Sexual Assault

- **Forensic Evidence Kit**
  - Permission from client
  - May require hours to complete
  - Nurse may have to testify in court, if a case is heard
  - Complete as per regional policies
  - Ensure instructions are followed for specimen collection
  - Informed consent
  - Ensure chain of evidence is not broken

Additional Notes:

Diagram: Body map, Examples of forms

III: THE SEXUAL ASSAULT EVIDENCE KIT (SAEK) GUIDELINES

After 72 hours have elapsed, only **pertinent** samples should be collected using the kit (see the "Time Line for Collecting SAEK Samples" on the inside cover of the Kit). The physician or nurse examiner should **use discretion** as to which samples are collected for forensic evidence. Their decisions should be based on the history of the assault, the time interval between the assault and the examination for the collection of evidence samples, and if possible, consultation with the investigating officer. As a guide, the longest reported times for the persistence of semen in various body cavities are specified in the uppermost box on the sheet entitled "Instructions for Evidence Collection". If the assault occurred more than 72 hours before the examination and if pertinent, it is suggested that the following samples be taken:

a) Buccal FTA sample for DNA
b) Vaginal specimens
c) Underwear worn at time of assault (clothing if relevant)
d) Documentation of injuries

Prepubertal children
Use the kit only if the assault has occurred within 24 hours. (For abuse or assaults over 24 hours refer to the hospital's child abuse form or see the Ontario Hospital Association Manual).

When the patient is under the age of 16 it is mandatory BY LAW to report the assault to the Children's Aid Society. It is their decision whether or not to notify the police and/or the parents.

Use the kit in all cases where there is likelihood that there will be physical evidence (including non-penetration or non-penile penetration cases) regardless of the status of the assailant (i.e., known or unknown). The forensic evidence may have limited use in cases where the victim knows the identity of the assailant. Consult with the investigating officer when deciding what evidence to collect.

IMPORTANT: Once the kit is open, never leave evidence unattended.

B. TO RELEASE THE KIT TO POLICE

Release of SAEK to police (Consent Form II)

The patient must sign the consent form (II) in order to release the SAEK to the police. Otherwise the police require a search warrant to obtain the evidence.
The consent to release the kit can be signed by the physician/nurse examiner or the police officer.

C. DISTRIBUTION OF FORMS:

Distribution of the forms to the hospital, police, and the forensic laboratory is listed at the bottom of each form.

INSTRUCTIONS FOR EVIDENCE COLLECTION
DOCUMENT EVIDENCE COLLECTION ON ATTACHED FORM ------ DETACH AND DISCARD INSTRUCTIONS

IMPORTANT: Evidence collected and documented in this kit should be based on the history of the assault. The time interval between an assault and the attendance at a hospital or medical facility will determine what samples to collect. The following specimens should be collected up to the times specified: VAGINAL, up to 7 days; ORAL, up to 24 hours; BLOOD, up to 48 hours; RECTAL and URINE, up to 3 days. In addition, reference to the "Sexual Assault Forensic Evidence Form" will assist in sample collection. When possible, consult with the investigating officer. Collect evidence in the order that is outlined below for the best forensic practice. Secure all containers. Ensure bar-coded item labels are affixed to evidence containers in a way that allows the barcode to be scanned.

NOTE: If possible, the patient should not void, until Steps #1 to 9 have been completed to avoid loss of evidential material. If not possible, avoid wiping or save tissue in container 7-4 and freeze.

NOTE: In cases when the kit is not submitted to the police immediately, place the completed kit containing underwear into the evidence-drying pouch, seal and freeze.

STEP #1: CLOTHING AND DROPSHEET (Collected by nurse at discretion of physician/nurse examiner in consultation with officer).

Have the patient stand on the two layers of paper provided (1-9). The larger sheet is placed on the floor, with the smaller sheet placed on top. Remove each item of clothing (including shoes) separately. Place articles of clothing in separate paper bags (1-1 to 1-8) as removed. Bag items over paper to prevent loss of trace material. Affix the bar-coded item label(s). Secure each bag with tape. Carefully fold the TOP SHEET of paper to enclose any debris and place in envelope (1-9). Affix the bar-coded item label. Secure the envelope with tape. Discard the bottom sheet. The evidence-drying pouch may be used to hold the other bags or may be used to hold a large, bulky clothing item. Place packaged clothing and drop sheet in a secure location until forwarded to the investigating officer.

BODY EVIDENCE

STEP #2: ORAL SWABS AND SMEAR

Take 2 ORAL SWABS (2-1 and 2-2; preferably taken simultaneously) by thoroughly rubbing along gum and teeth margin. Using either swab, make an oral smear (2-3) by rolling the swab onto the "frosted" side of the slide. Allow slide to air dry and place in holder. Add the bar-coded item label on the holder. Secure the holder with tape. Place holder into the self-sealing envelope provided. Place swabs in swab box provided. Affix the bar-coded item label(s) to it. Ensure the box is properly closed.

For Hospital Use Only. Swab is not included in the kit:
Take pharyngeal swab for gonorrhea if oral penetration has occurred.

STEP #3: FINGERNAIL CLIPPINGS/SCRAPINGS

Note: If clippings are to be done, do not take scrapings. If clippings are collected, use a different, clean, sterile pair of scissors for each hand. Scissors are not provided.

Collect FINGERNAIL CLIPPINGS/SCRAPINGS (3-1 for left hand; 3-2 for right hand) for each hand separately. Place hand over respective paper, clip or scrape fingernails and fold paper to enclose contents. Place wooden scraper 3-1 and 3-2 back into their respective containers. Place containers and corresponding folded paper into their respective envelopes. Affix bar-coded item label(s). Secure in self-sealing envelope(s).

STEP #4: SKIN SWABS

Moisten a swab in sterile water. Using swab, remove any deposits on the skin including bitemarks. Use one sterile swab for each site. Individually place each swab in a swab box provided (4-1, 4-2, 4-3, 4-4). Affix the bar-coded item label(s). Ensure the box(es) is/are properly closed.

STEP #5: HEAD HAIR AND COMBING

Unfold paper containing comb provided in envelope 5-1. Have patient shed HAIRS on paper by massaging scalp and combing hair. Fold paper containing comb and hair and return it to envelope 5-1. Affix the bar-coded item label. Secure in the self-sealing envelope.

STEP #6: BLOOD

A total of 4 tubes of blood may be required. For children defer all blood work until it is required for forensic purposes. An appropriate volume for children is 5 ml.

6-1 (Grey Top) Take 1 tube of BLOOD for alcohol and drug analysis. Do not fill the tube completely as it might crack if frozen. Place a numbered SAEK seal over the tube cap. Affix the bar-coded item label. Place the tube in the protective holder. Place holder in the bag provided for Toxicology samples. Seal the bag and freeze or refrigerate.

For Hospital Use Only. Tubes are not included in the kit:
Collect 5 ml of BLOOD for Hepatitis B screen, 5ml of BLOOD for hold (future HIV testing or baseline HIV testing if patient accepts HIV PEP) and if necessary, 5 ml of BLOOD for HCG. Other tests may be medically indicated. Refer to medical guidelines regarding HIV and hepatitis protocol.

PROCEED WITH GENERAL EXAMINATION.

Guidelines: a) Respect need for privacy and appropriate draping.
b) Vaginal specula: For procedures 9-1 and 9-2 warm speculum under tap water - DO NOT USE lubricant or lubricated specula.
c) Prepubertal: If there is no evidence of genital bleeding or trauma to external genitalia area an internal, manual or speculum examination should not be done unless medically required. An anaesthetic should be used only if medically indicated. Proceed externally with swabs 8-1 and 8-2.

STEP #7: PUBIC HAIR AND FOREIGN MATERIAL

Cut out any deposits found in the pubic hair. Place in paper provided in envelope 7-1, fold and return to envelope 7-1. Comb the pubic hair for loose hairs, fibres, etc., with comb onto paper provided in envelope 7-2. Place combings and comb on paper, fold to enclose contents and return to envelope 7-2. Place any FOREIGN MATERIAL (hairs, fibres, etc.) found in vagina/rectum on paper provided in envelope 7-3, fold and return to envelope 7-3. If foreign material requires freezing (e.g. used condom, tissue after voiding), place material in vial 7-4 close and freeze in a secure area. A used tampon or sanitary napkin can be placed in bag 7-5 which should then be closed and frozen in a secure area. Affix the proper bar-coded item label(s) to the container(s). Place in self-sealing envelope(s)

STEP #8: EXTERNAL GENITALIA

Use two swabs (8-1 and 8-2; Note: preferably taken simultaneously) moistened with sterile water to collect any deposits on external genitalia from a female patient. For a male patient, use one swab only (8-1), moisten in sterile water and collect material from the exterior surface of the penis. Place swab(s) in swab box provided. Affix the bar-coded item label(s) to it. Ensure that the box is properly closed.

STEP #9: VAGINAL SWABS AND SMEAR

Take 2 swabs of the VAGINAL FORNIX (not cervix) (9-1 and 9-2; preferably taken simultaneously). Swab thoroughly. (In pre-pubertal females use swabs moistened in sterile water and swab the introitus which is the external area around the opening of the vagina to the hymen). Using either swab, make a vaginal smear (9-3) by rolling the swab onto the "frosted" side of the slide. Allow slide to air dry. Place in holder. Affix the bar-coded item label on the holder. Secure the holder with tape. Place holder into the self-sealing envelope provided. Place swabs in swab box provided. Affix the bar-coded item label(s) to it. Ensure the box is properly closed.

For Hospital Use Only. Do not submit with kit. Swabs are not included in the kit:
In Adult Females:
Do a cervical swab for gonorrhea and chlamydia and a vaginal swab for trichomonas.
In Prepubertal Females:
Moisten swabs in appropriate transport medium and swab introitus for gonorrhea, chlamydia and trichomonas.
In Males:
Anal swabs for gonorrhea and chlamydia may be indicated.

STEP #10: RECTAL SWABS AND SMEAR

After cleansing anal area with sterile water, take RECTAL SWABS (10-1 and 10-2; preferably taken simultaneously). Using either swab, make a rectal smear (10-3) by rolling the swab onto the "frosted" side of the slide. Allow slide to air dry. Place in holder. Add the bar-coded item label on the holder. Secure the holder with tape. Place holder into the self-sealing envelope provided. Place swabs in swab box provided. Affix the bar-coded item label(s) to it. Ensure the box is properly closed. Use 7-3 for foreign material found in the rectum. Affix bar-coded item label and freeze sample.

For Hospital Use Only. Swab is not included in the kit:
Do rectal swab for gonorrhea and chlamydia if rectal penetration has occurred.

STEP #11: BUCCAL SWAB ON FTA PAPER

Have patient thoroughly rinse mouth with 10ml sterile water and discard. Using swab 11-1, thoroughly rub the inside of the cheeks, tongue and gums with the foam tipped applicator using an up and down motion. Alternatively, the patient may perform this step if the patient feels more comfortable. Handle the collection card by the edges only (wearing gloves). Firmly press both sides of the applicator onto the circle on the collection card using a rocking motion. Affix the bar-coded item label to the card. Place the collection card and desiccant into the self-sealing bag provided (11-1).

STEP #12: URINE

Collect URINE for drug and alcohol analysis in a sterile container (not provided in the kit). Pour at least 10 ml of URINE into container 6-2 containing preservative. Replace cap, close tightly. Affix the bar-coded item label. Place a numbered SAEK seal over the lid. Place samples 6-1 and 6-2 in the bag provided for Toxicology samples. The seals provided can also be used on the bag provided. Please refrigerate or freeze the samples.

NOTE: Use the information box on the Sexual Assault Forensic Evidence Form (pg 3) for recording any additional information that may be of forensic relevance.

V: SEXUAL ASSAULT FORENSIC EVIDENCE FORM
(To be completed by examining physician/nurse examiner)
PRINT LEGIBLY AND PRESS HARD

Kit No._____

HISTORY

Did the assailant kiss, lick or bite any area of the patient's body (non-genital)? If yes, specify what occurred: ☐ Yes ☐ No ☐ U/K

Were alcohol or drugs used within 24 hours prior to the assault? If yes, describe type, amount, and time period. ☐ Yes ☐ No ☐ U/K

Were alcohol or drugs used between the time of the assault and sample collection? If yes, describe type, amount, and time period. ☐ Yes ☐ No ☐ U/K

Describe any physical or mental impairment experienced prior to, during, or after the assault. When were these symptoms experienced?

BODY EVIDENCE

Sample	Reason collected?	Done	Not Done
STEP 4: Deposits on skin (swabs) (for foreign body fluids)			
4-1 Site _____	_____		
4-2 Site _____	_____		
4-3 Site _____	_____		
4-4 Site _____	_____		
STEP 5: 5-1 Combing of head hair		☐	☐
STEP 6: Regardless of the history, the following sample should be collected: 6-1 Blood for alcohol/drug(s) analysis Time taken: _____		☐	☐

HISTORY

Females Only:

At the time of the assault was the patient menstruating?	☐ Yes	☐ No	☐ N/A
At the time of the examination was the patient menstruating?	☐ Yes	☐ No	☐ N/A
Prior to the assault had there been any vaginal bleeding?	☐ Yes	☐ No	☐ N/A
Since the assault has there been any new vaginal bleeding?	☐ Yes	☐ No	☐ N/A

Was there penetration or attempted penetration of the patient's vagina by:

1) the assailant's penis?	☐ Yes	☐ No	☐ U/K
Was there ejaculation by assailant?	☐ Yes	☐ No	☐ U/K
If yes, specify: Internal ☐ External ☐			
If external specify location_____			
Was a condom used?	☐ Yes	☐ No	☐ U/K
If yes, did it remain intact?	☐ Yes	☐ No	☐ U/K
2) the assailant's mouth/tongue (cunnilingus)?	☐ Yes	☐ No	☐ U/K
3) the assailant's finger?	☐ Yes	☐ No	☐ U/K
4) an object? Specify: _____	☐ Yes	☐ No	☐ U/K

Males Only:
Did the assailant attempt or perform fellatio on the patient? ☐ Yes ☐ No ☐ U/K

GENITAL/ANAL EVIDENCE

Sample	None Found	Done	Not Done
STEP 7: 7-1 Deposits in pubic hair (clippings in envelope)	☐	☐	☐
7-2 Combing of pubic hair (envelope)	☐	☐	☐
7-3 Foreign material from any location (envelope) Location: _____ Description: _____	☐	☐	☐
7-4 Foreign item requiring freezing (vial) Location: _____ Description: _____	☐	☐	☐
7-5 Bag for tampon or sanitary napkin Description: _____	☐	☐	☐
STEP 8: 8-1 External genitalia or penile swab		☐	☐
8-2 External genitalia or penile swab		☐	☐
STEP 9: 9-1 Vaginal swab		☐	☐
9-2 Vaginal swab		☐	☐
Time: _____ 9-3 Vaginal smear		☐	☐

: No._____

MEDICAL STAFF:

Hospital Name	Hospital address		Hospital Telephone Number
Physician/Nurse Examiner	Name (Print)	Date	Signature
Assisting Nurse	Name (Print)	Date	Signature

A. Person transferring items to police (To be completed by the physician/nurse examiner/hospital staff member transferring exhibits to police):

Name (Print)	Signature	Date and Time of transfer

B. Police officer receiving items:

Receiving Officers Name (Print)	Badge	Signature
Police Service (Print)		Division / Detachment

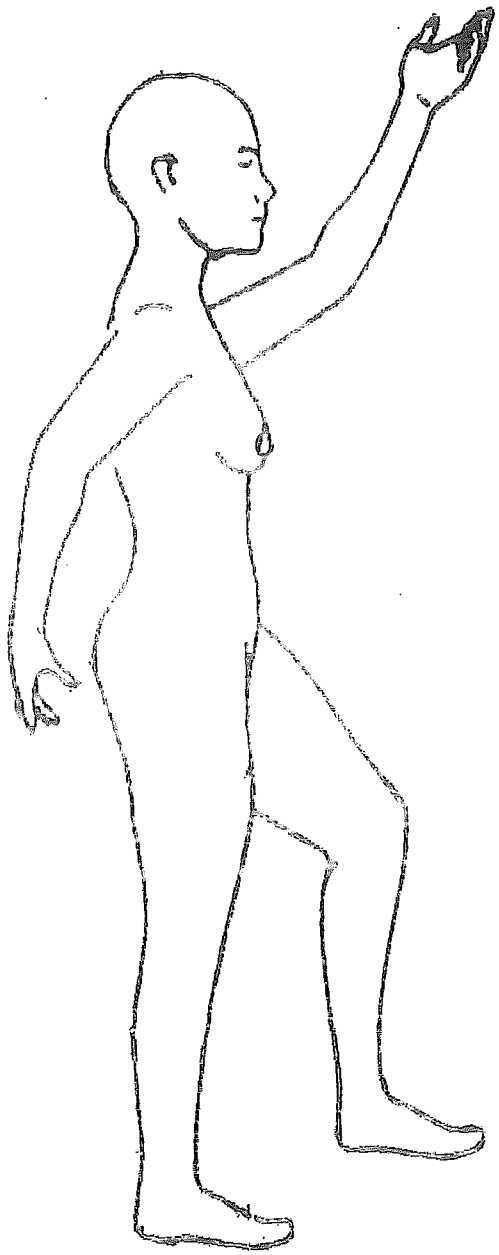
VI: PHYSICAL EXAMINATION FORM

Kit No. _____

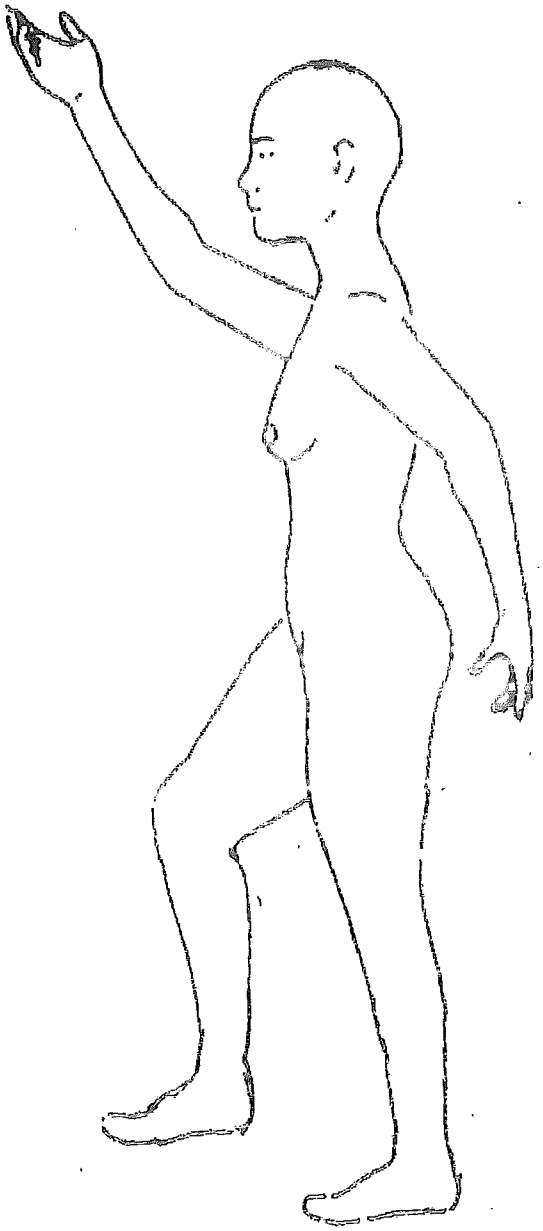
Mark all injuries relevant to the assault as well as areas of tenderness and Woods light findings on the diagram. Describe colour, appearance and size of injuries. Provide a brief history of injuries. **USE QUOTATION MARKS IF YOU ARE USING THE EXACT WORDS OF THE PATIENT.**

DESCRIPTION OF INJURIES

Body – Profile Right



Body - Profile Left



Physician/Nurse Examiner's Signature	Date	Time
Hospital Records - White Copy	Police - Gold Copy	

VI: PHYSICAL EXAMINATION FORM

Kit No. _____

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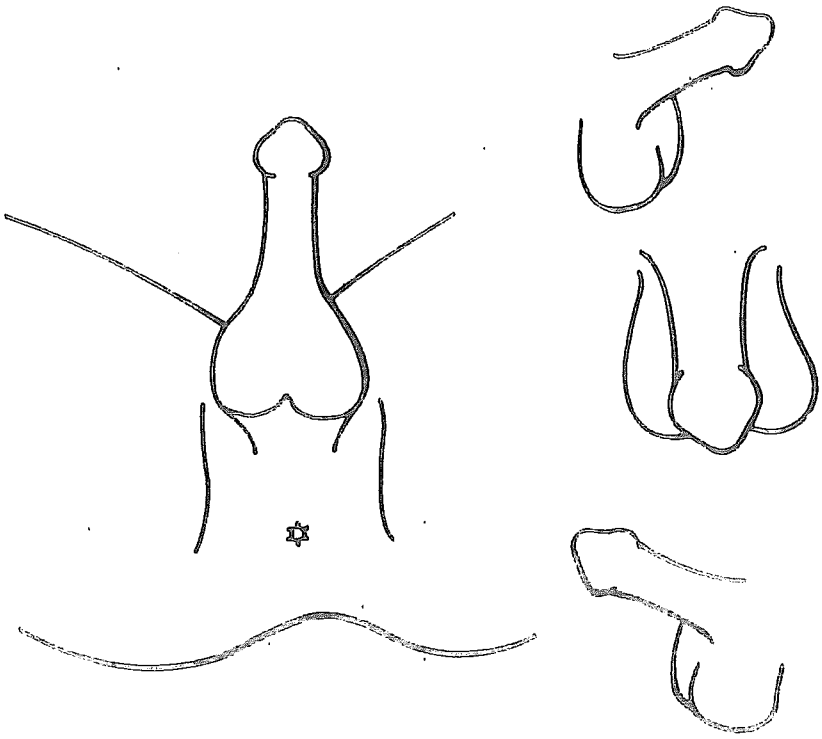


FOR MALE PATIENT

Penis:

Scrotum:

Anus:

Rectum:

Physician/Nurse Examiner's Signature	Date	Time
Hospital Records - White Copy	Police - Gold Copy	

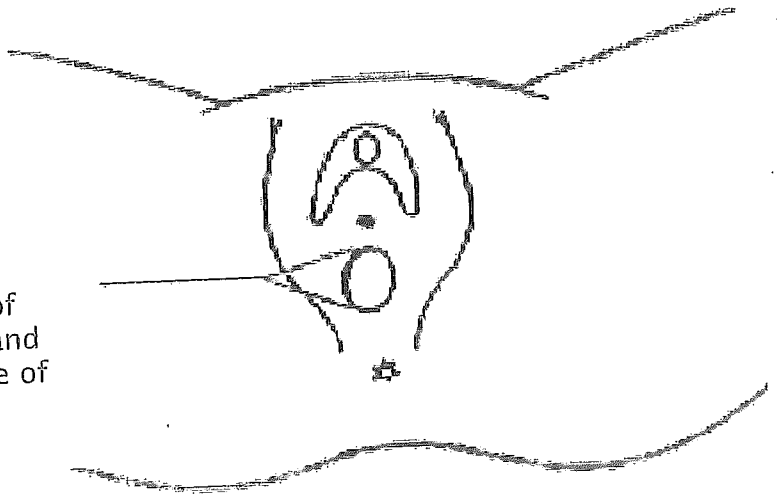
VI: PHYSICAL EXAMINATION FORM

Kit No. _____

Mark all injuries relevant to the assault as well as areas of tenderness and Woods light findings on the diagram. Describe colour, appearance and size of injuries. Provide a brief history of injuries. **USE QUOTATION MARKS IF YOU ARE USING THE EXACT WORDS OF THE PATIENT.**

PREPUBERTAL FEMALE

Draw in outline of Hymen and note size of vaginal injuries



Labia, Majora and Minora:

Posterior Fourchette and Introitus:

Hymen:

Anus and Rectum:

CHILDREN

Stages of secondary sex characteristic development should be noted for all children/adolescents according to the tanner staging described below

Tanner Staging: Girls: Breasts _____ Pubic Hair_____

Boys: Genitals_____ Pubic Hair_____

Girls: Breast development

- Stage 1: Pre-adolescent elevation of papilla only.
- Stage 2: Breast bud stage: elevation of breast and papilla as small mound. Enlargement of areola diameter.
- Stage 3: Further enlargement and elevation of breast and areola, with no separation of their contours.
- Stage 4: Projection of areola and papilla to form a secondary mound above the level of the breast.
- Stage 5: Mature stage: projection of papilla only, due to recession of the areola to the general contour of the breast.

Boys: Genital development:

- Stage 1: Pre-adolescent. Testes, scrotum and penis are of about the same size and proportion as in early childhood.
- Stage 2: Enlargement of scrotum and testes. Skin of scrotum reddens and changes in texture. Little or no enlargement of penis at this stage.
- Stage 3: Enlargement of penis, which occurs at first mainly in length. Further growth of testes and scrotum.
- Stage 4: Increased size of penis with growth in breadth and development of glands. Testes and scrotum larger scrotal skin darkened.
- Stage 5: Genitalia adult in size and shape.

Both sexes: pubic hair

- Stage 1: Pre-adolescent. The vellus over the pubes is not further developed than that over the abdominal wall (i.e. no pubic hair).
- Stage 2: Sparse growth of long, slightly pigmented downy hair, straight or slightly curled, chiefly at the base of the penis or along labia.
- Stage 3: Considerably darker, coarser and more curled. The hair spreads sparsely over the junction of the pubes.
- Stage 4: Hair now adult in type, but area covered is still considerably smaller than in the adult. No spread to the medial surface of thighs.
- Stage 5: Adult in quantity and type with distribution to the horizontal (or classically 'feminine') pattern. Spread to the medial surface of thighs but not up linea alba or elsewhere above the base of the inverse triangle (spread up the linea alba occurs late and Is rated Stage 6)

Physician/Nurse Examiner's Signature	Date	Time

Hospital Records - White Copy	Police - Gold Copy