SEXUAL ASSAULT SEMINAR

LEARN HOW TO PERFORM A FORENSIC EXAM AND PROVIDE COMPASSIONATE CARE FOR YOUR PATIENTS

FEATURED SPEAKER
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SUBMIT YOUR QUESTIONS HERE EARLY!

SCAN ME
- FB Event RSVP -

THURSDAY, MARCH 11TH, 2021
7:00-8:30 PM AST

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For more information, you may contact us at: SO-WIM@sgu.edu

Sexual Assault Workshop 3.11.21 Notes

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Melissa Harper Presentation Notes

- **Introduction:** Mellissa worked in a level 1 trauma center → practices currently in rural Virginia in trauma clinic setting as a forensic nurse

- General facts
    - Majority are males, but females also commit a large portion
    - Usually there is a Sexual Assault Response Team (SART)
    - **Sexual assault definition:** any sexual act that is unwanted towards the person it is being inflicted on (general term)
        - Full erection/ejactulation is not necessary
        - Motivated by aggression, rage, power and control, and sex
        - Most states claissfy rape with three critiera
            - Any vaginal, oral, or anal penetration
            - Lack of consent (verbal, physical, and resistance), or if victim is unable to give consent (too young, lack of capacitation)
                - Age of consent is 14-18 years old, varies by state
            - Threat or use of force
                - Many victims fear death and weapon use
                - Most sexual assaults do not use weapons → More common in stranger rapes
    - **Resistance:** most women do not resist, less likely if they have been sexualy assaulted before or if they know their atacker
        - **People who physically struggle, plead, reason → the rape is more likely to be completed**
            - People who draw attention, run → make it less likely to be completed
            - Teach people to yell and draw attention
        - Supine is most common position
    - **Reporting:** few victims report their assault to law enforcement
        - No set time to seek care, sooner the better
            - Most take 12 hours or more to report, but not any less valid
        - More likely to report to law enforcement if it was a stranger, they were hurt, sought medical care, and if a weapon was used
        - Very few patients are “acting out’ or hysterical when the report is made
            - Most times they are in shock, little energy, may not appear “upset”
            - No right or wrong way to respond
            - Look “shell shocked” flat affect

        - Uncommon to be screaming, upset
    - **EtOH use and sexual assault** are less likely to be reported because they dont really remember or feel like they will not be believed because they were intoxicated
        - Rape more likely to be complete
        - ⅔ of assaults include alcohol/drugs

- Types of forensic evaluations
    - Sexual crimes
    - Suspect exams
    - Hit and runs → certain makes/models leave evidence (paint, chrome, etc)
    - Child abuse/neglect
    - Elder abuse/neglect
    - Attempted homicide, suicide
        - Staging occurs, need to gather evidence to determine what happened
    - Injuries from weapon use
    - Intimate partner violence, strangulation
        - Very common to occur together, very rare to see intimate partner violence without strangulation
    - Red flag cases, suspicious cases, especially in vulnerable populations
        - LGBT, trafficking, male, elderly, child

- **Process:** observation → question → hypothesis → experiment → analysis → conclusion

- Role of Forensic Nurse
    - ID survivors of violence, and are trained to assess patient or know who to refer to
    - Document properly, take hx and PE
        - Know how to gather evidence and to minimize trauma to prevent increased trauma to patient
        - Be aware of cultural & special considerations that could increase trauma
        - Treatment of life threats, injuries, pain, anxiety
        - Top place is ED or specilaized clinic for sexual assault
        - Make sure to clarify at the end (Melissa puts in parenthesis)
            - Did you hear, see, feel, etc anything to gather as much info as possible to document the senses which is heightened in the survival mode of trauma
        - Written, photographed of the physical evidence, digital is preferred

        - **Documentation** → use clock face (12-3-6-9) to state where injury was with diagrams
    - Obtain consent
        - For care and release of medical information to parties (police, etc.)
    - Police reporting (can be blind)
        - Federal law that patient can have it collected anonymously or without making a police report
    - Crisis intervention, nurse is advocate
        - Victim advocate early on at the bedside
    - Evidence collecting, preservation, chain of custody
    - Medication, testing for STI, counseling and follow-up
        - Prophylaxis for STIs, HIV within first 48 hours but can go to 3 days
        - Verify if they have had Hep B vaccine → check titer if they have had the series
            - Low titer means they must repeat series
        - Emergency contraceptive
        - **Follow CDC guidelines for STI care, and HIV, Hepatitis care**
            - STI guidelines have a seperate section for sexual assault
            - Princeton university publishes yearly about emergency contraception
    - Discharge, teaching, follow up
        - Who do they need to see after leaving, injury care <2 weeks to be reevaluated and photographed
        - Homicide risk screening if they are survivors of domestic violence
            - Safety planning and referral to safe shelter if needed
            - Counseling ASAP
    - Testimony (presentations)
        - Injury/lack of injury and why
    - Community education, current/past standards of care, self-care
        - What was the standard of care during that time versus now for court
    - **Critical for forensic nurses to partake in self-care**
- **Multidisciplinary Team Approach**
    - Patient is the center of care
    - Attorney, law enforcement, advocates, mental health, health providers, crime lab, EMS, etc.

- Typical findings to look for in sexual assault
  - **Medical Evaluation Findings**
    - Loss Of Consciousness
    - Substance abuse with LOC
    - Chest pain, head injury
    - Life-threatening trauma
    - Pregnant
    - Vaginal/rectal bleeding
    - Patient requests physician
  - **Female anatomy**
    - Injuries can begin to heal quickly within one day ⟶ Sooner they come in the better
    - Hymenal tissue looks different in postbuescent patients than prepubescent
      - Younger patients have more hymen tissue around vaginal opening that recedes with age
    - Injuries, abrasions on the labia majora
      - Lower half towards the posterior area of the labia majora is most common area of injury
    - Cervix for redness, petechial hemorrhage, discharge
      - Culture for STIs to rule things out/in
      - *Note:* Circumferential redness around the os in the cervix can often be confused with trauma
    - Bruising of urethra
    - Hematoma in the vaginal canal, lacerations
    - * Look for/Collect any hair that does not belong to patient
    - Check perianal folds, even with vaginal assault
    - Look for any bruising, petechiae, posterior fourchette tear
    - Use the colposcope to examine which allows magnification and has a camera to document within 48 hours
  - **General appearance:** Shell shocked, flat affect
  - **Oral**
    - Soft/hard palate of the mouth see bruising, petechiae
    - Under the tongue bruising
  - **Rectum:** dentate line is the most common area of injury with anal assault
    - Look like a stellate pattern if patient is relaxed, but is not lacerations
    - Should look pink and healthy

- **Male anatomy**
  - Anatomy stays fairly consistent regardless of age unlike female anatomy
  - Most common sites of injury is head of penis and glands, may have injuries on the shaft
    - Bite, suction injuries
    - Degloving
  - More severe injuries are anal with males
- **Non genital injuries:** bruises, bite marks, burns
  - Petechial hemorrhaging on scalp from being yanked from roots
  - Strangulation → petechial hemorrhaging in eyes
    - Make sure to have the patient look up, down, side to side
    - Thumb mark on the chin
  - Grab marks can be circular or crescent shaped
    - 18 hours for brown yellowing bruising to see
  - Hand injuries
    - Broken nails, bruising, lacerations
  - Injury cross planes is concerning
  - Clean cuts = knife
  - Handprints have sparing
  - Bite marks need to be documented first then swabbed
  - Defensive wounds
  - Should never see wounds between legs outside of sexual assault
  - 6 cm or larger bruising on eldery is highly suggestive of abuse
  - Facial tears, multiple skin tears concerning for abuse
- **Presentation Considerations**
  - Underlying mental health
  - Alcohol, drugs (confounders)
  - Delay in seeking care, lost of evidence, deteriorating health
  - Kissing, fondling, cunnilingus, fellatio common can still allow evidence to collect even if its not penis/vaginal penis/anal
- **Beyond the "usual" symptoms → indications of drug involved assaults**
  - "Hangover" not consistent without amount of drugs/alcohol ingested
  - Unexplained bodily fluid, person they don't know in the bed, others have told them they were assaulted
  - Vaginal/rectal pain, no memory
  - Partially dressed, undressed, unknown how
  - Unexplained injuries
  - Cannot remember some or all of the event but suspect

            - Unsure if consented or were assaulted because of EtOH/drug intact
        - Witnesses may report that they were acting out of character for how much alcohol/drugs they consumed

- Medical Intervention
    - Most heal within 48-72 hours
    - Very few will have physical injuries that require care. Patients maybe injured but not require intervention
    - Longer it takes to show up for care → the less likely the injury can be identified and evidence collected
    - **Sexual Homicides**
        - Face and extremities are most common area of physical injury
        - Significant have documted Anal-genital injury
        - Large portion die of blunt-force AG trauma
            - Perforated injury, prolonged death
    - Increased risk of injury with educations status because of fighting back, use of fingers, alcohol use, virgins
        - Less likely to sustain with parity

- Sexual Assault Among Different Groups
    - **Treat males similar**, but they have insult to masculinity, worry about perception and sterotypes against them (i.e.people will think they are gay, etc.)
        - Provide similar medical care, important to treat and recognize this
        - Males are more likely to fight back → head trauma
    - **Younger age**
        - Statistically has an increased number of injuries; whites 4x more likely to have genital injury than blacks
            - Darker skin tone perhaps results in missing the injuries → need to check carefully
    - **No statistical difference in presence of injury between non-consensual/consensual groups**
        - Injuries can look similar b/w groups but if labia minora injuries present it can strongly suggest sexual assault (uncommon in conseual group)
            - More likely to have 2+ injuries in non consensual group
    - **Digital penetration**
        - Still need to do a pelvic exam if they agree -- still have genital injuries

        - Do not include “redness” since it is non-specific and not considered to be specific enough as an injury
            - Need to add tears, bruising, petechiae which are more specific

- Helpful Articles to learn more
    - **McCann et al (2007)** is great article on healing of injuries in pubescent/adolescent girls
    - **Adams Classification/Interpretation of Medical Findings in Suspected Child Sexual Abuse**

- Reason for Lack of findings
    - Too intoxicated/relaxed to leave injuries
    - Efforts by offender to prevent evidence transfer
    - Forensic nurses are unavailable, incorrect exam techniques
    - Other evidence, videos, cell phones for evidence -- not just on the body
    - Heal quickly
    - Unaware of the assault
    - Nonpenetrating contact
    - Not sure what is considered a finding
    - Delayed reporting
    - Injury from post assault
    - Post-assault hygiene -- shower, shave, change clothes to destroy evidence (offender)

- **Techniques and Tools**
    - 5 days within assault to collect evidence for penis/vaginal contact
        - Semen can be found up to 5 days in the vagina
    - Mouth and anus have <3 days to collect
    - History of the event is critical
        - Prepubescent do NOT interview, sent to forensics for interview
            - Can be lead, impressionable
    - Drug evidence
        - Blood: 24 hours
        - Urine: 5 days
        - **No sample after 5 days**
        - Opiates stay longer than cocaine, etc.
    - Every state in the US has evidence kit with step-by-step instructions on how to collect evidence

        - Follow exactly in order to properly collect evidence
        - Collect head down to toes
        - Outside of body than to inside of body (least to most invasive)
        - Most kits collect cut hair
        - Take underwear, pads/tampons
        - Pubic hair cut if they have it
        - Swabs of external and internal genitalia, perianal
    - Kids have a modified kit, no internal swabbing or blood collection just oral swab to compare DNA
- **Toluidine Blue Dye** -- nuclear stain that stains ruptured cells for trauma
    - Deep blue = reactive
    - Burns on open injury so not used commonly now with colposcope
- **Alternate light source** to scan for fluorescent (semen) and swab, can see bruising, bites
    - Record as what you see but cannot identify it as a bite mark/bruise etc so report as a different color, etc
        - Makeup, etc will look like bruising or a finding under alternate light source so be careful
    - Semen has a protein band, glows (emits light) while blood absorbs light and appears dark
        - Urine also emits light but less than semen
    - Use it to further highlight a finding you see in ambient lighting
- **Foley catheters** can be used to see findings in a young child?? Tanner stage 3

Questions

1. **How do you ask questions without triggering a patient or causing more trauma?**
    i. *Never make them talk about what they don't want to talk about. "Tell me what you think is important for me to know."*
    ii. *These patients will already be triggered and anxious, but it is important to be sensitive and respectful for where they are at at that time. Respect the boundaries and don't make them go past where they don't want to go. Explain the pros and cons if you need to, but respect their decision.*

    b. **Do you find that taking photographs is and doing the physical exam is triggering and causes anxiety for the patient?**
    i. *Explain the procedure step by step and minimize what you need to do during the evidence kit.*
    ii. *Hardest part is the anogenital exam or the part of the body where they were assaulted. Many patients report that once they cry and release their emotions, it helps with the difficult nature.*

iii. *There will be pieces that are triggers, but we are there to support and it can be helpful for them to have personal supporters as well.*

c. **What can be done to minimize additional trauma for the patient?**

i. *Try not to overwhelm them. When collecting-- "this is what this is and this is why we are collecting it". If patient starts crying during sensitive parts of the exam, encourage it-- this often helps the patient's mental health following their assault. Talk patients through exams one step at a time. Show caring, kindness, and compassion to all patients.*

2. **If there is a superficial vaginal or skin injury that needs repair, can you do the suturing?**
   a. *NO, but if the patient needs it and it is superficial an NP in clinic can do this, but otherwise they are sent to the local ED for laceration repair.*

3. ***Is there a limit to when the rape kit can be done if they don't report right away?***
   a. *Less than 24 hr: blood and urine*
   b. *24 hour - 5 days: urine only*
   c. *> 5 days: no samples collected*

Type of Assault	Maximum Collection Time
External • Cunnilingus (thighs/external genitalia sample only) • Saliva on skin (bitemarks, kissing, etc.) • Strangulation (neck sample only)	• Within 96 hours (4 days/no smears if sole allegation) • Within 96 hours (4 days/no smears) • Within 48 hours (2 days/no smears)
Vaginal • Penile penetration • Digital penetration (thighs/external genitalia sample only)	• Within 120 hours (5 days) • Within 48 hours (2 days/no smears if sole allegation)
Anal • Penile penetration • Digital penetration (perianal/buttocks sample only	• Within 72 hours (3 days) • Within 48 hours (2 days/no smears if sole allegation)
Oral • Fellatio	• Within 24 hours (1 day)

4. **How can testing for STIs at time of victim presentation determine whether they were given by the offender vs the victim was already infected prior to assault (i.e., how are timelines determined, especially if the offender is not found/able to be tested)?**
   a. *Depends on the organism.*
   b. *There may be some virulent strains of gonorrhea where someone is positive within a few days, but it's uncommon. If the test is positive within a few days, it's likely they had it beforehand.*

c. *If it's a child, it is usually suspected as part of the assault.*

5. **When examining a male victim of sexual assault, what aspects of the examination are the same and what aspects are different?**
    a. *Males treat similar to females, but is a huge insult to their ego (they think people might think they are gay)*
    b. *Rectal intercourse events are generally more common than oral.*

6. **As a general rule, and when possible, should the examiner and patient be the same gender?**
    a. *Absolutely does not matter. Females seem to respond well if exam is carried out by same sex of offender → shows them there are good males). Sometimes exams are limited secondary to cultural differences.*
    b. *Always have a chaperone present, even if the examiner is of the same sex of the patient. It is too big a risk to not have a chaperone (especially if alcohol or drugs are involved).*

7. **What forensics are required to conduct an examination on a sexual and physical assault victim who has recently been buried?**
    a. *Another level of what they might need, but if went to ME, examiner must be familiar with sexual assault injuries and know how to carry out the examination. However, once the body starts to decompose or the body begins to relax, evidence/injuries can look drastically different. This is why this requires someone who knows what exactly they are looking for, be able to examine anatomy, and know how injuries can change post-mortem.*

8. **How do you help a victim that wants to protect their aggressor by not reporting them?**
    a. *Super common. Doesn't mean we give up on trying to help them. These patients are usually afraid of death. Until they are ready to leave the relationship we keep working with them. Don't force them to do anything they don't want to do. Allow patients to come to the decision on their own. Give patients all the information needed to make their decision and encourage them that this is a safe place to return to if they do eventually come to the decision to leave their aggressor.*

9. **If a patient comes in with their potential offender (i.e., spouse or family member) how can you safely ask them to leave the room for privacy without escalating the situation?**
    a. *Usually say "i need to take you to the bathroom for a urine sample. Hey we have to go for X-Rays or CTs and you can't be in the room. They're going to probably be*

gone for a long time, so maybe you can go home and when they are finished we can call you back?"

b. *There is always a way → find it!*

10. H**ow long does it take to become a SANE nurse?**

a. *40-60 hours + clinical hours*

b. *https://www.forensicnurses.org/page/40HourSANE*

11. Do **doctors have a course equivalent to the SANE training? Or is there any training doctors can take to be especially helpful to sexual assault victims?**

a. *Can take the same courses. Adult and then pediatric but not the exam*

12. What percentage of patient's die from primary/secondary injuries of sexual assault/rape?

a. *1% die in connection to their SA; 4-5% have critical injuries*

13. Transgender SA

a. *Verify preferred pronouns. Whole separate protocol due to changed anatomy (surgical changes, hormonal therapy changes). A lot of patients will refuse to let you look at their genitalia, but do as much as they are willing to see. Treat them like any other patient while also adressing any additional things that go along with transgender clinical concerns. Different evidence considerations for these patients.*

14. How do you approach a patient you believe has been sexually assaulted based on the injuries but denies the assault, or does not want to discuss it

a. *You have to confront it head on. Can sometimes be painful, but try to be gentle about it. "I'm not saying I don't believe you, but let me tell you what I am concerned about and why I am concerned." Show empathy. Explain why patient's exam findings do not relate to the details of their reported story. Relay this information gently and without being aggressive or condescending. Don't outright say "I think you're lying or I don't believe you". Confront these patients with heart and genuine concern.*

Vets going out to homes can be witness to sexual adult/child sexual assault. Also, animal abuse can be a sign of other abuse that is occuring in the household.