

MASSACHUSETTS SEXUAL ASSAULT NURSE EXAMINER PROGRAM  
PROTOCOL FOR ADULT/ADOLESCENT SANEs and EMERGENCY  
DEPARTMENT CLINICIANS

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## SECTION VI

### CARING FOR SPECIAL PATIENT POPULATIONS

#### **Adolescent Patients (12 - 17 Years)**

##### **Principles of Care**

While some adolescents usually respond well to safe touch (e.g. touching on shoulder or arm), sexual assault patients need to have their physical boundaries respected to avoid feeling that they have no control over who can touch their bodies.

- Always ask if it is okay before you initiate any touch.
- Respect the patient's personal boundaries. For example, do not pressure them for details they are not comfortable providing, or discuss details of the assault with their guardian without their consent.
- Inform them what you are required to do as a mandated reporter (see "Mandated Reporting" below).

**Be Honest:** Do not tell adolescents you will keep secrets or not tell anyone if you know you cannot. You can tell the patient that you will do your best to support them and help them feel safe, but do not make any promises you cannot keep or may not be able to keep. Remember, telling an adolescent that you will "try" to do something is usually taken as a promise! Regaining their own trust of self and of others is extremely important for the patient. Sexual assault victims often feel tremendous shame and guilt, so the more you let them control information surrounding the assault, the better they will feel.

##### **Helpful Tips for Working with Adolescents**

- As with adults, adolescent patients should be given control over their exam, including setting the pace of their exam.
- Allow adolescent to choose their support people such as a parent, guardian, friend or rape crisis advocate.
- Engage with the adolescent using non-threatening questions.
- Listen without judgment.
- Be mindful of your body language; try not to appear rushed or distracted.
- Allow the teen to set the pace of this encounter.
- Do not promise what you can not deliver, especially as it pertains to confidentiality
- Avoid asking "why" questions. "Why" questions tend to put people on the defensive. Instead, consider rephrasing such as: "Can you tell me more about \_\_\_\_\_?"
- Match the adolescent's emotional state unless it is hostile. Reflecting on someone's mood helps the individual feel understood.
- Recognize and respect possible potential ambivalence. Reassure the patient that ALL of his/her feelings are normal.

##### **Obtaining Adolescent Consent**

- Adolescent patients may independently seek post-assault care under MGL Chapter 112/Section 12F.
- All adolescents have the opportunity to consent and decide who is present for the exam without the influence of the parent/guardian.
- Parents/guardians must be informed that a forensic examination/forensic evidence collection will not be completed without the explicit consent of the adolescent.
- Adolescent patients must consent to SANE care, completing a forensic examination and forensic evidence collection, and sign the Form 1 Patient Consent.
- Adolescents < 16 years should be informed that their forensic evidence kit will be analyzed by the crime lab, whether or not they choose to report their assault to the police.
- Adolescents who are 16 -17 years of age should be informed that their forensic evidence kit will not be analyzed unless they report their assault to the police.
- Adolescent patients should be notified that the SANE is a mandated reporter and must submit a 51A report to the Department of Children and Families (see Mandated Reporting below).

# MASSACHUSETTS SEXUAL ASSAULT NURSE EXAMINER PROGRAM PROTOCOL FOR ADULT/ADOLESCENT SANEs and EMERGENCY DEPARTMENT CLINICIANS

---

- While the adolescent may not want to report their assault to the police, a 51A filing indirectly notifies the local criminal justice system. However, adolescents should be notified that they have the right to participate in discussions/decisions about their level of interaction with the criminal justice system.

## **Mandated Reporting (Also see [Section III: Mandatory Reporting](#))**

- Mandated reporting is required by SANE clinicians for all patients < 18 years of age when there is concern or report of sexual assault, **regardless** of the relationship between the patient and the assailant.
- The mandated report for child/adolescent sexual abuse/assault is known as a 51A, and is filed with the Department of Children and Families (DCF). The 51A report is a two-phase process: immediate verbal report and follow-up with a written report.
- DCF is required to “screen in” for investigation of all 51As that involve the abuse by a guardian or potential caregiver and if there is a concern for the Commercial Sexual Exploitation of Children (CSEC).
- While DCF may “screen out” and thus not investigate 51As for abuse/assault committed by non-caregivers, DCF is required to refer ALL 51As filed for sexual abuse/assault to the local District Attorney’s Office.
- While the adolescent may not want to report their assault to the police, a 51A filing indirectly notifies the local criminal justice system. However, adolescents should be notified that they have the right to participate in discussions/decisions about their level of interaction with the criminal justice system.
- While most adolescents present for care with a parent or guardian, there are times when an adolescent will request that their parent/guardian not be notified of their sexual assault. However, because of the mandatory reporting requirement, the SANE/Clinicians should:
  1. Explain that they cannot guarantee that the patient’s parent/guardian will not learn this information.
  2. Ascertain the patient’s concerns about their parent/guardian knowing about their assault and whether it poses a safety risk to the patient. The SANE/Clinician should notify the hospital social service department if there are concerns for patient safety.
  3. Tell the patient that you will verbally communicate with DCF about the patient’s concerns and also document such concerns on the written 51A
  4. Ask the patient if there is a supportive person in their life who could help the patient in discussing the assault with the patient’s parent/guardian

## **Use of the MA Pediatric Sexual Assault Evidence Collection Kit (MA Pedi Kit) for Adolescents**

- While the MA Pedi Kit was designed for patients 11 years of age and younger, there may be situations in which the SANE/Clinician determines that based on the patient’s emotional and physical development, the younger adolescent would benefit from the use of the MA Pedi Kit.
- In these situations, the SANE/Clinician should limit their interview of the patient to the basic questions of Who, What, Where and When, and questions to guide forensic evidence collection. In addition, these patients may benefit from a forensic interview and referral to a Pediatric SANE/Medical Provider at the local Children’s Advocacy Center (CAC).

## **Preparing Female Adolescent Patients for the SANE Exam (See [Appendix 4](#))**

The following guidelines will help SANE/Clinician decision-making when determining the best approach for conducting a limited pelvic examination and evidence collection.

- **The adolescent, who has NOT reached menarche.** If a patient has not reached menarche:
  1. The SANE/Clinician may determine that utilizing the MA PEDI Kit is the preferred evidence kit. In this case, refer to MA PEDI Kit Instructions.
  2. A speculum exam should never be done for a patient who has not reached menarche, as unestrogenized hymenal tissue is extremely sensitive. In these situations, the SANE should only obtain external genital swabs.
  3. Document reason for not obtaining vaginal swabs on MSAECK Step 14 Envelope.
  4. If there is a concern for significant bleeding or a foreign body, consult ED Attending.

# MASSACHUSETTS SEXUAL ASSAULT NURSE EXAMINER PROGRAM PROTOCOL FOR ADULT/ADOLESCENT SANEs and EMERGENCY DEPARTMENT CLINICIANS

---

- **Adolescent HAS reached menarche but has never had a speculum exam.**

A speculum exam should **not** be done for adolescents who have never had a speculum exam. In these situations, labial traction, Q-tip exam of the hymen and/or use of vaginal swabs without the speculum should be used (see below). If there is a concern for significant bleeding or a foreign body, consult with ED Attending.

- **Adolescent HAS reached menarche AND has previously had a speculum exam.**

In this situation, a speculum exam may be done with the patient's consent. If the patient reports pain or requests the exam to be stopped, the SANE/Clinician should immediately stop the exam. If a speculum exam is not completed, less invasive examination techniques (labial traction, Q-tip exam of the hymen, and/or evidence collection utilizing vaginal swabs without the speculum) should be used (see below) with patient consent.

Adequate lighting is an important adjunct when utilizing the following techniques in order to maximize visualization:

- **Labial Traction:** Gently retract the labia majora between the thumb and forefinger, pulling the labia downward and outward (towards examiner) until hymen is well visualized. This technique allows good visualization of hymen, vaginal walls, and internal structures. If using this technique, with the use of a speculum, apply labial traction and visually inspect the area **before** inserting the speculum. This will prevent misinterpretation of any redness that the speculum insertion might cause.
- **Q-tip Exam of Hymen: This exam should only be done on an estrogenized hymen (the hymen becomes estrogenized at menarche).** Gently roll the Q-tip along the inside aspect of the entire hymenal rim assessing the edges for lacerations, abrasions, granulated tissue clefts, tears, narrowing and scars.
- **Evidence Collection using Vaginal Swabs without Speculum:** If the patient cannot tolerate a speculum exam, carefully pass the collection swabs through the hymenal opening to obtain forensic evidence. If the hymen is estrogenized the patient should tolerate this portion of the exam well. If the patient is uncomfortable or complains of pain the SANE/Clinician should stop the exam. As a last resort, the SANE may allow the patient to collect the vaginal swabs under the direct observation of the SANE.

## Commercial Sexual Exploitation of Children (CSEC)

1. Overview
  - a. A commercially sexually exploited child is a child under the age of 18 who engages, agrees to engage in, or offers to engage in sexual conduct in exchange for money, food, shelter, clothing, education, or care. It is *not* unusual for these teens to not identify as victims.
  - b. CSEC is a form of child sexual abuse. Because the victims cannot consent to **ANY** sexual activity, they are victims, **NOT** "child/teen prostitutes". The above statement is true regardless of whether or not they perceive themselves as victims
  - c. As with other forms of sexual abuse, these children/teens are targeted because they are vulnerable and are often groomed by their perpetrator with attention, promises of "love," gifts and/or other valued items.
  - d. CSEC includes sex trafficking, child pornography, and child sex tourism.
2. Statistics
  - a. The most frequently identified age of a person entering the commercial sex industry in the U.S. is 12-14 years for females and 11-13 for males.
  - b. 70-90% of commercially sexually exploited youth have a history of prior child sexual abuse.
  - c. As many as one-third of teen runaways/throwaways will become involved in prostitution within 48 hours of leaving home.
  - d. Shelter is the primary traded commodity in return for sexual activity; almost 50% of minors engaging in commercial sex do so for a place to stay.
3. Risk Factors

# MASSACHUSETTS SEXUAL ASSAULT NURSE EXAMINER PROGRAM PROTOCOL FOR ADULT/ADOLESCENT SANEs and EMERGENCY DEPARTMENT CLINICIANS

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- a. Societal:
    - Lack of awareness about CSEC
    - Sexualization of children in society, media etc.
  - b. Community:
    - Peer pressure
    - Social norms/isolation
    - Gang involvement
  - c. Relationship:
    - Family conflict/disruption
  - d. Individual:
    - High risk of child abuse, neglect, maltreatment
    - Homeless, runaway, “throwaway”, LGBTQIA, high risk of being systems involved (DCF, DYS, etc.)
4. General Indicators
- a. Multiple reports of running away with no explanation of whereabouts.
  - b. Unexplained absences from school for a period of time.
  - c. New clothes or accessories with no explanation as to how they were obtained.
  - d. Police reports of child located in areas known for prostitution.
  - e. Brands or scarring indicating ownership (tattoos, brands etc.).
  - f. Sexual paraphernalia such as condoms, lubrication, sex toys, etc.
  - g. Hotel keys, bags, receipts, etc.
  - h. Presence of overly controlling “boyfriend” or older female.
  - i. Multiple cell phones/electronic devices.
  - j. Minors with slips of paper/notebooks containing phone numbers, dollar amounts, hotel names etc.
  - k. Lies about age/identity.
  - l. Looks to others before answering questions.
  - m. Uses terminology such as “the life,” “the game,” “daddy,” “wifey,” or “the track.”
5. Tips for Working with CSEC Victims
- a. Recognize that the youth may not identify themselves as a victim.
  - b. Be sensitive about asking too much too soon.
  - c. Build rapport over multiple encounters if possible.
  - d. Assess and satisfy immediate, basic needs of youth first:
    - Shelter & Food
    - Safety Planning
    - Mental Health
    - Detox if necessary

## **Patients with Intellectual/Developmental Disabilities (I/DD) and/or Physical Disabilities**

Patients with Intellectual and Development Disabilities (I/DD) may require extra time and alterations to the medical forensic exam, as is true of patients with physical disabilities. Although most patients with physical disabilities do not have I/DD challenges, these sections are combined because many people with I/DD may have physical mobility challenges that require exam alterations.

### **General Tips**

- When caring for a patient with an intellectual/developmental disability (I/DD), always PRESUME competence first.
- Patients ages 18 – 59, who have disabilities, are their own guardian unless adjudicated otherwise in a court of law, and are **able** to consent to SANE care and a forensic exam.
- If the patient cannot consent to a forensic exam or forensic evidence collection due to a cognitive or intellectual disability, follow MA SANE Informed Consent Protocol (Also see [Section IV: Obtaining Patient Consent](#)) for guidance regarding guardian or administrative consent.

# MASSACHUSETTS SEXUAL ASSAULT NURSE EXAMINER PROGRAM PROTOCOL FOR ADULT/ADOLESCENT SANEs and EMERGENCY DEPARTMENT CLINICIANS

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- Parents accompanying the patient are not automatically the patient's guardian. However, if they report being the patient's guardian, request to see guardianship documents.
- The SANE/Clinician is required to obtain consent for the SANE exam from the patient/patient's appointed guardian. Consent can be obtained in person or via phone. Be certain to document in medical record the name of the person giving consent over the phone.
- If a guardian does not accompany the patient to the hospital, and the patient is unable to independently answer questions, contact **DPPC Hotline 1-800-426-9009**. Request to speak to the on-call agency representative who can assist in obtaining consent from the guardian.
- If there are strong indicators that a sexual assault has occurred, and the guardian is refusing evidence collection, DPPC can obtain a temporary order of protection to allow evidence collection if the patient consents. (DPPC staff can usually obtain a protective order within hours and fax it to the hospital).
- An impartial ASL, Signed English, or other appropriate translators should be accessed to assist in consent, exam, and rape crisis counseling processes if the patient is unable to communicate verbally.
- If the patient is not able to sign the consent form because of upper extremity mobility impairment or compromised manual dexterity, the SANE/clinician should obtain verbal consent from the patient for each component of the exam and have an impartial witness sign as a witness on the consent form.
- As with all patients, regardless of guardianship status, a SANE will **NOT** conduct an exam or complete evidence collection without the patient's consent.

## Communication Barriers

Some individuals with a physical disability, including (but not limited to) those with multiple sclerosis or cerebral palsy, may have speech that is difficult to understand at times. Their speech may be slightly slurred, leading to misconceptions that they are intoxicated or even cognitively impaired. It is essential not to make assumptions or allow others in the health care team to color your perceptions of the patient before assessing them yourself.

- If the patient is unable to communicate verbally, an impartial ASL, Signed English, or other appropriate translators should be accessed to assist in the consent, exam, and rape crisis counseling processes.
- If the patient is unable to provide the history of the assault due to I/DD or dementia, document the name of the person who provided the history of the incident or the signs/symptoms that raised concern for sexual abuse/assault on MSAECK Form 3. For situations in which the details of the assault are unknown, the SANE should conduct as many steps of evidence collection as the patient allows/can tolerate.

## Tips for Effective Communication

- Allow adequate time for the patient to provide the history of their assault.
- Give your whole unhurried attention to the patient—be patient and encouraging.
- Avoid the temptation to put words into the patient's mouth—do not speak for them or try to correct them.
- Do not be afraid to ask for clarification if you do not understand.
- Remember that speech impairment is not related to intelligence.

## Consent Considerations

To ensure that patients with intellectual/developmental disabilities (I/DD) are treated with dignity and respect, the following approaches may be beneficial:

- The SANE/Clinician may need to allow more time for the consent process so that the patient has sufficient time to ask questions, have questions answered, and to communicate consent before the patient signs the consent form.
- A person with I/DD may indicate understanding or agreement by nodding their head, raising a hand, making a signal, or orally answering questions.
- After each step or procedure is explained, the SANE/Clinician should ask the patient to confirm their understanding through an individualized expression of consent.
- The SANE/Clinician may ask the patient to explain their understanding of any procedure described.

# MASSACHUSETTS SEXUAL ASSAULT NURSE EXAMINER PROGRAM PROTOCOL FOR ADULT/ADOLESCENT SANEs and EMERGENCY DEPARTMENT CLINICIANS

---

- Patients with I/DD may not initially reveal their disability. The SANE/Clinician must develop a relationship of trust and respect with the patient to reveal the full extent of the patient's disability. Establishing trust with the patient reduces the chance that the patient will feel intimidated.
- Patients with mental health conditions deserve the same dignified and respectful approach used for patients without such challenges. In addition, patients with mental health challenges may remain competent to give informed consent.
- A person with mental health challenges may be admitted to the Emergency Department with an emergency restraining order as a precautionary protective measure. However, a Section 12 restraint does **not** necessarily mean that the patient cannot give consent for a medical forensic exam SANE exam and evidence collection. When the patient is deemed medically safe and can participate with the exam, the SANE/Clinician should obtain the patient's written consent on Form 1.

## **Obtaining Medical History and History of Assault**

- It is important to know the nature of any physical impairment, underlying disease, or injury to perform the exam safely.
- Patients with a spinal cord injury (SCI) should be assessed for level of injury and history of autonomic dysreflexia (AD). If the patient has a history of AD, the attending physician must conduct the pelvic examination.
  - Assess the patient for a history of muscle spasms and triggers.
  - Assess patient for latex allergy.

## **Experience with Pelvic Exams**

As with all patients, inquire about the patient's history of pelvic examinations by asking the following:

1. Have you ever had a pelvic or speculum exam before?
2. Do you know what a speculum is?
3. What was your experience with the exam?
4. What positions have been most comfortable for you?
5. Do you experience increased muscle spasms or dysreflexia with pelvic exams?
6. What can I do to make the exam more comfortable for you?

## **Conducting the Forensic Exam: General Exam Tips**

- RELAX—project confidence and knowledge, don't be afraid to admit what you don't know, and ASK for help from the patient or other providers.
- Do NOT touch or move a patient's wheelchair or assistive device without the patient's permission.
- Whenever possible, keep assistive devices within reach of the patient.
- Ask patients what has worked for them in the past with exams, transfers and **involve** the patient as much as they desire.
- Ask patient if they should disrobe before getting on the table or after.
- Keep assistants/people in the room to a minimum and ensure that the patient consents to their presence.
- Adjust the lighting and limit distractions according to the patient's comfort level, especially for patients with autism or dementia.
- Speak directly to the patient (especially when using an interpreter) and always presume competence; ask follow-up questions of the guardian/caregiver only if unable to elicit the information from the patient.
- Provide the patient extra time to process the question and be able to answer.
- Always tell the patient what you are doing, why you are doing it, and always make sure you have their consent for each step of exam.
- "Check-in" frequently with the patient to ensure that they are physically and emotionally comfortable with the exam.
- For patients unable to communicate due to I/DD or dementia with a significant concern or abuse/assault, the SANE should conduct as many steps of evidence collection as the patient allows/can tolerate.

# MASSACHUSETTS SEXUAL ASSAULT NURSE EXAMINER PROGRAM PROTOCOL FOR ADULT/ADOLESCENT SANEs and EMERGENCY DEPARTMENT CLINICIANS

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- Bear in mind that people, especially women, with disabilities may have a history of unpleasant experiences with healthcare providers, making the exam more arduous and anxiety-provoking
- Remember that people with disabilities, including people with spinal cord injury, can feel painful or unpleasant sensations when stimulated; be gentle during all aspects of the exam.
- The physical safety of the patient and SANE is paramount!

## **Modifications to Forensic Exam and MSAECK Steps**

As is true of all patients, patients with I/DD or physical disabilities have unique circumstances that may require adjustment to the order of MSAECK step completion to fit the patient's tolerance level. Providing multiple breaks, using distractors such as music/TV/books, and other calming/soothing measures may be very helpful. Modifications to the following MSAECK steps may be indicated:

### **1. Step 2: Toxicology Testing**

- a. If the SANE/Clinician has concerns for a drug-facilitated assault that occurred within the past 96 hours, and the patient consents, collect blood and urine samples in accordance with MA SANE Protocol. For patients with a bladder regimen or indwelling catheter, consider incorporating the patient's scheduled regimen into the exam AFTER swabbing for forensic evidence from the external genitalia and perineum, and before the speculum exam, the primary nurse should catheterize or have the patient self-catheterize for a sample.
- b. If the patient has an indwelling catheter, collect a urine sample from the leg bag and a fresh sample from the bladder and document on each sample from where they were obtained.

### **2. Step 3: Oral Swabs and Smear**

The examiner may need to be aware of difficulties a patient may have in holding their mouth open for the swabbing. Ask the patient what assistance they need for this - consider effective techniques that may have worked for them when having had dental work.

### **3. Step 5: Head Hair Combing**

The examiner may need to hold the paper or have an assistant hold the patient's head over the paper during the combing (make sure that it is acceptable to the patient to hold their head in this manner or have the patient comb their own hair while you hold the paper).

### **4. Step 6: Fingernail Swabs**

Patients who are tactile defensive (such as those on the autism spectrum) may not tolerate this. Ask patient if they would like to assist and let them swab their own nails.

### **5. Steps 7A, 7B and 8: Foreign Material Collection and Clothing Collection**

These steps will need to be altered based on the individual physical impairment of the patient. For example, patients who cannot stand will not be able to stand on the foreign material collection sheet to disrobe. Additionally, patients who have balance problems may be unable to complete this Step in the traditional manner. Make sure to ASK the patient what they can tolerate and assist them as needed with disrobing. Suggested Alterations:

- a. If the patient arrives via ambulance, save the sheet from the stretcher
- b. Place the foreign collection sheet on the exam table and leave in place until the patient has disrobed and the exam is complete.
- c. If the patient prefers to disrobe while in their wheelchair, try tucking sheets around the wheelchair – avoiding the wheels – to catch debris as the patient disrobes
- d. If patient uses a wheelchair, do not put the chair on the paper as debris from the wheels can contaminate evidence
- e. Based on history, it may be indicated to swab the patient's wheelchair—always ask permission first
- f. If the wheelchair is at home (ambulances will not transport a wheelchair), and the crime has been reported, suggest that the police collect evidence from the chair at home

### **6. Step 10: Additional Swabbing**

No alterations are anticipated. Remember to ask permission to swab wheelchairs or assistive devices and document the locations of each swab collection.

# MASSACHUSETTS SEXUAL ASSAULT NURSE EXAMINER PROGRAM PROTOCOL FOR ADULT/ADOLESCENT SANEs and EMERGENCY DEPARTMENT CLINICIANS

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## 7. **Step 11: Pubic Hair Combing**

Refer to positioning techniques for pelvic exam below

## 8. **Steps 12, 13, 14: External Genital Swabs, Perianal Swabs/Smears and Vaginal Swabs/Smears**

During the pelvic exam portion of the exam, refer to the pelvic exam information below. During this portion of the exam, the actual evidence collection should be carried out as per protocol.

### **Note:**

- If water-soluble Lidocaine gel is applied to the perineum or anal area to reduce the risk of dysreflexia; this should be done **AFTER** swabs are collected for forensic evidence.
- Urine catheterization for patient comfort or to reduce the risk of autonomic dysreflexia, should be done by the primary nurse PRIOR to the speculum exam, but AFTER evidence collection to avoid contamination.

## 9. **Step 15: Anal Swabs and Smears**

Because there is a risk of Autonomic Dysreflexia (AD) when obtaining rectal swabs and smears, consult with Emergency Department (ED) Provider, and perform this collection step in collaboration with ED Provider only when indicated. Hospital staff should follow ADR procedures below for prevention and treatment techniques.

## 10. **Step 16: Completion of Forms**

Complete mandated report forms, both written and verbal reports if indicated ([see Section III: Mandatory Reporting](#)):

- 19 C — Report of Abuse of Persons with Disabilities (18-59 years of age)
- Provider Sexual Crime Report (PSCR) Kit Form 2A
- If assault occurred in health care/long-term care facility, speak with hospital staff regarding the need to file a Health Care Quality (HCQ) Report with the MA Department of Public Health
- Assist with Victim Compensation processes

## **Alterations to Digital Photography Protocol**

Photographing injuries is often a crucial part of the evidence collection exam; however, patients with mobility impairments may not be able to assume the traditional positioning for forensic photography. For instance, they may not be able to turn their head to establish identity when photographing back wounds, or they may not be able to move their legs into position for an ideal photo.

### Recommendations:

1. Thoroughly and carefully document all bruises and wounds on Form 4 body map to correlate with photos obtained.
2. If you cannot establish the patient's identity by including the patient's face in a photo, include a distinguishing mark or scar near the wound in the photo if possible.
3. Be creative with positioning for the photos.
4. Document any mobility limitations that interfere with ideal forensic photography.
5. Remember to drape and position all patients appropriately to ensure privacy and dignity, bearing in mind that these photos may be enlarged and displayed to a courtroom.

## **Mandatory Reporting**

MA SANEs and hospital clinicians are responsible for contacting the Disabled Persons Protection Commission (DPPC) to provide a verbal report for a sexual assault involving a person with disabilities.

### **Disabled Persons Protection Commission (DPPC)**

For patients 18 to 59 years

Immediate verbal report: 1-800-426-9009

## **Post-Assault Services for Persons with Disabilities**

The Sexual Assault Response Unit (SARU) within the Disabled Persons Protection Commission (DPPC) provides I/DD sexual assault survivors with free and confidential information and assistance accessing trauma services. SARU navigators help survivors with a disability access post-sexual assault services, such as medical care, legal help, financial assistance, and counseling. SARU Peer Support staff offer the



# MASSACHUSETTS SEXUAL ASSAULT NURSE EXAMINER PROGRAM PROTOCOL FOR ADULT/ADOLESCENT SANEs and EMERGENCY DEPARTMENT CLINICIANS

---

I/DD sexual assault survivor with encouragement, active listening, peer support, inspiration, and belief. SARU staff is also available to help friends, families, and support staff access services. In addition, the SARU provides technical assistance and case consultation to professionals throughout the state.

To contact the SARU during regular business hours, please call 617-727-6465 x301

To report suspected abuse or neglect against a person with a disability, please call the Disabled Persons Protection Commission's 24-Hour Hotline at 1-800-426-9009 (TTY: 1-888-822-0350)

## **Incarcerated Patients**

The risk of sexual assault in prisons, jails, and house of correction is significant. Incarcerated sexual assault patients deserve compassionate care that is respectful, dignified and considerate of the patient's safety. At the same time, the SANE/clinician must consider their own safety and that of other hospital staff during all aspects of the patient encounter. This includes appropriate alterations to exam procedures in collaboration with the accompanying Correctional Officer (CO) and specific documentation and discharge planning considerations.

## **Important Considerations**

- Maintain a safe environment for patient and SANE/clinician.
- At all times the CO needs to remain in the room with the patient.
- Keep supplies organized, and any sharp objects at a safe distance from the patient. Remove items from your lab coat pockets that can be easily accessed when in close contact.
- Never give anything to the patient.
- Never allow the patient to make a phone call.
- Never take the patient away from an area without the consent of the Correctional Officer (CO).
- Never relay any information or perform "favors" for the patient.
- Never share personal information about yourself, your family or your co-workers.
- Do not ask the CO to verbally relay any health/clinical information.
- Do not ask the CO about details of the patient's assault.
- Do not divulge any treatment timeframes or schedules with the patient.
- Consult with the patient's escorting CO if restraints interfere with patient care and evidence collection procedures. Follow the instructions of the CO as he/she is the most knowledgeable about the patient's safety risks.

## **MSAECK Exam Modifications:**

1. **Step 1 Documentation Forms:** Signing their name may be awkward for the patient if restrained.
  - a. **Prior to giving patient a pen consult with the CO to confirm that it is safe to give the patient a pen for signing. If the patient cannot sign with a pen, document that verbal consent was obtained on Form 1- Consent.**
2. **Step 2 Toxicology Testing:** Obtaining blood draw and urine sample may require restraint management.
3. **Step 3 Oral Swabs and Smear:** No alterations.
4. **Step 4 DNA Saliva Collection:** No alterations.
5. **Step 5 Head Hair Examination and Combing:** Use of restraints may interfere with evidence collection. Consult with the CO regarding restraint management.
6. **Step 6 Fingernail Swabs:** Evidence collection may be awkward if the patient is restrained.
7. **Steps 7A & 7B Foreign Material Collection:** This step may require alteration based on the patient's restraint status. Oftentimes, the clothing worn during the assault is collected at the correctional facility, using their chain of custody protocol, prior to hospital transport. Therefore prior to obtaining patients consult with CO.

# MASSACHUSETTS SEXUAL ASSAULT NURSE EXAMINER PROGRAM PROTOCOL FOR ADULT/ADOLESCENT SANEs and EMERGENCY DEPARTMENT CLINICIANS

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- a. Handcuffed and shackled patients will have balance issues preventing the completion of these steps in the traditional way.
- b. It may be impossible to collect clothing without the removal of restraints. If restraints must remain, clothing may be cut-off, with patient and CO consent. Be sure to document how and why the clothing/evidence was collected on the evidence collection envelope.
8. **Step 8 Clothing:** No alterations.
9. **Step 9 Bite Marks:** Use of restraints may interfere with evidence collection. Consult with the CO regarding restraint management.
10. **Steps 10-15 Additional Swabs, Pubic Hair Combing, External Genital Swabs, Perianal Swabs, Vaginal Swabs and Smear, Anal Swabs and Smear, and Pelvic Exam:** Use of restraints may interfere with examination and evidence collection. Consult with the escorting CO for assistance regarding restraint management prior to this portion of the exam.
  - a. Ensure that the patient's privacy is maintained in the best way possible.
  - b. Drape and position the patient to ensure privacy and dignity.
  - c. If approved by CO, consider turning the stretcher so the patient is facing the wall.

## Forensic Photography

- Restrained patients may have difficulties in assuming traditional positions for forensic photography. Consult with the patient's escorting CO regarding restraint management.
- Appropriately drape and position the patient to ensure privacy and dignity.
- Be creative with positioning.
- If unable to include patient's face in the photo: include distinguishing marks or scars to help establish the patient's identity.
- Carefully document all bruises and wounds on the body maps to correlate with photos.

## Documentation Considerations

1. **Form 1: Consent**
  - a. Patient Address: Correctional Facility
  - b. Follow-up Phone Call: Correctional Health Service Department
2. **Form 2A: Information Pertaining to Assault and Kit Tracking Form/Provider Sexual Crime Report (PSCR):**
  - a. Document the name of the correctional facility in field entitled "Specific Surroundings at time of Assault"
  - b. Place a copy of the completed PSCR in a hospital envelop and mark envelop as "SANE Discharge Envelope A." Seal the envelope and address to: Warden/Sheriff, Correctional Facility. Provide the envelope to the escorting CO for delivery to the correctional facility.
  - c. Fax copy of PSCR to the Executive Office of Public Safety and Security (EOPSS).
3. **Form 3: Patient's Report of Incident:** No alterations.
4. **Form 7: Treatment and Discharge**
  - a. Aftercare Instructions
    - Do not write in dates for follow-up.
    - Discuss future treatment options in general terms with the patient. Due to security reasons, do not divulge any treatment timeframes or schedules with the patient. However, express to the patient that the SANE's treatment plan is a recommendation.
    - Assure that follow-up care will be facilitated by the Correctional Facility's Healthcare Staff.
  - b. Safety Planning
    - If the patient states that they do not "feel safe" returning to the correctional facility, communicate that information to the Emergency Department Physician, the escorting CO, and the Correctional Health Service Charge Nurse. Document the communication and note whom you spoke to convey the information on Form 7 under Additional Information/Follow-up Section.
  - c. The SANE/Clinician must contact the Correctional Health Service Charge Nurse prior to the patient's discharge from the hospital to report/review the SANE/clinician's discharge instructions.

**MASSACHUSETTS SEXUAL ASSAULT NURSE EXAMINER PROGRAM  
PROTOCOL FOR ADULT/ADOLESCENT SANEs and EMERGENCY  
DEPARTMENT CLINICIANS**

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- d. Using a hospital envelop, place the completed pink copy of Form 7 in an envelope and mark the outside of the envelope as "SANE Discharge Envelope B." Address: "Attention Health Service Department Charge Nurse" with the name of the Correctional Institution. Seal the envelope and provide the envelope to the patient's escorting CO for transport back to the correctional facility.

**MSAECK Transportation**

The accompanying CO can transport the kit to the Crime Lab (first log the kit into the logbook, and then sign it out when you hand it over to the CO). **NOTE:** If the reported assailant is an employee of the correctional facility, notify the MA State police for kit pick-up and transport to the Crime Lab.

**MA TRACK Kit System**

SANEs should provide hospital staff with relevant information for MSAECK/Toxicology Kit collection for incarcerated patients, for entry into the MA TRACK-Kit System.

**Mandatory Reporting**

Complete Mandatory Reporting Forms as necessary (Refer to Section III: Mandatory Reporting).