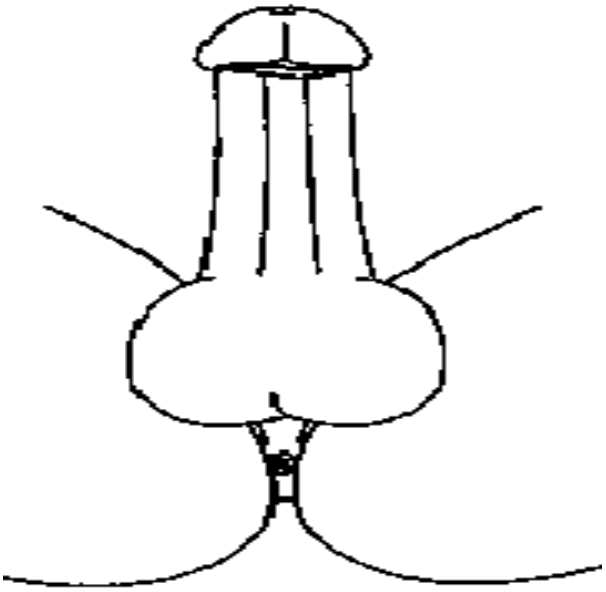
Fluorescence

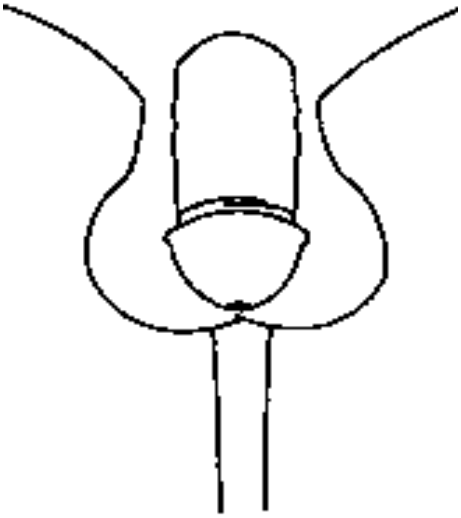
Alternate Light Source _____ Yes _____ No

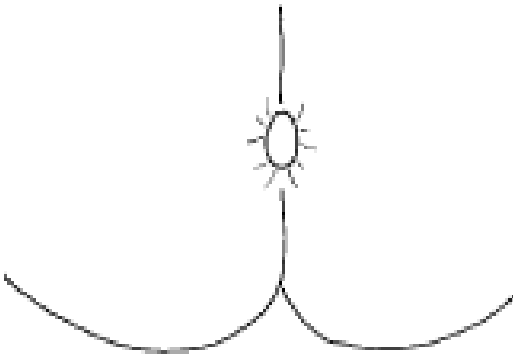
Was fluorescence observed _____ Yes _____ No

List sites: _____

PHYSICAL EXAMINATION OF MALE – Include all signs of tenderness, trauma, discharge and scars. Illustrate signs of trauma and document sites of fluorescence.







Genital/ Anogenital Photographs _____ Yes _____ No

If yes, complete documentation on page 12

Genital/ Anogenital Photographs with Toluidine Blue _____ Yes _____ No

Additional Comments: _____

Fluorescence

Alternate Light Source _____ Yes _____ No

Was fluorescence observed _____ Yes _____ No

List sites: _____

Photograph Inventory (optional):

Identification of areas photographed (e.g., right cheek, right thigh, left arm, vulva, vagina,, hymen, etc.)

9. ANAL-GENITAL CHART:

FEMALE / MALE GENERAL

Tanner Stage											
Female:						**Male:**					
Breast	1	2	3	4	5	Genitals	1	2	3	4	5
Pubic Hair N/A	1	2	3	4	5	Pubic Hair N/A	1	2	3	4	5

	WNL	ABN	Not Examined	Describe
Inguinal adenopathy				
Medial aspect of thighs				
Perineum				
Vulvovaginal discharge				
Urethral discharge				
Anal discharge				

FEMALE	WNL	ABN	Not Examined	Describe
Labia majora				
Clitoris				
Labia minora				
Periurethral tissue/urethral meatus				
Hymen				
Posterior fourchette				
Fossa navicularis				
Vagina				
Cervix				
Other (describe):				

Genital exam position used: (check all that apply):
____ Supine Lithotomy ____ Supine Frog-legged ____ Supine Knee Chest ____ Prone Knee Chest

MALE	WNL	ABN	Not Examined	Describe
Penis Circumcised ___ Yes ___ No				
Urethral Meatus (e.g., discharge, redness)				
Scrotum				
Testes				
Other (describe):				
FEMALE / MALE ANUS	WNL	ABN	Not Examined	Describe
Buttocks				
Perianal skin				
Anal verge / folds / rugae				
Anal tone (e.g., spasm,laxity)				
Rectal ampulla				
Other (describe):				

Genital Exam done with: _____ Direct Visualization _____ Digital Imaging System

Method of exam for anal tone: _____ Observation _____ Digital Exam

Anal exam position used: _____ Supine _____ Prone _____ Lateral recumbent

10. EXAMINATION FINDINGS:

Physical examination reveals:

_____ Physical Findings _____ No Physical Findings

SUMMARY OF PHYSICAL FINDINGS:

____ Oral trauma ____ Genital trauma _____ Anal Trauma ____ Other physical trauma

_____

_____

_____

_____

_____

PHOTOGRAPHY:

_____ Yes _____ No

HAWAII STATE SEXUAL ASSAULT EVIDENCE COLLECTION KIT USED:

_____ Yes _____ No

FOLLOW – UP:

Check (√) if applicable:

_____ Return for follow-up exam with private health provider or gynecologist

When: _____

_____ Referral for further STI testing if not treated

_____ Follow-up by Department of Human Services – Child Welfare Services (DHS-CWS)

_____ Referral for counseling given

_____ Other: _____

_____ Examiner's Time In: _____ AM / PM

Examiner's Signature

_____ Examiner's Time Out: _____ AM / PM

Examiner's Name (Please Print)

Address and phone number where you can be reached:

Address: _____ Phone: _____

_____

POLICE REPORT # _____

ATTACHMENT - A

ATTACHMENT USED: Yes_____ No_____

LABORATORY SPECIMENS

Check (√) if Done:

___Urine Test for Pregnancy: ____ Positive ____ Negative ____ Pending

___ Gonorrhea: ____ Endocervical ____ Vaginal ____ Rectal ___ Penile ____ Oral ____ Urine

___ Chlamydia: ____ Endocervical ____ Vaginal ____ Rectal ___ Penile ____ Urine

___ Herpes: Specify Site: _____

___ Complete Urinalysis

___ Drug Screening

___ HIV Protocol (only to be offered to 13 yrs old and older for exposure within 72 hours)

___ Other: (Specify) _____

WET MOUNT

Wet Mount slide prepared: _____ Yes _____ No

Slide interpreted by examiner: _____ Yes _____ No

Motile sperm observed: _____ Yes _____ No

Non-motile sperm observed: _____ Yes _____ No

Monilia observed _____ Yes _____ No

Trichomonas observed: _____ Yes _____ No

POLICE REPORT # _____

ATTACHMENT B

ATTACHMENT USED: Yes_____ No_____

Note: Presumptive treatment for children who have been sexually assaulted or abused can be considered but it is not widely recommended. If the examiner chooses to treat, the following is recommended:

			Medication Administered / Dispensed By: (Initials)	Info Given for Medication By: (Initials)
PLAN				
1.		Pregnancy prophylaxis (Emergency Contraception) – **FEMALES**		
a)	___	Ulipristal (Ella) 30mg p.o. single dose (Physician has informed patient of possible risks and side effects of such Rx if pregnancy were to occur)	_____	_____
b)	___	Levonorgestrel (Plan B One-Step) 1.5mg p.o. single dose (Physician has informed patient of possible risks and side effects of such Rx if pregnancy were to occur)	_____	_____
c)	___	Not given (patient declined)		
	___	Not given (contraindicated)		
		Reason: _____		
PLAN				
2.		Sexually Transmitted Disease prophylaxis / treatment **(FOR CHILDREN LESS THAN 45 kg)**		
a)		Routine Treatment		
	___	Ceftriaxone 125 mg i.m. single dose	_____	_____
		PLUS		
	___	Erythromycin Base 50 mg/kg/day Orally divided into 4 doses daily for 14 days	_____	_____
b)	___	Not given (await culture results)		
	___	Not given (patient declined)		
	___	Not given (other) specify _____		
		Sexually transmitted disease prophylaxis / treatment **(FOR CHILDREN GREATER THAN 45 kg)**		
a)		Routine Treatment		
	___	Ceftriaxone 500 mg. i.m. single dose	_____	_____
		PLUS		
	___	Azithromycin 1 gm p.o. single dose	_____	_____
b)	___	Not given (await culture results)		
	___	Not given (patient declined)		

POLICE REPORT # _____

3. HIV Prophylaxis – (**FOR 13 YRS OF AGE & OLDER ONLY)**

a) ___ Truvada 200 / 300 mg / 1 p.o. everyday #5 _____ _____

___ Isentress 400 mg / 1 p.o. twice a day # 10 _____ _____

b) ___ Not given (patient declined)

___ Not given (other) specify _____

4. Hepatitis B Vaccination

a) ___ Given _____ _____

b) ___ Not given (already vaccinated)

___ Not given (contraindicated)

___ Not given (patient declined)

___ Not given (other) specify _____

5. Comfort Kit Medication

a) ___ Acetaminophen liquid, 160 mg/tsp. _____ _____
15 mg/kg (maximum dose = 650 mg) single dose
Take _____ mg p.o.

_____ _____

Administered / Dispensed / Prescribed By (Signature) Date

_____

Print Name

Bar Code # _____ **Police Report #** _____

APPENDIX A: NON-FATAL STRANGULATION / SUFFOCATION SUPPLEMENTAL FORM

Patient Name: _____

Strangulation / Suffocation is a serious event that can occur in the context of sexual assaults. Many times strangulation / suffocation presents **NO VISIBLE INJURIES**. It is important to ask about strangulation / suffocation in all sex assault cases, and document positive disclosure or any signs and symptoms.

NOTE:

- Strangulation is impeding the normal breathing or circulation of the blood by applying pressure on the throat or the neck with any part of the body or ligature;
- Suffocation is impeding normal breathing by blocking the nose and mouth; or applying pressure to the chest.

Was the patient strangled? ☐ No ☐ Yes

How many times did strangulation occur? _____

Why/how did the strangulation stop?_____

How did strangulation occur? (Check all that apply)

☐ Right hand ☐ Left hand ☐ Both hands ☐ Unknown ☐ Chokehold maneuver

☐ Other (describe) _____

What is the measurement of the patient's neck circumference? _____

Describe mannequin demonstration (where applicable)

_____

_____

Was the patient suffocated? ☐ No ☐ Yes

How many times did suffocation occur? _____

Why/how did the suffocation stop?

_____

Pressure on: Nose and Mouth? ☐ No ☐ Yes Chest? ☐ No ☐ Yes (describe)_____

_____

_____

Was the patient shaken during the incident?

☐ No ☐ Yes (describe) _____

Was the patient's head pounded against any object during the incident?

☐ No ☐ Yes (describe) _____

Was the assailant wearing any jewelry on hands or wrists?

☐ Unknown ☐ No ☐ Yes (describe) _____

Describe what the pressure felt like during strangulation and/or suffocation:

_____

_____

What was the patient thinking during the strangulation and/or suffocation?

_____

_____

What did the assailant say before, during, or after the strangulation and/or suffocation?

_____

_____

What was the assailant's demeanor during strangulation and/or suffocation?_____

Signs/Symptoms of Strangulation and/or Suffocation
The following signs/symptoms should be asked about, assessed for and documented in writing, with body mapping, and by photo-imaging (if applicable). **Check ALL that apply.**

Head/Scalp

☐ Petechiae on scalp
☐ Pulled hair
☐ Contusions / bump
☐ Cuts / abrasions
☐ Other _____
☐ Nausea
☐ Vomiting

Face

☐ Red, flushed
☐ Petechiae (Red Spots)
☐ Scratch marks
☐ Cuts / abrasions
☐ Other _____

Eyes & Eyelids

☐ Bloody red eyeball
☐ Petechiae eyeball
  ☐ *Right*
  ☐ *Left*
☐ Petechiae eyelid
  ☐ *Right*
  ☐ *Left*
☐ Ptosis
  ☐ *Right*
  ☐ *Left*
☐ Other _____

Nose

☐ Bloody nose
☐ Broken nose
☐ Petechiae
☐ Cuts / abrasions
☐ Other _____

Ears

☐ Petechiae
  ☐ *Right*
  ☐ *Left*
☐ Bleeding from ear
  ☐ *Right*
  ☐ *Left*
☐ Auditory changes
☐ Cuts / abrasions
☐ Other _____

Mouth

☐ Swollen tongue
☐ Swollen lips
☐ Cut / abrasions
☐ Petechiae
☐ Bruising
☐ Other _____

Neck/Under Chin

☐ Redness
☐ Scratch marks
☐ Cuts / abrasions
☐ Bruises
☐ Neck pain _____ (Pain scale 0–10)
☐ Swelling
☐ Ligature marks
☐ Subcutaneous emphysema
☐ Fingernail impressions
☐ Other _____

Shoulders

☐ Redness
☐ Scratch marks
☐ Bruise(s)
☐ Cuts / abrasions
☐ Other _____

Chest

☐ Redness
☐ Scratch marks
☐ Cuts / abrasions
☐ Bruises
☐ Subcutaneous emphysema
☐ Other _____

Behavioral

☐ Agitation
☐ Combative
☐ Anxiety
☐ Memory disruption
☐ Confusion
☐ Other _____

Neurological

☐ Loss of consciousness
☐ Involuntary urination
☐ Involuntary defecation
☐ Seizures
☐ Headache ____ (Pain scale 0–10)
☐ Dizziness
☐ Faintness
☐ Tinnitus
☐ Visual changes
☐ "Saw Stars" or Spots
☐ Other _____

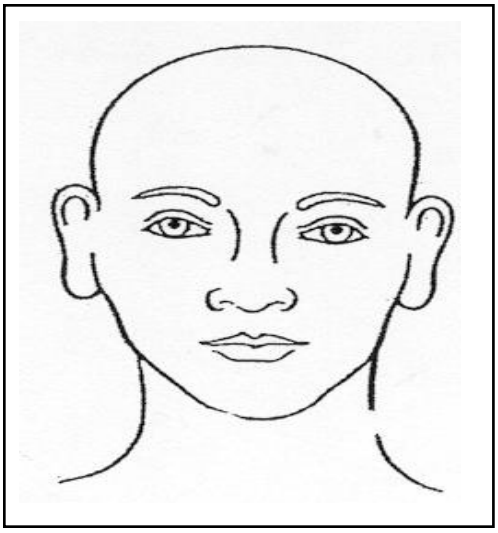
Throat/Voice

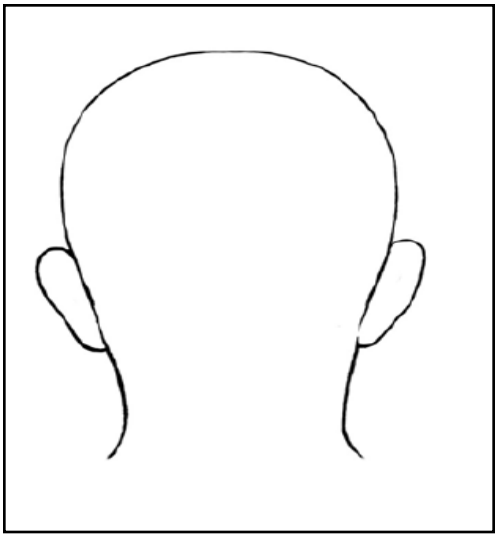
☐ Dysphagia
☐ Odynophagia (painful swallowing)
☐ Dysphasia
☐ Aphasia
☐ Drooling or inability to swallow
☐ Throat pain____ (Pain scale 0–10)
☐ Raspy voice/ hoarseness
☐ Coughing
☐ Change in voice pitch
☐ Other _____

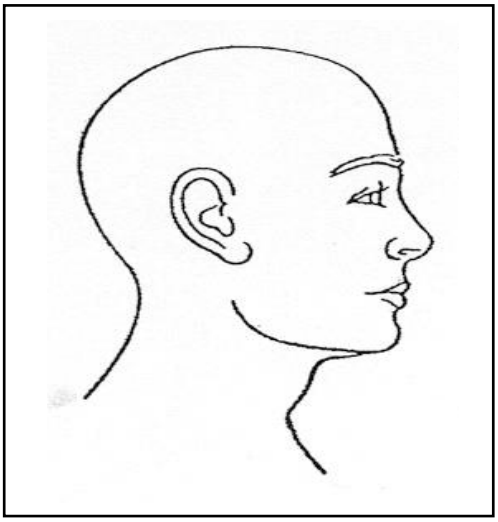
Respiratory

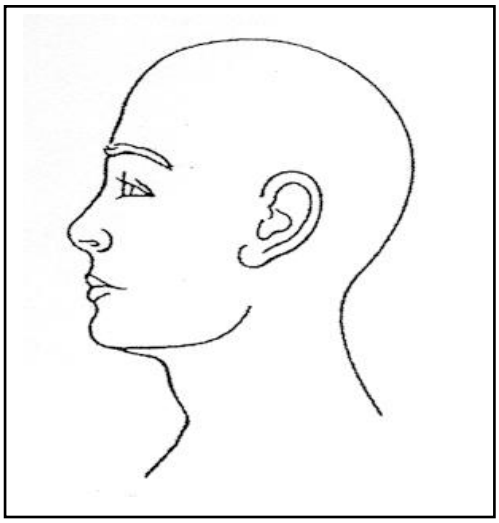
☐ Stridor
☐ Hoarseness
☐ Trouble catching breath
☐ Hyperventiliation
☐ Respiratory Distress
☐ Hemoptysis
☐ Other _____

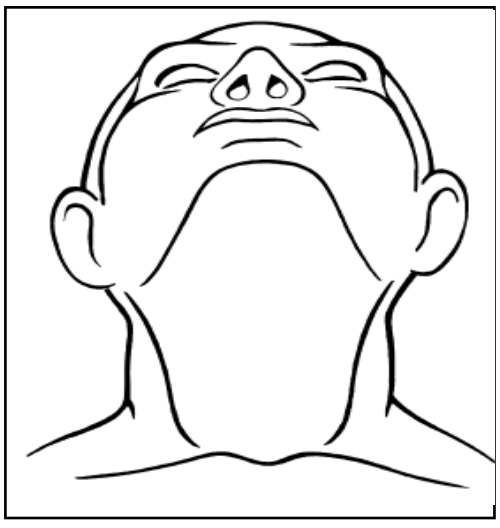
Please indicate all injuries checked above on the body maps below.

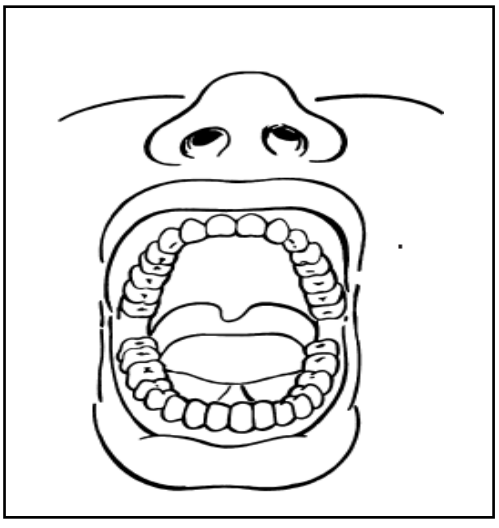




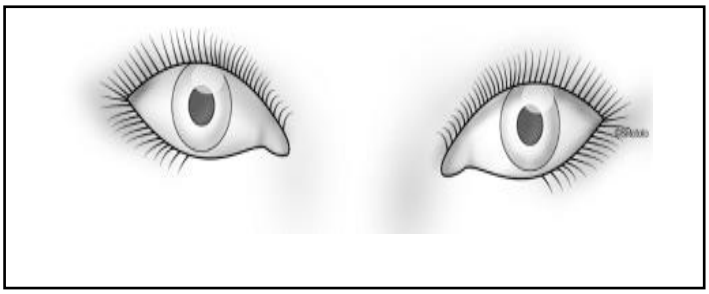


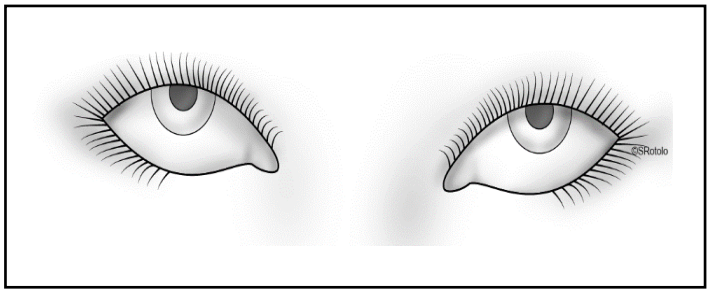


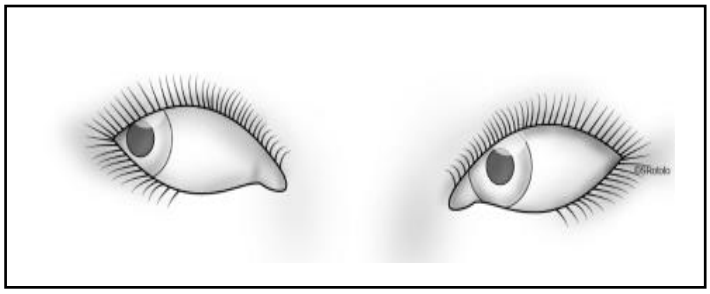


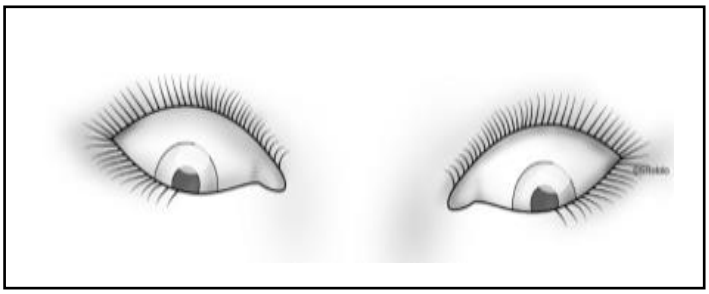


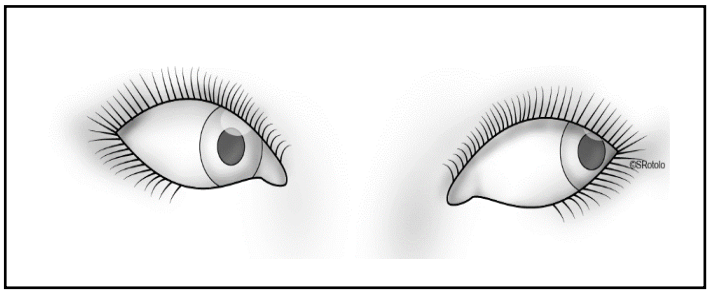
Please indicate all injuries checked above on the body maps below











Notes

HAWAII STATE SEXUAL ASSAULT EVIDENCE COLLECTION KIT INSTRUCTIONS

Revised 07/2020

This kit is designed as a guide for the physician or nurse examiner in the collection of evidentiary specimens for analysis by the crime laboratory servicing your area. All markings should be done using permanent black ink.

Barcode labels provided in the kit should be affixed for identification purposes to kit-related documents and envelopes.

STEP 1: **"STEP 1: AUTHORIZATION FOR COLLECTION, RELEASE, AND STORAGE OF SEXUAL ASSAULT EVIDENCE COLLECTION KIT" (Not supplied in kit)**

Fill out all information requested and have victim (or parent/guardian, if applicable) and witness sign where indicated.

STEP 2: **"MEDICAL-LEGAL RECORD AND SEXUAL ASSAULT INFORMATION FORM" (Not supplied in kit)**

Fill out all information requested on form and have examining physician or nurse examiner sign and date where indicated.

STEP 3: **CLOTHING AND FOREIGN MATERIAL**

Unfold and place clean bed sheet on floor. Remove paper sheet from Foreign Material Bag, unfold and place over bed sheet. Instruct victim to stand in center of paper sheet and carefully disrobe. Collect each item as removed and place in separate clothing bag (e.g., collect victim's underpants and place in Underpants bag) (additional bags provided: Outer Clothing, Other Clothing, and Bra). Refold paper sheet on which victim stood in a manner to retain any foreign material present then initial paper sheet and return to Foreign Material bag. Tape all bags shut (using red evidence tape - not supplied in kit), initial tape and fill out all information requested on bag labels.

Notes:

1. If victim is not wearing the clothing worn at the time of the alleged assault, collect only the items that are in direct contact with the victim's genital area.
2. If victim changed clothing after the assault, inform police they will need to collect clothing worn at the time of the assault.
3. Do not cut through any existing holes, rips, or stains in the victim's clothing.
4. Do not shake out victim's clothing or microscopic evidence may be lost.
5. If additional clothing bags are required, use only new paper (grocery-type) bags.
6. Plastic bags will only be used for temporary transfer of wet/damp items and not used for more than 24 hours / long-term storage.
7. If practicable, swabbing an item too wet to be dried is feasible.

NOTE

This note pertains to the Swab Drying Box and its use in steps using swabs.

After all swab specimens have been placed into the swab drying box, lock drying box with numbered lock and air-dry for the maximum time on dial.

STEP 4: **DRIED SECRETIONS (Alternative sites)**

Notes:

1. An alternative light source should be used in the following procedure.
2. An example of an alternative site would be a bite mark on the victim's body that would be swabbed for saliva.
3. If additional swabbings are needed, use additional swabs from stock. After drying swabs return them to their original paper sleeve. Mark sleeve with area the dried secretion was taken, then initial sleeve and place them in Dried Secretions envelope.

Remove all components from envelope. Collect dried secretions (such as semen, blood, saliva, etc.) by lightly moistening the swab(s) with the distilled water provided, then thoroughly swabbing the suspected area(s) with the swab(s). Dry swabs should follow the use of a wet swab. Allow swab(s) to air-dry in drying box. Place swab(s) in the swab box provided, then write site where the sample was collected on swab box and initial. Return swab box to the Dried Secretions envelope. Seal and fill out all information requested on envelope.

STEP 5: **ORAL SWABS (Collect only if oral-genital contact occurred)**

Note: Do not moisten swabs prior to sample collection.

Remove all components from envelope. Carefully swab the buccal area and gum line with the four swabs provided and allow swabs to air-dry in drying box. Place swabs in "Step 5: Oral Swabs" box provided and initial. Return swab box to the Oral Swabs Envelope. Seal and fill out all information requested on envelope.

STEP 6: **KNOWN SAMPLE: BUCCAL SWAB (For DNA work-up)**

Notes:

1. **Step 5: ORAL SWABS must be conducted prior to Step 6.**
2. Do not moisten swabs prior to sample collection.
3. Have victim rinse mouth with water several times prior to collection of the KNOWN SAMPLE: BUCCAL SWAB.

Remove all components from envelope. Carefully swab the buccal area and gum line with the four swabs provided and allow swabs to air-dry in drying box. Place swabs in "Step 6: Buccal" box provided and initial. Return swab box to the Known Sample: Buccal Swab envelope. Seal and fill out all information requested on envelope.

STEP 7: **HEAD HAIR COMBING (To obtain foreign material)**

Remove swabbie towel and comb from envelope. Unfold towel and place on flat surface. With the victim holding head directly over the towel, instruct victim to run comb through all areas of hair in downward strokes so that any loose hair will fall onto towel. Place comb in center of towel, then refold towel in manner to retain both comb and any evidence present. Initial towel and return folded towel to the Head Hair Combing envelope. Seal and fill out all information requested on envelope.

STEP 8A: **FINGERNAIL SWABBINGS (Right Hand) (Collect only if victim scratched assailant's skin or clothing)**

Note: Moisten swabs prior to sample collection.

Remove all components from envelope. Lightly moisten the swab(s) with the distilled water provided, then thoroughly swab the fingernail(s) of the right hand with the swab(s). Dry swabs should follow the use of a wet swab. Allow swab(s) to air-dry in drying box. Place swab(s) in the "Step 8A: Right Hand Fingernails" swab box provided, then return swab box to the Fingernail Swabbings (Right Hand) envelope. Seal and fill out all information requested on envelope.

STEP 8B: **FINGERNAIL SWABBINGS (Left Hand) (Collect only if victim scratched assailant's skin or clothing)**

> **Note:** Moisten swabs prior to sample collection.

Remove all components from envelope. Lightly moisten the swab(s) with the distilled water provided, then thoroughly swab the fingernail(s) of the left hand with the swab(s). Dry swabs should follow the use of a wet swab. Allow swab(s) to air-dry in drying box. Place swab(s) in the "Step 8B: Left Hand Fingernails" swab box provided, then return swab box to the Fingernail Swabbings (Left Hand) envelope. Seal and fill out all information requested on envelope.

STEP 9: **PUBIC HAIR COMBING (To obtain foreign materials)**

Remove swabbie towel and comb from envelope. Unfold towel and place under victim's buttocks. Using comb provided, comb pubic hair in downward strokes so any loose hair and/or debris will fall onto towel. Place comb in center of towel, then refold in manner to retain both comb and any evidence present. Initial folded towel and return to the Pubic Hair Combing envelope. Seal and fill out all information requested on envelope.

STEP 10A: **VAGINAL (Collect only if vaginal assault occurred or was attempted)**

> **Notes:**
> 1. Moisten swabs as applicable prior to sample collection.
> 2. Foreign objects such as tampons, recovered during the examination should be placed in a leak-proof, screw top container (not provided in kit). Initial the container and package as described in Step 3.

Remove all components from envelope. Using the four swabs provided, carefully swab the vaginal vault and allow swabs to air-dry in drying box. Place swabs in the "Step 10A: Vaginal" swab box provided and initial box. Return swab box to the Vaginal swabs envelope. Seal and fill out all information requested on envelope.

> **Note:** After completing the above procedure, if any additional fluid is present in the vaginal vault, collect fluid using additional swabs (not provided). Allow swabs to air-dry in the drying box, then return them to their original paper sleeve. Mark sleeve "Additional Vaginal Swabs", then initial sleeve and place in Vaginal Swabs envelope.

STEP 10B: **EXTERIOR GENITALIA**

> **Note:** Moisten swabs as applicable prior to sample collection.

Remove all components from envelope. Using four swabs provided, carefully swab the external genitalia and allow swabs to air-dry in drying box. Place swabs in the "Step 10B: External Genitalia" swab box provided and initial box. Return swab box to the External Genitalia swabs envelope. Seal and fill out all information requested on envelope.

STEP 11A: **PERIANAL SWABS (Collect only if rectal assault occurred or was attempted)**

Remove all components from envelope. Using the four swabs provided, carefully swab the perianal area and allow swabs to air-dry in drying box. Place swabs in "Step 11A: Perianal" swab box provided and initial box. Return swab box to the Perianal swabs envelope. Seal and fill out all information requested on envelope.

> **Note:** After completing the above procedure, if any additional fluid is present, collect fluid using additional swabs. Allow swabs to air-dry in drying box, then return them to their original paper sleeve. Mark sleeve "Additional Perianal swabs", then initial sleeve and place in the Perianal swabs envelope.

STEP 11B: **ANAL/RECTAL SWABS (Collect only if rectal assault occurred or was attempted)**

Remove all components from envelope. Using the four swabs provided, carefully swab the rectal canal and allow swabs to air-dry in drying box. Place swabs in "Step 11B: Anal/Rectal" swab box provided and initial box. Return swab box to the Anal/Rectal swabs envelope. Seal and fill out all information requested on envelope.

> **Note:** After completing the above procedure, if any additional fluid is present, collect fluid using additional swabs. Allow swabs to air-dry in drying box, then return them to their original paper sleeve. Mark sleeve "Additional Anal/Rectal Swabs", then initial sleeve and place in the Anal/Rectal swabs envelope.

FINAL INSTRUCTIONS FOR REPORTED CASES

1. Make sure all information requested on all forms, envelopes, and bag labels has been filled out completely.
2. With the exception of sealed and labeled Underpants and clothing bags, return all other evidence collection envelopes (used or unused), numbered lock, and photographs (if applicable) to kit box.
3. Initial then affix red police evidence seals where indicated on box top.
4. Fill out all information requested on kit box top, then affix biohazard label where indicated.
5. Place medical-legal form and the white copy of Step 1 in the "For Law Enforcement Copies of Forms" envelope affixed to the bottom of the kit box. Retain pink copy for Hospital/Examiner.
6. Transfer medical-legal form, sealed kit, and bagged clothing to local police department, where it will be secured until analysis of evidentiary specimens is needed.

Note: Any specimen(s) collected for hospital use *should not be placed in kit*, but should be sent to the hospital laboratory for analysis.

POLICE REPORT # _____

EVIDENCE REPORT

Name of Patient: _____

ITEM NO.	DESCRIPTION OF ITEM	COLLECTED AND IN SEXUAL ASSAULT KIT
1.	Authorization For Collection And Release Of Evidence And Information Form	
2.	Hawai'i State Medical-Legal Record and Sexual Assault Information Form	
3.	Foreign material	
4.	Dried secretions swabs (site:)	
5.	Oral swabs	
6 A	Known sample: buccal swab	
6 B	Known sample: blood collection	
7.	Head hair combing	
8.	Known head hair	
9 A	Fingernail scrapings (right hand)	
9 B	Fingernail scrapings (left hand)	
10 A	Pubic hair combings	
10 B	Known pubic hair	
11	Vaginal swabs/Wet Mount	
12	Rectal swabs	
13	Dry box lock #	
14	Photographs	
15	Other (specify:)	
16	Other (specify:)	
ITEM NO.	**DESCRIPTION OF CLOTHING**	**COLLECTED WITH SEXUAL ASSAULT KIT**
A	Outer clothing (specify:)	
B	Outer clothing (specify:)	
C	Patient's underpants	
D	Patient's brassiere	
E	Other (specify:)	

CHAIN OF CUSTODY

ITEM	FROM	TITLE	TO	TITLE	DATE	TIME
	Print: Sign:		Print: Sign:			
	Print: Sign:		Print: Sign:			
	Print: Sign:		Print: Sign:			
	Print: Sign:		Print: Sign:			
	Print: Sign:		Print: Sign:			

Bar Code: _____ Police Report # _____

STEP 1: AUTHORIZATION FOR COLLECTION, RELEASE, AND STORAGE OF SEXUAL ASSAULT EVIDENCE COLLECTION KIT

Please initial and sign where appropriate.

MEDICAL-FORENSIC EXAMINATION:

- **_____ I consent to a medical-forensic examination and sexual assault evidence collection kit (SAK).**

I understand this examination is conducted for medical evaluation relating to a sexual assault, and to collect evidence. This may include history taking, physical examination, photographic documentation of physical findings, prophylactic treatment for sexually transmitted infection and pregnancy, and collection of evidence. I understand I can stop the examination at any time, and can decline any portion of the examination or collection of any sample. I also understand this examination will be provided at no cost to me, even if I do not choose to report to law enforcement.

LAW ENFORCEMENT REPORTING: (Initial one)

- **_____ Report to law enforcement.** I choose to report to law enforcement. I give permission for the SAK collected during the examination, including photographs, medical findings, and related information to be released to law enforcement for use in investigation and potential prosecution. I understand the medical information gathered through this examination may be used as evidence in a court of law. I further understand the evidence collected may be submitted to a forensic laboratory for analysis, and law enforcement will receive the results for use in investigation and potential prosecution.

- **_____ No report to law enforcement.** I do not wish to report to law enforcement at this time but understand I can change my mind and report at a later time. I further understand the SAK collected during the medical-forensic examination will be stored at either the county police department or sexual assault center (depending on my decision below) and will not be submitted to a forensic laboratory for analysis at this time. However, if I later report to law enforcement, I understand the evidence may then be submitted for analysis and law enforcement will receive the results for use in investigation and potential prosecution.

UNREPORTED CASES ONLY: SAK STORAGE (Initial one)

- **_____ Unreported SAK storage at police department.** I do not want to report to law enforcement at this time but want my SAK and other items collected at the time of the medical-forensic examination to be transferred and stored at the police department. I understand my SAK will only be identified numerically, and will be transferred and stored in a manner that protects my identity. I further understand that if I later decide to file a police report, I may contact the county sexual assault center or police and inform them of my stored SAK.

- **_____ Unreported SAK storage at sexual assault center.** I do not want to report to law enforcement at this time but want my SAK and other items collected at the time of the medical-forensic examination to be transferred and stored at the county sexual assault center listed below. I further understand that if I later decide to file a police report, I may contact the county sexual assault center or police and inform them of my stored SAK.

UNREPORTED CASES ONLY: SAK DISPOSAL INFORMATION

- **_____ Date of Disposal.** I understand my unreported SAK, in accordance with Act 113 (SLH 2018), will be stored for a minimum of 6 years for survivors 18 years of age and older at the time of the sexual assault, and for a minimum of 20 years for survivors under 18 years of age at the time of the sexual assault, regardless of where it is stored. I further understand that if I report to law enforcement outside of the SAK retention period, my SAK may already have been disposed.

If you have any questions or need information, please contact your county sexual assault center:

Child and Family Service - Maui Sexual Assault Center (Maui County)	(808) 873-8624
Kapi`olani Medical Center for Women & Children - The Sex Abuse Treatment Center (O`ahu)	(808) 524-7273
YWCA - Sexual Assault Support Services (Hawai`i Island)	(808) 935-0677
YWCA - Sexual Assault Treatment Program (Kaua`i)	(808) 245-4144

Printed Patient Name	Patient Signature	Date
Printed Legal Guardian (if applicable)	Legal Guardian Signature	Date
Printed Witness Name/Title	Witness Signature	Date

Revised January 2019

White - Law Enforcement Pink - Examiner Records Yellow - Patient

Sexual Assault Victim Rights Notification

This notice provides general information about rights you may have under Hawaii law HRS 844G-7(d) and resources that may be available to you. For specific information, you may go to the official Hawaii Sexual Assault Response and Training (HSART) Program website link provided below or call your county sexual assault center.

Question: As a sexual assault victim, what rights do I have under Hawaii law?

Answer: As a victim of sexual assault, you have the right to:

1. Not report the assault to law enforcement at this time, but still have the choice to change your mind and report the assault at a later time. If you do report it, the sexual assault evidence collection kit may be tested.
2. Receive a medical-forensic examination, based on current eligibility standards, regardless of whether you choose to report the assault to a law enforcement agency.
3. Receive support from, and consultation with, a crisis worker at the time that a sexual assault evidence collection kit is collected; provided that sufficient funding is available.
4. Be provided at the time of your medical-forensic examination, contact information for a liaison that can provide guidance and answers to questions or concerns you may have.
5. If you choose not to report to the police, you may also choose whether your sexual assault evidence collection kit is stored with a sexual assault center or law enforcement.
6. Information on how to report a previously unreported case and have your kit tested.
7. Information about Crime Victim Compensation and other services available to you.
8. Information about the current location, analysis date and status, and estimated disposal date of your sexual assault evidence collection kit.
9. Notification, upon written request, when there is any major development, as defined in section 801D-2, in a case you reported to a law enforcement agency, including whether the case has been closed or reopened.
10. Designate a person to receive the information provided in items 6 thru 9 above, on your behalf.

Resource websites:

- Act 113 (SLH 2018): https://www.capitol.hawaii.gov/session2018/bills/GM1214_.pdf
- HRS Chapter 844G: http://www.capitol.hawaii.gov/hrscurrent/Vol14_Ch0701-0853/HRS0844G/HRS_0844G-.htm
- HSART Program: http://ag.hawaii.gov/cpja/home/hawaii-sexual-assault-response-and-training-hsart-program/

Question: How do I find out the testing status of my kit?

Answer: You may:

1. If you have a kit barcode number, go to: https://trackit.hawaii.gov/
2. If you don't have a kit barcode number, go to: http://ag.hawaii.gov/hisaki/home/contact-us/
3. Contact your county sexual assault center.

Question: What resources may be available to me?

Answer:

- Victim support services through your county sexual assault center.
- Crime victim compensation. Resource website: http://dps.hawaii.gov/cvcc/
- Counseling and testing of sexual assault victims and the testing of charged or convicted person for human immunodeficiency virus status (§325-16.5). Resource website: https://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0325/HRS_0325-0016_0005.htm

Victim's Name _____ Victim's Signature _____ Date: _____

Legal Guardian _____ Legal Guardian Signature_____ Date: _____

White – Agency Copy Pink – Med-Legal/SAK Copy Yellow – Victim Copy

(rev 8/2021)

SECTION 8: HISTORICAL BACKGROUND

1. Memorandum Agreement dated September 10, 1999 and signed by the county police chief, county prosecuting attorney, and the state attorney general, to promote uniform evidence collection procedures, standardized medical protocols, and consistency in the investigations of sexual assault cases.

2. Memo dated August 7, 2009, from the Department of the Attorney General, Crime Prevention and Justice Assistance Division, Grants and Planning Branch Chief to the Sex Abuse Treatment Center, Hawaii SART Program Manager and Sex Abuse Treatment Center, Crisis Intervention Program Manager. *Subject: Confidentiality of Medical-Legal Forensic Examination Protocols, Statewide Medical-Legal Collaborative Project.*

3. Statewide Sexual Assault Medical-Legal Protocol Participants Listing

MEMORANDUM AGREEMENT

RECITALS

WHEREAS, the Undersigned Parties (hereafter referred to as the "Parties") seek to ensure that victims of sexual assault receive efficacious treatment and care;

WHEREAS, the Parties wish to promote uniform evidence collection procedures, standardized medical protocols and consistency in the investigation of sexual assault cases;

WHEREAS, the Parties seek to preserve the rights of all persons under the Constitution of the United States and the Constitution of the State of Hawaii;

WHEREAS, a Committee for Standard Medical-Legal Protocol for Sexual Assault (hereafter referred to as the "Committee"), comprised of members of the law enforcement, medical, social service and legal communities in the State of Hawaii was convened to develop protocols and procedures to fulfill the above-recognized goals;

WHEREAS, the Committee has developed protocols and standard evidence collection procedures which are embodied in the Sexual Assault Evidence Collection Kit;

NOW THEREFORE, IT IS AGREED BY AND BETWEEN THE PARTIES AS FOLLOWS:

That the Parties, their employees, agents, representatives, consultants and/or independent contractors shall use the Hawaii State Sexual Assault Evidence Collection Kit, its protocols and procedures for all examinations for evidence of a sexual assault or an attempted sexual assault. The Parties, their employees, agents, representatives, consultants and/or independent contractors shall make such observations and perform such tests as may be required for the recording of the data required by the procedures contained in the Hawaii State Sexual Assault Evidence Collection Kit.

DATED: SEP 10 1999.

SO AGREED:

DEPARTMENT OF THE
ATTORNEY GENERAL
STATE OF HAWAII

By: EARL I. ANZAI
ATTORNEY GENERAL

DEPARTMENT OF THE
PROSECUTING ATTORNEY
CITY AND COUNTY OF HONOLULU

By: PETER CARLISLE
PROSECUTING ATTORNEY

DEPARTMENT OF THE
PROSECUTING ATTORNEY
COUNTY OF MAUI

By: RICHARD BISSEN
PROSECUTING ATTORNEY

OFFICE OF THE
PROSECUTING ATTORNEY
COUNTY OF HAWAII

By: JAY KIMURA
PROSECUTING ATTORNEY

OFFICE OF THE
PROSECUTING ATTORNEY
COUNTY OF KAUAI

By: MICHAEL SOONG
PROSECUTING ATTORNEY

HONOLULU POLICE DEPARTMENT

By: LEE D. DONOHUE
CHIEF OF POLICE

MAUI COUNTY POLICE DEPARTMENT

By: THOMAS PHILLIPS
CHIEF OF POLICE

HAWAII COUNTY POLICE DEPARTMENT

Wayne Carvalho

By: WAYNE CARVALHO
CHIEF OF POLICE

KAUAI COUNTY POLICE DEPARTMENT

George Freitas

By: GEORGE FREITAS
CHIEF OF POLICE

LINDA LINGLE
GOVERNOR

MARK J. BENNETT
ATTORNEY GENERAL

LISA M. GINOZA
FIRST DEPUTY ATTORNEY GENERAL

STATE OF HAWAII
DEPARTMENT OF THE ATTORNEY GENERAL
CRIME PREVENTION AND JUSTICE ASSISTANCE DIVISION
235 S. BERETANIA STREET, SUITE 401
HONOLULU, HAWAII 96813
(808) 586-1150
cpja.ag.state.hi.us

August 7, 2009

MEMORANDUM

To: Tony Wong
Program Manager – Hawaii SART Program
Sex Abuse Treatment Center

Cindy Shimomi-Saito
Crisis Intervention Program Manager
Sex Abuse Treatment Center

From: Adrian Kwock
Chief, Grants & Planning Branch

Re: Confidentiality of Medical-Legal Forensic Examination Protocols
Statewide Medical-Legal Collaborative Project

The intent of the protocols, produced by the VAWA-funded project, is to promote uniform evidence collection procedures, standardized medical guidelines, and consistency in the investigation of sexual assault cases statewide. Attorney General Mark J. Bennett has indicated that these protocols are to be considered confidential. Therefore, distribution needs to be controlled and the protocols are to be issued only to the agencies for which they were intended. Each user agency needs to set up its internal procedure to ensure confidentiality.

The Attorney General has also instructed that if a Freedom of Information Act or Uniform Information Practices Act (Modified) request for these protocols is received, the request is to be forwarded to him for a response.

In distributing the protocols, please inform agencies regarding this confidentiality provision.

Thank you.

Approved:

Mark J. Bennett

STATEWIDE SEXUAL ASSAULT MEDICAL-LEGAL PROTOCOL
PARTICIPANTS

Hawaii
Lincoln Ashida, Deputy Prosecuting Attorney, County of Hawaii
Detective Randall Medeiros, Hawaii County Police Department-Juvenile Aid Section
Cathy Stevens, RN, Sex Assault Nurse Examiner (SANE)
Judith Fitzgerald, M.D., Hilo Medical Center

Maui
Davelyn Tengan, Deputy Prosecuting Attorney, County of Maui
Detective Darryl Johnson, Maui Police Dept., Criminal Investigation Division, Child Sex Assault
Shannon Tolley, Maui Kokua Services, Inc.
William Kepler, M.D.

Oahu
Paul Wong, Deputy Prosecuting Attorney, City and County of Honolulu
Captain George McKeague, Honolulu Police Dept., CID, Adult/Juvenile Sex Crimes Detail
Lieutenant Wayne Fergerstrom, Honolulu Police Dept., CID, Adult/Juvenile Sex Crimes Detail
Detective Dennis Kim, Honolulu Police Dept., CID, Adult/Juvenile Sex Crimes Detail
Detective David Do, Honolulu Police Dept., CID, Adult/Juvenile Sex Crimes Detail
Wayne Kimoto, Criminalist, Honolulu Police Dept., Scientific Investigation Section
Tracy Tanaka, Criminalist, Honolulu Police Dept., Scientific Investigation Section
Adriana Ramelli, Director, Sex Abuse Treatment Center
Cindy Shimomi-Saito, Clinical Program Manager, Sex Abuse Treatment Center
Victoria Schneider, M.D., Kapi'olani Medical Center for Women and Children
M. Stanton Michels, M.D., Kapi'olani Medical Center for Women and Children
Robert Bidwell, M.D., Kapi'olani Medical Center for Women and Children
Gregg Shimomura, M.D., Kapi'olani Medical Center for Women and Children
Kari Wilhelm, Attorney at Law, Roeca, Louie & Hiraoka

Kauai
Michael Soong, Prosecuting Attorney, County of Kauai
Shaylene Iseri-Carvalho, Deputy Prosecuting Attorney, County of Kauai
Lieutenant William Ching, Kauai Police Department
Joan Luzney, Director, YWCA Sex Abuse Treatment Program
Renae Hamilton, YWCA Sex Abuse Treatment Program
Mary Jo Sweeney, Department of Health-Maternal Child Health
Eric Wortman, M.D., Kauai Medical Clinic
Linda Leavitt, RN, Emergency Room, Wilcox Hospital
Merrilyn Schwichtenberg, RN, Emergency Room, Wilcox Hospital