



**Maryland Department of Health
and Mental Hygiene**



**Maryland
Institute for
Emergency
Medical
Services
Systems**

December 1, 2015

The Honorable Lawrence J. Hogan, Jr.
Governor
State of Maryland
100 State Circle
Annapolis, MD 21401-1991

The Honorable Thomas M. Middleton
Chair
Senate Finance Committee
3 East, Miller Senate Office Building
Annapolis, MD 21401-1991

The Honorable Peter A. Hammen
Chair
House Health and Government Operations Committee
Room 241, House Office Building
Annapolis, MD 21401-1991

RE: Report on the Improved Access to Sexual Assault Medical Forensic Examinations in Maryland –
House Bill 963/Chapter 627, Section 2(g) of the Acts of 2014)

Dear Governor Hogan, Chairman Middleton, and Chairman Hammen:

Pursuant to House Bill 963 (Chapter 627, Section 2(g) of the Acts of 2014), Annotated Code of Maryland, the Department of Health and Mental Hygiene (DHMH) and the Maryland Institute for Emergency Medical Services Systems (MIEMSS) are submitting this report regarding improved access to sexual assault medical forensic examinations in Maryland.

Thank you for your continued interest in the public health of the State. If you should have any questions or comments, please do not hesitate to contact Joyce Dantzler, MS, MCHES, Co-Chair, Chief, Center for Injury and Sexual Assault Prevention, DHMH, at 410-767-1372, or Carole Mays, RN, MS, CEN, Co-Chair, Director, Trauma and Injury Specialty Care Program, MIEMSS at 410-706-3932.

Sincerely,

Van T. Mitchell
Secretary, DHMH

Kevin G. Seaman, M.D., FACEP
Executive Director, MIEMSS

Enclosure

Cc: Patricia Gainer JD, MPA, Deputy Director, MIEMSS
Clifford S. Mitchell, MS, MD, MPH, Director, DHMH Environmental Health Bureau
Sarah Albert, MSAR #10238



**Planning Committee to Implement
Improved Access to Sexual Assault Medical
Forensic Examinations in Maryland**



**Report to the Governor, the Senate Finance Committee, and the
House Health and Government Operations Committee**

Regarding

**Improved Access to Sexual Assault Medical Forensic
Examinations in Maryland**

House Bill 963/Chapter 627, Section 2(g) of the Acts of 2014)

December 2015



**Planning Committee to Implement
Improved Access to Sexual Assault Medical
Forensic Examinations in Maryland**



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I. Executive Summary

House Bill (HB) 963 was enacted in the 2014 Legislative Session to address concerns about access to sexual assault forensic exams (SAFEs) in Maryland. The bill required that: 1) on or before July 1, 2014, each hospital that provides emergency medical services shall have a protocol to provide timely access to a sexual assault medical forensic examination by a forensic nurse examiner (FNE) or a physician to a victim of an alleged rape or sexual offense who arrives at the hospital for treatment; 2) a Planning Committee to Implement Improved Access to Sexual Assault Medical Forensic Examinations in Maryland be established; and 3) on or before December 1, 2015 the Planning Committee shall submit a report on its findings and recommendations, including any legislation required to implement the recommendations, to the Governor, the Senate Finance Committee, and the House Health and Government Operations Committee. The Planning Committee met monthly between November 2014 and October 2015 and solicited input from sexual assault victims and professionals working with victims. Below is a summary of the Planning Committee's findings and recommendations: the full report of the committee follows.

Findings

Victims of sexual assault in Maryland may access SAFEs through varied entry points. Victims may initially contact 911 or a sexual assault hotline, walk into an Emergency Department (ED), be brought to an ED by police, or be transported by Emergency Medical Services (EMS).

There is a burden on victims who present for treatment at a hospital without a Sexual Assault Medical Forensic Examination program (SAFE program) or a "non-SAFE" hospital. Victims who choose to have a SAFE must then go to another hospital, often resulting in hours of delay, possible loss of critical evidence, difficulty with transport to the SAFE facility, and may even lead to a violation of the victim's privacy rights. In addition, transportation may not be covered by insurance or other public or private sources, all of which create a major barrier to receiving a SAFE.

Across the State, there is a lack of standard response protocols for Law Enforcement, EMS and medical providers in facilitating access to medical/forensic services. In particular, there is no standard response protocol for "non-SAFE" hospital EDs regarding victims' rights and options. Enactment of HB 963 (Health-General Article §19-310.2, Annotated Code of Maryland); required all hospitals with an ED to have a protocol addressing appropriate responses to sexual assault victims. In Maryland, there are currently 46 acute care hospitals with EDs. Thirty eight submitted their policies to the Committee. Twenty four of the hospitals submitting policies are recognized as SAFE programs.

Other barriers to timely access to SAFEs include lack of 24/7 access to a forensic examination at some SAFE programs due to FNE staffing shortages, low physician reimbursement, lack of public education, limited reimbursement for mobile SAFEs, and language and cultural barriers.

Other states seeking to increase access to SAFEs have met with varying degrees of success. Their approaches include: 1) comprehensive centers with nurses trained to assist multiple types of victims including domestic violence and the elderly; 2) Mobile SAFE units outfitted with the necessary equipment for a SAFE nurse to travel to victims and perform the exam; and 3)



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telemedicine technology, which uses video conferencing to increase access to medical forensic expertise for victims in remote areas.

Planning Committee Recommendations

The Planning Committee to Implement Improved Access to Sexual Assault Forensic Medical Examinations in Maryland reached consensus on the following recommendations:

1. **Clarification of Statute and Regulation**

Designation of Sexual Assault Forensic Exam Programs should be clarified to eliminate discrepancies between Criminal Procedure Article, §924 and Code of Maryland Regulations (COMAR) 10.27.21.02.

2. **Emergency Medical Services (EMS)**

- a. The Maryland Institute for Emergency Medical Services Systems (MIEMSS) should list the SAFE programs in the Maryland Medical Protocols for EMS Providers;
- b. MIEMSS and Local EMS agencies should revise sexual assault treatment, transport, and training protocols for providers;
- c. Emergency Medical Dispatch Centers should review national guidelines and maintain a list of SAFE programs within their jurisdiction;
- d. EMS training should include transport decision-making, a Trauma-Informed Approach to care, Law Enforcement and mandated reporting requirements, victims' rights and options for reporting and evidence collection, evidence preservation, confidentiality/privacy considerations, and emergency medical record documentation requirements; and
- e. Treatment and transport protocols should, at a minimum, contain the following recommendations:
 - i. Sexual assault victims should be transported to the nearest hospital ED that provides SAFE exams, unless the victim refuses, requires another type of specialty care, is medically unstable, or requests to be taken to an alternate facility;
 - ii. Whenever possible, the receiving hospital should be notified in advance to have a place for the patient to be received in a private area;
 - iii. Instructions on a Trauma-Informed Approach to care should be provided;
 - iv. Instructions on evidence preservation should be included;
 - v. HIPAA*, confidentiality considerations, and Emergency Medical Record documentation should be included; and
 - vi. Base stations protocols and procedures should indicate SAFE programs as specialty referral centers and should direct victims of sexual assault to a SAFE program when possible.

* The Health Insurance Portability and Accountability Act of 1996



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3. **Law Enforcement (LE)**

- a. Every LE agency should adopt a policy and establish a protocol for responding to individuals reporting a sexual assault. It should be noted that victims are not required to report to LE and federal law prevents conditioning SAFE services on cooperation with LE;
- b. LE officers should be informed of the options and rights of sexual assault victims and be able to inform victims of these rights and options;
- c. Initial LE response should address the safety of the victim and assure that the victim is transported immediately for medical care and evidence collection, unless the victim refuses, or the report is outside of the advised time frame for evidence collection;
- d. LE should not dismiss EMS or delay transporting the victim for medical care;
- e. LE officers should communicate to victims of sexual assault that a SAFE may be important to investigative and apprehension efforts, but should be aware that a victim has the right to choose whether or not they receive an exam;
- f. All biological evidence or specimens, including urine samples for drug screening, should be collected only at a medical facility;
- g. LE should work with the jurisdiction's local sexual assault crisis program, as established under Criminal Procedure Article, §11-923, and Sexual Assault Response Team to assure that victims have access to advocacy and other services; and
- h. LE training should include a Trauma-Informed response, which includes recognizing the range of responses to sexual assault, instructions regarding preservation of evidence, instructions regarding emergent medical needs of the victim, the rights and options of sexual assault victims, and the roles and responsibilities of other emergency responders.

4. **Hospital Policy**

- a. SAFE programs located in jurisdictions with more than one hospital should establish mobile SAFE teams and protocols to provide SAFEs off-site;
- b. Sexual assault victims should have access to SAFEs at all hospitals with an ED. If a victim presents at a hospital without a SAFE program, a local mobile SAFE program should go to the victim;
 - i. Both SAFE programs and non-SAFE hospitals are encouraged to collaborate to implement this recommendation as soon as possible. However, creating mobile SAFE teams presents a number of logistical, legal, and institutional issues that may prevent providers from immediate implementation. Recognizing this, all hospitals with an ED (including those with and those without a SAFE program) should have a plan regarding implementation of this recommendation no later than October 1, 2016. This plan should include identification of all obstacles and potential resolutions, including the need for legislative and regulatory changes. Mobile teams should be established by SAFE programs and non-SAFE hospitals should formulate Memorandums of Understanding or on-boarding/credentialing visits of Forensic Nurses Examiners (FNEs). These agreements should function promptly after a plan is created, and no later than October 1, 2017;^{1*}
- c. The Maryland Hospital Association (MHA) and the Maryland Coalition Against Sexual Assault (MCASA) should provide input and collaborate with the Maryland Office of the

* As per Health-General Article 19-310.2, all hospitals are currently required to have a policy in place.



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Attorney General (OAG) to develop statewide SAFE policies to increase access to SAFEs By law:

- i. Health care providers and personnel should not contact LE without the consent of the sexual assault victim, with a few limited exceptions;
 - ii. Health care providers should be informed on mandated reporting laws including definitions of “child abuse” and “vulnerable adult”;
 - iii. Materials on victims’ rights should be made available to all sexual assault victims;
- d. Health care providers should be informed of the options available to victims of sexual assault and should advise them of these options;
- e. SAFE programs must include access to victim advocates and FNEs. SAFE programs should be connected and in close communication with local sexual assault crisis programs as established under Criminal Procedure Article, §11-923 to ensure that a victim advocate is always present when a victim undergoes a SAFE;
- f. All hospitals should provide all sexual assault victims with information regarding local sexual assault crisis programs and access to victim advocates, whether a SAFE is performed or not. This recommendation applies to all hospitals, and includes those with or without SAFE programs.
- g. SAFE programs should offer 24/7 access to a SAFE;
- h. SAFE programs should establish at least one staff position for a FNE. The staff person’s duties include performing SAFEs that are required during regular staffing hours, and coordination and mentoring of other FNEs in the SAFE program. SAFE programs may find that it is most effective to expand the SAFE program to also include other forms of personal violence, such as domestic violence, child abuse, and elder abuse;
- i. MHA or other similar body should appoint a committee to review the needs of pediatric sexual assault victims and how they can be better addressed. This committee may also consider the possibility of Registered Nurse Forensic Examiner–Pediatric (FNE-Ps) and their availability to work with the Maryland Children’s Alliance, Child Advocacy Centers, and the Maryland Child Abuse Medical Providers Initiative as defined by Health-General Article §13-2201;
- j. SAFE programs should obtain written authorization from the patient to release any of their information to non-health entities, including: LE, Crime Lab, Toxicology Lab, Sexual Assault Crisis Center/Victim Advocacy, Prosecutor, and any non-health provider; and
- k. All hospitals should provide an nPEP starter pack (HIV post-exposure prophylaxis) to all eligible patients.

5. Sexual Assault Response Teams (SARTs)

- a. SAFE programs should participate in local SARTs. SAFE responses should maintain and strengthen community based connections, including working with local prosecutors, LE, and victim advocates; and
- b. Statistics regarding SAFEs and related matters should be collected by SARTs using uniform data collection methods and should be submitted to the MCASA to be shared statewide.

6. Reimbursement

- a. Increase the current physician reimbursement rate of \$80 for a medical forensic examination;
- b. Provide reimbursement for mobile FNEs;



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- c. Provide payment for interhospital transportation costs;
- d. Continue to work with the Criminal Injuries Compensation Board (CICB) to provide reimbursement for nPEP to victims eligible for CICB, and develop alternative sources of funding for victims who are not CICB eligible;
- e. Revise COMAR 10.12.02 to include reimbursement for nPEP screening in hospitals with approved nPEP protocol (including baseline testing, initial counseling, and starter pack);
- f. Increase the current Sexual Assault Reimbursement Unit program budget;
- g. Extend the timeframe for reimbursement to support better victim services; and
- h. Ensure that victims are not responsible for the costs associated with SAFEs received outside of Maryland by working together with sexual assault response agencies in our neighboring jurisdictions.

7. Public Education

A statewide campaign should be undertaken to inform the community, including LE, EMS, and health care providers about options for victims of sexual assault. This should include the location and accessibility of SAFE programs, how to seek medical treatment, reporting options, and how to contact local sexual assault crisis programs.

Conclusion

The Planning Committee's full report, findings, and recommendations follow. The Planning Committee appreciates the opportunity to work with the Governor and the General Assembly to improve Maryland's response to sexual assault victims.



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II. Committee Recommendations

The Planning Committee to Implement Improved Access to Sexual Assault Forensic Medical Examinations in Maryland has reached consensus on the following recommendations:

1. Designation of Sexual Assault Forensic Exam Programs

- a. Clarify Criminal Procedure §11-924 for accuracy and consistency:

Designation of facilities by the Department of Health and Mental Hygiene

The nearest facility to which a victim of sexual assault may be taken shall be designated by the Department of Health and Mental Hygiene (DHMH) in cooperation with:

- (1) The Medical and Chirurgical Faculty of the State of Maryland; and
- (2) The State's Attorney in the subdivision where the sexual assault occurred.

- b. Clarify Code of Maryland Regulations (COMAR) 10.27.21.02 for accuracy and consistency:

10. Department of Health and Mental Hygiene

27. Maryland Board of Nursing

21. Registered Nurse – Forensic Nurse Examiner

02. Definitions

B. (20) "SAFE" program means a facility authorized by the Department of Health and Mental Hygiene to provide forensic nursing services.

- c. Identify the appropriate entity to designate and monitor the effectiveness of SAFE programs in Maryland.

2. Emergency Medical Services

- a. The Maryland Institute for Emergency Medical Services Systems (MIEMSS) should list SAFE programs in the Maryland Medical Protocols for EMS Providers;
- b. MIEMSS and Local EMS agencies should revise sexual assault treatment, transport, and training protocols for providers (see Appendix E);
- c. Emergency Medical Dispatch Centers should review national guidelines and maintain a list of SAFE programs within their jurisdiction;
- d. EMS training should include:
 - i. Transport decision-making;
 - ii. Trauma-Informed Approach to care;
 - iii. Law enforcement (LE) and mandated reporting requirements;
 - iv. Victims' rights and options for reporting and evidence collection;



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- v. Evidence preservation, including instructions to the victim;
 - vi. HIPAA and confidentiality/privacy considerations specific to sexual assault victims;
 - vii. Emergency Medical Record documentation requirements and considerations; and
 - e. Treatment and transport protocols should, at a minimum, contain the following recommendations:
 - i. Sexual assault victims should be transported to the nearest hospital Emergency Department (ED) that provides SAFEs, unless the victim refuses, requires another type of specialty care, is medically unstable, or requests to be taken to an alternate facility;
 - ii. Whenever possible the receiving hospital should be notified in advance to have a place for the patient to be received in a private area;
 - iii. Instructions on Trauma-Informed Approach to care;
 - iv. Instructions on evidence preservation;
 - v. HIPAA, confidentiality considerations and Emergency Medical Record documentation; and
 - vi. Base station protocols and procedures should indicate SAFE programs as specialty referral centers and should direct victims of sexual assault to a SAFE program when possible.
 - 3. Law Enforcement
 - a. Every LE agency should adopt a policy and establish a protocol for responding to individuals reporting a sexual assault (see template in Appendix F). It should be noted that victims are not required to report to LE, and federal law prevents conditioning SAFE services on cooperation with LE;
 - b. LE officers should be informed of the options and rights of sexual assault victims and be able to inform victims of these rights and options;
 - c. Initial LE response should address the safety of the victim and assure that the victim is transported immediately for medical care and evidence collection, unless the victim refuses, or the report is outside of the advised time frame for evidence collection;
 - d. LE should not dismiss EMS or delay transporting the victim for medical care;
 - e. LE officers should communicate to victims of sexual assault that a sexual assault forensic exam (SAFE) may be important to investigative and apprehension efforts, but should be aware that a victim has the right to choose whether or not to receive an exam;
 - f. All biological evidence or specimens, including urine samples for drug screening, should be collected only at a medical facility;
 - g. LE should work with the jurisdiction's local sexual assault crisis program, as established under Criminal Procedure Article, §11-923, and Sexual Assault



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Response Team to assure that victims have access to advocacy and other services; and

- h. LE training should include:
 - i. Trauma-informed response;
 - ii. Recognizing the range of responses to sexual assault;
 - iii. Instructions regarding preservation of evidence, including advising the victim;
 - iv. Instructions regarding emergent medical needs of the victim;
 - v. The rights and options of sexual assault victims; and
 - vi. The roles and responsibilities of other emergency responders, including forensic nurses and victim advocates.
- 4. Hospital Policy
 - a. SAFE programs located in jurisdictions with more than one hospital should establish mobile SAFE teams and protocols to provide SAFEs off-site;
 - b. Sexual assault victims should have access to SAFEs at all hospitals with an ED. If a victim presents at a hospital without a SAFE program, a local mobile SAFE program should go to the victim;
 - i. Both SAFE programs and non-SAFE hospitals are encouraged to collaborate to implement this recommendation as soon as possible. However, creating mobile SAFE teams presents a number of logistical, legal, and institutional issues that may prevent providers from immediate implementation. Recognizing this, all hospitals with an ED (including those with and those without a SAFE program) should have a plan regarding implementation of this recommendation no later than October 1, 2016. This plan should include identification of all obstacles and potential resolutions, including the need for legislative and regulatory changes. Mobile teams should be established by SAFE programs and non-SAFE hospitals should formulate Memoranda of Understanding or on-boarding/credentialing visits of a Forensic Nurse Examiners (FNE). These agreements should function promptly after a plan is created, and no later than October 1, 2017;*
 - c. The Maryland Hospital Association (MHA) and the Maryland Coalition Against Sexual Assault (MCASA) should provide input and collaborate with the Maryland Office of the Attorney General (OAG) to develop statewide SAFE policies to increase access to sexual assault exams. By law:
 - i. Medical providers and personnel should not contact LE without the consent of the sexual assault victim, with a few limited exceptions;
 - ii. Medical providers should be informed on mandated reporting laws including definitions of “child abuse” and “vulnerable adult”; and

* As per Health-General Article 19-310.2, all hospitals are currently required to have a policy in place.



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- iii. Victims' rights materials should be made available to all sexual assault victims;
 - d. Medical providers should be informed of the options available to victims of sexual assault and should advise them of these options;
 - e. SAFE programs must include access to victim advocates and FNEs. SAFE programs should be connected and in close communication with local sexual assault crisis programs as established under Criminal Procedure Article, §11-923 to ensure that a victim advocate is always present when a victim undergoes a SAFE;
 - f. All hospitals should provide all sexual assault victims with information regarding local sexual assault crisis programs and access to victim advocates, whether a SAFE is performed or not. This recommendation applies to all hospitals, and includes those with or without SAFE programs.
 - g. SAFE programs should offer 24/7 access to a SAFE;
 - h. SAFE programs should establish at least one staff position for a FNE. Staff duties should include performing SAFEs that are required during regular staffing hours, and coordination and mentoring of other FNEs in the SAFE program. SAFE programs may find it effective to expand the forensic program to include other forms of personal violence, such as domestic violence, child abuse, and elder abuse;
 - i. MHA or another similar body should appoint a committee to review the needs of pediatric sexual assault victims and how they can be better addressed. This committee may also consider the possibility of Registered Nurse Forensic Examiner–Pediatric (FNE-Ps) and their availability to work with the Maryland Children's Alliance, Child Advocacy Centers, and the Maryland Child Abuse Medical Providers Initiative as defined by Health-General Article §13-2201;
 - j. SAFE programs should obtain written authorization from the patient to release any of their information to non-health entities, including:
 - i. LE;
 - ii. Crime Lab;
 - iii. Toxicology Lab;
 - iv. Sexual Assault Crisis Center/Victim Advocacy;
 - v. Prosecutor; and
 - vi. Any non-health provider; and
 - k. All hospitals should provide an nPEP (post-exposure prophylaxis) starter pack to all eligible patients.
5. Sexual Assault Response Teams (SARTs)
- a. SAFE programs should participate in local SARTs. SAFE responses should maintain and strengthen community based connections, including working with local prosecutors, LE, and victim advocates; and



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- b. Statistics regarding SAFEs and related matters should be collected by SARTs using uniform data collection methods and should be submitted to the MCASA to be shared statewide (see Appendix H).
6. Reimbursement
- a. Increase the current physician reimbursement rate of \$80 for a SAFE;
 - b. Provide reimbursement for mobile FNEs;
 - c. Provide payment for inter-hospital transportation costs;
 - d. Continue to work with the Criminal Injuries Compensation Board (CICB) to provide reimbursement for nPEP to victims eligible for CICB, and develop alternative sources of funding for victims who are not CICB eligible;
 - e. Revise COMAR 10.12.02 to include reimbursement for human immunodeficiency virus (HIV) nPEP screening in hospitals with approved nPEP protocol (including baseline testing, initial counseling, and starter pack);
 - f. Increase the current Sexual Assault Reimbursement Unit program budget;
 - g. Extend the timeframe for reimbursement to support better victim services; and
 - h. Ensure that victims are not responsible for the costs associated with SAFEs received outside of Maryland by working together with sexual assault response agencies in our neighboring jurisdictions.
7. Public Education
- a. A statewide campaign should be undertaken to inform the community, including LE, EMS, and health care providers of the following options for victims of sexual assault:
 - i. The victim may seek medical care only without reporting to LE;
 - ii. The victim may seek medical care for a SAFE to collect evidence without reporting to LE;
 - iii. The victim may seek medical care, forensic examination, and report to LE;
 - iv. Each jurisdiction has a SAFE program providing SAFE services. The MCASA should continue to maintain the SAFE program listing and contact information; and
 - v. Each county and Baltimore City should have access to a local sexual assault crisis program, as established under Criminal Procedure Article §11-923, that provides a 24/7 hotline and accompaniment at the ED. MCASA should continue to maintain the listing and contact information of local sexual assault crisis programs.



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III. Introduction

House Bill (HB) 963 was enacted in the 2014 Legislative Session to address concerns about access to sexual assault forensic exams (SAFEs) in Maryland. House Bill 963 “Hospitals – Protocol for Sexual Assault Forensic Medical Examinations and Planning Committee” created Health-General Article §19-310.2 and required that each hospital that provides emergency services, have a protocol to provide victims timely access to SAFEs by FNEs or physicians on or before July 1, 2014. This bill also established the Planning Committee to Implement Improved Access to Sexual Assault Forensic Medical Examinations in Maryland.

The charge to the Planning Committee was as follows:

- (1) Review the protocols that certain hospitals are required to have under §19-310.2 of the Health-General Article;
- (2) Examine the barriers to providing care for individuals seeking a SAFE;
- (3) Study reimbursement issues for providers that offer SAFEs to the community;
- (4) Examine the protocols of EMS providers and local Law Enforcement agencies to direct sexual assault victims to a hospital with the capability to provide a SAFE;
- (5) Determine best practices on how to educate the community on where to access SAFE services;
- (6) Study and make recommendations about the optimal caseload level to maintain a high level of quality and competency among SAFE practitioners;
- (7) Consider geographic differences in the State as the differences relate to the provision of SAFE services;
- (8) Consider hospital reporting requirements regarding the number of victims who present and the actions taken;
- (9) Review practices in other states that increase the availability of SAFEs;
- (10) Develop and recommend protocols to enhance protections for sexual assault victims’ rights and privacy;
- (11) Receive public testimony from stakeholders; and
- (12) Adopt recommendations that are consistent with the State’s all-payer model contract approved by the federal Center for Medicare and Medicaid Innovation.

In addition, the Planning Committee was charged with submitting a report on or before December 1, 2015, on its findings and recommendations, including any legislation required to implement the recommendations, to the Governor and, in accordance with § 2-1246 of the State Government Article, the Senate Finance Committee and the House Health and Government Operations Committee.²

² “Hospitals – Protocol for Sexual Assault Medical Forensic Examinations and Planning Committee” (Maryland House Bill 963, May 15, 2014). Annotated Code of Maryland, Section 19-310.2, Chapter 627.



Planning Committee to Implement Improved Access to Sexual Assault Medical Forensic Examinations in Maryland



The Planning Committee consisted of 14 members appointed by the Governor, representing the Maryland Department of Health and Mental Hygiene (DHMH), the Maryland Institute for Emergency Medical Services Systems (MIEMSS), the MCASA, SAFE and non-SAFE hospitals, victim advocates, SAFE coordinators, local LE, and the Board of Nursing (see Appendix A: Committee Membership).

The inaugural meeting of the Planning Committee took place on November 13, 2014; notice of the meeting was published in the Maryland Register, as were all, subsequent meetings. The Committee met monthly from November 2014 through October 2015. All meeting minutes can be found at http://phpa.dhmh.maryland.gov/ohpetup/SitePages/rsapp_home.aspx

Four sub-committees were formed to work on the deliverables as outlined in the legislation: Victim Care, Law Enforcement/Emergency Medical Services, Reimbursements, and Public Testimony. These groups were tasked with reviewing the current system, identifying issues and gaps, reviewing state and national best practices, and proposing recommendations for the Maryland system.

IV. Use of Terms

Adolescent: A person who is in the period of human growth and development that occurs after childhood and before adulthood, typically from age 10-18 years.³

Adult: A person who has attained the age of majority. The age of majority is the legally defined age at which a person is considered an adult, with all the attendant rights and responsibilities of adulthood. The age of majority in Maryland is 18 years.⁴

Child: An individual younger than 18 years old; EMS protocol defines a child as anyone under age 15. For the purpose of sexual assault examinations, a child is an individual under the age of 13 years.⁵

COMAR: Code of Maryland Regulations.

DHMH: Maryland Department of Health and Mental Hygiene.

Emergency Medical Services (EMS): For the purposes of this report, this term refers to pre-hospital emergency medical services.

³ The World Health Organization: Adolescent development;
http://www.who.int/maternal_child_adolescent/topics/adolescence/dev/en/.

⁴ Md. Ann. Code General Provisions Art., § 1-401(2015).

⁵ COMAR 10.12.02.02: Department of Health and Mental Hygiene: Adult Health: Rape and Sexual Offenses – Physician and Hospital Charges.



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MCASA: The Maryland Coalition Against Sexual Assault is the federally recognized state sexual assault coalition. Members include all of Maryland’s sexual assault crisis programs.

MIEMSS: The Maryland Institute for Emergency Medical Services Systems.

nPEP: Non-occupational post-exposure prophylaxis; a medical intervention designed to prevent HIV infection after exposure to the virus. Prophylaxis is only available with a prescription.⁶

Patient: See “victim.” The term “patient” is also used when discussing the role of medical providers.

Rape: As defined by the 2013 Maryland Uniform Crime Report, penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim.

Rape Kit: The “Maryland State Police Victim Sexual Assault Evidence Collection Kit” or a comparable kit. The contents of this kit can be found in Appendix S. For the purposes of this report, all kits will be referred to as “rape kits”.

Registered Nurse Forensic Examiner (FNE): A Registered Nurse Forensic Examiner certified by the Maryland Board of Nursing (MBON).⁷ This term is used interchangeably with SANE (Sexual Assault Nurse Examiner), SAFE (Sexual Assault Forensic Examiner), and Forensic Nurse Examiner (FNE) to denote the individual who provides the exam.

Registered Nurse Forensic Examiner–Adult (FNE-A): Registered Nurse Forensic Examiner–Adult is a registered nurse certified by the MBON to practice as a forensic nurse examiner with respect to forensic examinations performed on adults and individuals thirteen years or older.⁸

Registered Nurse Forensic Examiner–Pediatric (FNE -P): A Registered Nurse certified by the MBON to practice as a forensic nurse examiner with respect to examinations of children who are younger than thirteen years old.⁹

Registered Nurse Forensic Examiner–Pediatric (FNE-AP): A Registered Nurse certified by the MBON to practice as a forensic nurse examiner with respect to examinations performed on individuals of all ages.¹⁰

⁶ The Center for Aids, Information & Advocacy. <http://www.centerforaids.org/nPEP.html>.

⁷ COMAR 10.27.21.02: Department of Health and Mental Hygiene: Board of Nursing: Definitions.

⁸ COMAR 10.27.21.02: Department of Health and Mental Hygiene: Board of Nursing: Definitions.

⁹ COMAR 10.27.21.02: Department of Health and Mental Hygiene: Board of Nursing: Definitions.



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Sexual Assault: Any type of sexual contact or behavior that occurs by force or without consent of the recipient of the unwanted sexual activity. Falling under the definition of sexual assault is sexual activity such as forced intercourse, sodomy, child molestation, incest, fondling, and attempted rape. It includes sexual acts against people who are unable to consent either due to age or lack of capacity.¹¹

Sexual Assault Crisis Center: As defined under Annotated Code of Maryland, Criminal Procedure Article, §11-923, programs that shall provide specialized support services, including a hotline and counseling services, to adult and minor alleged victims of sexual assault.

Sexual Assault Nurse Examiner (SANE): A registered nurse who has successfully completed a program which meets the Sexual Assault Nurse Examiner Standards of Practice established by the International Association of Forensic Nurses.¹²

Sexual Assault Response and Resource Team (SARRT) or Sexual Assault Response Team (SART): A multidisciplinary team within a jurisdiction providing a victim-centered, offender accountability-focused response to sexual violence in a community. Members typically include at least one of the following: forensic nurses, victim advocates, prosecutors, and Law Enforcement, in addition to other professions.¹³

Sexual Assault (Rape) Forensic Examination (SAFE): The sexual assault medical forensic exam is an examination of a sexual assault victim by a health care provider, ideally one who has specialized education and clinical experience in the collection of forensic evidence and treatment of these victims. The examination includes gathering information from the victim for the medical forensic history; an examination; treatment of injuries, documentation of biological and physical findings, and collection of evidence from the victim. Documentation of findings; information, treatment, and referrals for STIs, pregnancy, suicidal ideation, alcohol and substance abuse, and other non-acute medical concerns; and follow-up as needed to provide additional healing, treatment, or collection of evidence are all included in the SAFE. This exam is referred to as the “forensic medical examination” under the Violence Against Women Act (VAWA).¹⁴

¹⁰ [COMAR 10.27.21.02](#): Department of Health and Mental Hygiene: Board of Nursing: Definitions.

¹¹ United States Department of Justice, Office of Violence Against Women: The Violence Against Women Act of 1994.

¹² [COMAR 10.27.21.02](#): Department of Health and Mental Hygiene: Board of Nursing: Definitions.

¹³ Maryland Coalition Against Sexual Assault (MCASA), *The State of the State: Sexual Assault Forensic Examiner (SAFE) Programs in Maryland* (2012).

¹⁴ U.S. Department of Justice, Office on Violence Against Women, *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents*, 2d (April 2013).



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SAFE Nurse: A registered nurse certified by the MBON to practice as an FNE to perform a forensic medical examination.

SAFE Program: A facility authorized by the MBON that provides forensic nursing services.¹⁵

Survivor: As defined by the Merriam Webster Dictionary, a person that is able to continue to function or prosper despite hardships. Many people who suffer from sexual assault prefer this term. However, for consistency throughout the report, the term “victim,” as defined below, is used.

Trauma-Informed Approach: A perspective of care that aims to engage people with trauma experiences and recognize the presence of trauma symptoms. Trauma-Informed care is grounded in a thorough understanding of the neurological, biological, psychological, and social effects of trauma and the prevalence of these experiences in persons who receive mental health services. This approach also recognizes that traditional service approaches may re-traumatize consumers and family members. The approach is about creating a culture based on five core principles: Safety, Trustworthiness, Choice, Collaboration, and Empowerment.¹⁶

Victim: A sexual assault victim is someone who has been sexually assaulted. In this document, “victim” may refer to a female or male, a person whose gender identity may not conform to his or her sex, or someone who doesn’t identify as either male or female. There may be instances where individuals, such as unconscious person or persons with cognitive disabilities, do not actually disclose that they have been assaulted, but others suspect that this may be the case and may be lawfully able to seek help for them. It is important to note that because this document addresses a multidisciplinary response, the term “victim” is not used in a strictly criminal justice context. The use of “victim” simply acknowledges that persons who disclose they have been sexually assaulted should have access to certain services and interventions designed to help them be safe, recover, and seek justice.¹⁷

Victim Advocate: A person, whether paid or serving as a volunteer, who provides services to victims of sexual or dating violence, domestic violence, or stalking, under the auspices or supervision of a victim services program.¹⁸ See above for definition of Sexual Assault Crisis Center, the entities supervising victim advocates working with sexual assault victims.

¹⁵ COMAR 10.27.21.02: Department of Health and Mental Hygiene: Board of Nursing: Definitions.

¹⁶ Alameda County Trauma Informed Care: <http://alamedacountytraumainformedcare.org/trauma-informed-care/trauma-informed-care-vs-trauma-specific-treatment-2/>.

¹⁷ U.S. Department of Justice (April 2013).

¹⁸ <http://www.gpo.gov/fdsys/pkg/BILLS-113s47enr/pdf/BILLS-113s47enr.pdf>; Violence Against Women Act.



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Violence Against Women Act (VAWA): Federal law enacted in 1994 in recognition of the severity of crimes associated with domestic violence, sexual assault, and stalking. This Act enhances the investigation and prosecution of violence crimes against women.

Vulnerable Adult: An adult who lacks the capacity to care for his or her daily needs.¹⁹

V. Background and History

A timely, high-quality forensic medical examination can potentially confirm and address a sexual assault victim's concerns with sensitivity, minimize the trauma experienced, and promote healing. At the same time, it can increase the likelihood that evidence collected will aid in criminal case investigation, resulting in perpetrators being held accountable and further sexual violence prevented.²⁰

At present, every person in Maryland has access to facilities that provide SAFEs to victims either in their county of residence or in an adjacent county. According to COMAR 10.27.21.02, these programs are designated by the DHMH Maryland Board of Nursing (MBON), and are known as SAFE programs.²¹ However, it was found that there is no current oversight of program designation aside from FNE certification. Each hospital submits for review, a request to DHMH for reimbursement of costs incurred when performing a SAFE. These costs may include ED charges, labs, medications, and x-rays. The examination must be performed in the hospital submitting the request for reimbursement. The money for reimbursement through DHMH comes largely from state funds, supplemented with federal Preventive Health and Health Services Block Grant (PHHBG) funds.

Maryland law already requires every victim of sexual assault who wants a SAFE, be provided one free of charge. However, there is a current burden on self-reporting victims to, "get themselves to the right hospital," and an expectation that EMS will do the same.²²

Across the United States (U.S.), designated SAFE programs may be in hospitals, health clinics, mobile health units, or other alternative sites, including family justice centers or nonprofit sexual assault victim services programs. The majority of SAFEs in Maryland are conducted in hospital EDs. This location typically offers some level of security, is open 24-hours a day, and provides access to a wide array of medical and support services.²³

¹⁹ MCASA, Sexual Assault Legal Institute (September 2008).

²⁰ U.S. Department of Justice (April 2013).

²¹ COMAR 10.27.21.02: Department of Health and Mental Hygiene: Board of Nursing: Definitions.

²² Kelly, Ariana, Montgomery County Delegate, District 16. "HB 963 – Hospitals – Protocol for Sexual Assault Medical Forensic Examinations and Planning Committee," testimony, February 28, 2014, before the State of Maryland, Health and Government Operations Committee.

²³ U.S. Department of Justice (April 2013).



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The first SAFE programs in Maryland were created in 1993 at Civista Hospital (now University of Maryland Charles Regional Medical Center, Charles County) and Mercy Medical Center (Baltimore City). The first pediatric SAFE program was also established at Civista Hospital in 1993.²⁴ There are currently 24 SAFE programs in Maryland.

The State of Maryland EMS system is organized into five (5) regions. The following table and image detail which counties have access to which SAFE facilities based on EMS regionalization. Caroline, Queen Anne's, and Somerset Counties do not directly host a SAFE program, though there is access to a SAFE program in adjacent counties.

²⁴ MCASA, *The State of the State* (2012).



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Table 1: Maryland SAFE Program Location by Region/County

Region I	Region II	Region III	Region IV	Region V
<u>Allegany County</u> Western Maryland Regional Medical Center (A&P) <u>Garrett County</u> Garrett County Memorial Hospital (A)	<u>Frederick County</u> Frederick Memorial Hospital (A&P) <u>Washington County</u> Meritus Medical Center (A &P)	<u>Anne Arundel County</u> Anne Arundel Medical Center (A) University of Maryland (UM) Baltimore Washington Medical Center (A&P) <u>Baltimore City</u> Mercy Medical Center (A) University of Maryland Medical Center (P) <u>Baltimore County</u> Greater Baltimore Medical Center (A) MedStar Franklin Square Hospital Center (P) <u>Carroll County</u> Carroll Hospital Center (A) <u>Harford County</u> UM Upper Chesapeake Health System (A) <u>Howard County</u> Howard County General Hospital (A&P)	<u>Cecil County</u> Union Hospital (A) <u>Dorchester County</u> Dorchester General Hospital (A&P) <u>Kent County</u> UM Shore Medical Center at Chestertown (A) <u>Talbot County</u> UM Shore Health Memorial Hospital of Easton (A&P) <u>Wicomico County</u> Peninsula Regional Medical Center (A&P) <u>Worcester County</u> Atlantic General Hospital (A&P)	<u>Calvert County</u> Calvert Memorial Hospital (A) <u>Charles County</u> UM Charles Regional Medical Center (A&P) <u>Montgomery County</u> Shady Grove Adventist Hospital (A) <u>Prince George's County</u> Prince George's Hospital Center (A&P) <u>St Mary's County</u> MedStar St. Mary's Hospital (A)

Key: Adult (A), Pediatric (P), and Adult & Pediatric (A&P)



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Figure 1: EMS Regions: The Maryland Institute for Emergency Medical Services Systems



A. Rape in Maryland

According to the Rape, Abuse, and Incest National Network, the term sexual assault refers to sexual contact or behavior that occurs without explicit consent of the victim and includes penetration of the victim's body; attempted rape; forcing a victim to perform sexual acts; and fondling or unwanted sexual touching. As a form of sexual assault, the term rape is often used as a legal definition to specifically include sexual penetration without consent.²⁵

Thousands of Marylanders are affected by sexual violence each year; it is estimated that one in five (466,000) adult women in Maryland have been victims of forcible rape and one in six (359,000) adult men have been victims of sexual violence at some point in their lifetimes.²⁶ A 2011 survey of high school students found that 11.8% of girls and 4.5% of boys from grades nine through twelve reported being forced to have sexual intercourse at some point in their lives. Among rape victims above the age of 18, a survey found that 31.5% of woman and 16.1% of men reported physical injury as a direct result. From 2004-2006, an estimated 105,187 women and 6,526 males between the ages of 10-24 received medical care in U.S. EDs as a result of injuries sustained from sexual assault.²⁷

The total number of reported rapes in Maryland in 2013 was 1,169 (1,030 forced and 139 attempted). Rape accounted for 0.63% of all reported crimes, and 4% of reported violent crimes for the same year. Of the 24 jurisdictions in Maryland, 14 achieved a

²⁵ <https://rainn.org/get-information/types-of-sexual-assault/sexual-assault>. This generally accepted definition of rape varies from the definition used in Maryland's Criminal Law.

²⁶ Centers for Disease Control and Prevention: The National Intimate Partner and Sexual Violence Survey (NISVS) (2012); <http://www.cdc.gov/violenceprevention/nisvs/>.

²⁷ CDC: NISVS (2012).



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reduction or no change in the number of rapes reported in 2013, as compared to 2012.²⁸ For the purposes of these data, sexual violence is defined as any sexual act committed against someone without that person's freely given consent.²⁹ It is also important to note that the definition of the term "rape" has changed throughout the history of data collection. Throughout past data collection, the FBI had defined rape as, "the carnal knowledge of a female forcibly and against her will."³⁰

In Maryland, the following definition for rape went into effect January 1, 2013: "Penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim."³¹

This change in definition is important to note when considering national trends in rape statistics due to the new inclusion of male rape victims. Maryland State Police adopted this new definition January 1, 2015 for data collection. However, this report references only data collected prior to January 1, 2015, so is not reflective of the new definition.

²⁸ Maryland Governor's Office of Crime Control & Prevention, Analysis of Uniform Crime Report for 2013.

²⁹ CDC: NISVS (2012).

³⁰ Uniform Crime Report: Frequently Asked Questions about the Change in the UCR Definition of Rape, December 11, 2014.

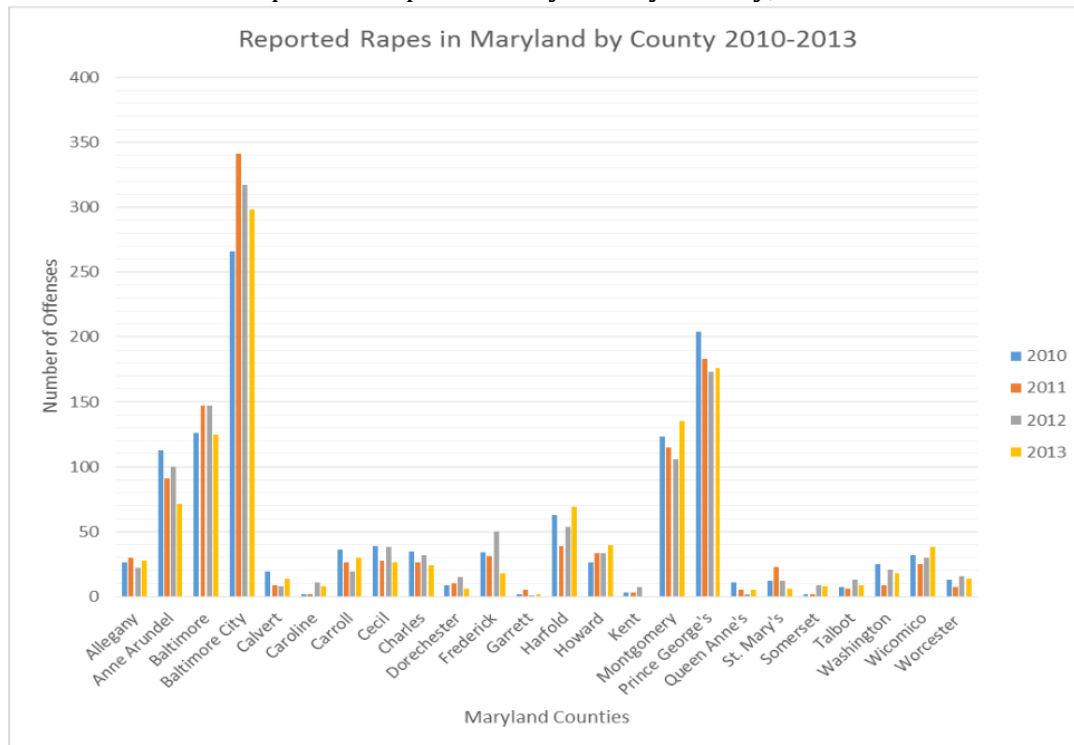
³¹ Uniform Crime Report: FAQ (2014).



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Table 2: Reported Rapes in Maryland by County, 2010 – 2013³²



* Data found in the 2013 Uniform Crime Report, Crime in Maryland, p. 26.

B. State of Maryland Current Practice

COMAR 10.12.02.03 provides that a victim of alleged rape or sexual offense shall be considered an emergency patient with special needs. Once identified, these victims are to be taken immediately to a private area for testing and examination. SAFEs shall be performed if the victim is seen within 120 hours of the alleged offense and may only be performed by a physician or FNE.³³ The majority of SAFEs are performed by FNEs.

A sexual assault victim may present to a hospital in one of many ways: they may self-report to a hospital, call for EMS treatment and transport, request LE support and transport, request or require interhospital transport, or refuse interhospital transport. The federal Emergency Medical Treatment and Labor Act is a federal law enacted in 1986 that insures public access to emergency medical services regardless of ability to pay.³⁴ Hospitals may offer interhospital transfers to stabilized individuals with specialized needs,

³² http://www.goccp.maryland.gov/msac/documents/2013_Crime_in_Maryland_UCR.pdf.

³³ COMAR 10.12.02.03: Department of Health and Mental Hygiene: Adult Health: Alleged Rape or Sexual Offense Victim Care.

³⁴ 42 USC 1395dd – Examination and treatment for emergency medical conditions and women in labor.



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such as sexual assault victims that require forensic examination. FNEs may be available to visit the hospital to provide the SAFE.

If the victim requires interhospital transfer to a SAFE hospital, and it is deemed necessary by the provider and agreed upon by the victim, the hospital should use a protocol that minimizes time delays, loss of evidence, and that address the victims' needs. It is important to note that all health care facilities receiving federal funds, including Medicare and Medicaid payments, are required to screen victims medically before transferring them to another exam site.³⁵

Current Maryland law, as mandated by Health-General Article §19-310, requires that on or before July 1, 2014, each hospital that provides emergency medical services shall have a protocol to provide timely access to a SAFE by an FNE or a physician to a victim of an alleged rape or sexual assault who arrives at the hospital for treatment.³⁶ Out of 46 facilities with recognized EDs, 38 submitted policies to the Committee for review. Policies were received from all 24 SAFE programs.

Maryland is also one of 18 States that has developed a basic standardized rape kit to be distributed (at no charge) to health care providers and other professionals who administer forensic examinations throughout the State.³⁷ The list of contents, documents required, and consent form for the Maryland State Police Evidence Collection Kit can be found in Appendix S. A review of the ED and SAFE program policies submitted show that not all Maryland SAFE programs are using this kit, while other programs supplement their exams with additional contents.

VI. Deliverable #1: Review the protocols that certain hospitals are required to have under §19-310.2 of the Health-General Article

At the request of the Planning Committee, the MHA asked the 46 hospitals in the State to submit their protocols for the treatment of sexual assault victims arriving in their EDs. Twenty-four of these 46 hospitals are recognized as SAFE programs, while as of the writing of this report, 40 responded to the request from the MHA (thirty eight submitted policies and two responded that they did not yet have a policy).

A review of the 38 protocols submitted reveals that all 38 hospitals offered the victim a quiet place for an interview and encouraged minimal discussion of the rape by hospital staff. Four hospitals did not offer the victim the option of Jane Doe reporting and

³⁵ U.S. Department of Justice (April 2013).

³⁶ "Hospitals – Protocol for Sexual Assault Medical Forensic Examinations and Planning Committee" (Maryland House Bill 963, May 15, 2014). Annotated Code of Maryland, Health-General Article, Section 19-310.2, Chapter 627.

³⁷ AEquitas: The Prosecutors Resource on Violence Against Women, *Summary of Laws & Guidelines: Payment of Sexual Assault Medical Forensic Examinations* (February 2012).



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or not reporting. All but seven hospitals provided guidelines in their protocols for handling medically unstable victims. Only one hospital's protocols did not state where victims should be transferred. The remaining protocols specified where victims were to be transferred, but provided no clarification for transport arrangements. Eight of the 38 protocols reviewed do not include guidelines for handling pediatric victims. In fact, the pediatric population currently has no facility with a mobile unit that can travel to other hospitals for the purpose of performing a forensic examination on children that are unstable and unable to be discharged or transported to a forensic program that provide SAFEs for children. A concise overview of Maryland's hospitals by region, including both SAFE and non-SAFE facilities, can be found in Appendix D.

Only 38 hospitals provided documentation of compliance with Health-General Article §19-310.2. Two hospitals responded that they did not have a policy, and it could not be determined if the remaining six hospitals were in compliance or not. As such, these eight hospitals should be held accountable for maintaining a protocol for the treatment of sexual assault victims arriving in their EDs. There is no penalty for non-compliance. It should be noted that as we continue to work with MHA, it is anticipated that protocols from the remaining hospitals will be submitted.

VII. Deliverable #2: Examine the barriers to providing care for individuals seeking a sexual assault medical examination

A. Community Awareness

Lack of public education, community awareness, and a lack of detailed response protocols for EMS, LE, and hospitals, may result in both victims and responders not always knowing where to access a SAFE program. There is an expectation that there is "no wrong door" for victims to access SAFEs and related services, again placing the burden on the victim if a specific facility cannot provide the services necessary. The need for greater public awareness, and provider education and response protocols, is discussed in greater detail in future deliverables.

B. Limited Numbers of FNEs

One of the barriers to providing care for individuals seeking a SAFE is the limited number of Maryland Board Certified Forensic Nurses throughout the state. As of this report, the MBON has approximately 150 nurses listed with this special training.³⁸ This number must be increased to ensure 24/7 coverage to victims of sexual assault. This topic shall be expanded upon in the discussion of practitioner competency and quality in Deliverable #6.

³⁸ Personal communication, Shirley Devaris, Maryland Board of Nursing, 2015.



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C. Varying Cultural Competencies

In May 2014, the Urban Institute was awarded a project by the National Institute of Justice to study cultural competency issues related to SAFE, and published *Accessing Sexual Assault Medical Forensic Exams: Victims Face Barriers*.³⁹ This study describes issues that individuals identified as non-English speaking, immigrants, and Native Americans may encounter which hinder their ability to access a SAFE. Information was gathered through online surveys of state-level sexual assault coalitions and local community-based service providers, case studies involving stakeholders, and focus groups with victims.

For non-English speaking victims of sexual assault, language barriers present challenges for victims attempting to understand the exam process and their rights, as well as, an increased difficulty communicating questions and concerns. Lack of interpretation services and translated written materials also hinders communication between the victim and first responders, SANEs, medical personnel, and social workers. It is important to note that according to the U.S. Census Bureau report entitled *Language Use in the United States: 2011*, 16.7% of the population in Maryland spoke a language other than English at home, 13.6% did not speak English well, and 3.6% did not speak English at all.⁴⁰

Cultural barriers were also identified. Service providers who lack sensitivity, patience, and cultural competency hinder access to victim services. In addition, lack of community education about available services and misinformation also contribute to this problem. Fear of the criminal justice system, as well as, fear of deportation makes it difficult for many victims to seek help, especially undocumented victims. Cultural norms involving shame, stigma, and lack of acknowledgement of sexual assault also serve as major barriers in some communities.

D. Pediatric SAFE for Acute Cases

Sexual assault acute care for children is lacking across the State. There are no mobile FNEs for child sexual assault, therefore; pediatric hospitals oftentimes serve as a backup for many localities when patients have acute needs. Children in Baltimore County and Baltimore City, as well as, other areas of Maryland need to be transferred to a Pediatric SAFE hospital such as MedStar Franklin Square Medical Center or University of Maryland Medical Center following stabilization.

³⁹ <http://www.urban.org/research/publication/accessing-sexual-assault-medical-forensic-exams>

⁴⁰ <https://www.census.gov/prod/2013pubs/acs-22.pdf>



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Most children will not present during the evidentiary window, but instead may present weeks, or even years later. This causes concern for evidence collection, but may often also delay necessary nPEP.

VIII. Deliverable #3: Study reimbursement issues for providers that offer sexual assault medical forensic examinations to the community

The Violence Against Women Act (VAWA) of 1994 required States or another entity to assume the full out-of-pocket costs for SAFEs in order to be eligible for Federal Services, Training, Officers, and Prosecution grant funding. Previously, mandating victim cooperation with LE in order to receive a free SAFE was a permitted condition under this federal legislation. Realizing this placed an undue burden on victims, VAWA 2005 stipulated that free SAFEs were not contingent upon a victim participating with the criminal justice system. VAWA 2005 also defined minimum requirements for a forensic medical examination to include the following: 1) examining physical trauma; 2) determining penetration or force; 3) interviewing the victim; and 4) collecting and evaluating evidence. In practice, each state or local jurisdiction decides what it will cover as part of the reimbursed examination. Some states cover only what is required by federal mandate, while other states provide additional covered services to the victim. A summary of nationwide costs and reimbursements can be found in Appendix I

Unlike most states which provide reimbursement for SAFEs to victims of rape and sexual assault through the Office of the Attorney General's victim compensation fund, Maryland provides reimbursement through DHMH. Programs in many other states, including Delaware, New York, and Pennsylvania, provide compensation not only to victims of rape and sexual assault but to victims of other major crimes as well, through Crime Victims Compensation programs. Under this approach, the federal government (through the Victims of Crime Act – VOCA – Victim Compensation Grant Program) is required to make an annual grant to eligible crime victim compensation programs that is equal to 60 percent of the amount awarded by the state program to victims of crime from state revenues during the two preceding fiscal years (OVC FY 2015 VOCA Victim Compensation Formula, U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crime, OMB No. 1121-0329, July 1, 2015). A summary of victim compensation in neighboring States can be found in Appendix J.

Maryland operates the nation's only all-payer hospital rate regulation system. This system is made possible, in part, by a 36-year-old Medicare waiver (codified in Section 1814(b) of the Social Security Act) that exempts Maryland from the Inpatient Prospective Payment System and Outpatient Prospective Payment System and allows Maryland to set rates for these services. Under the waiver, all third parties pay the same rate. The State of Maryland and the Centers for Medicare & Medicaid Services expect that the all-payer model will be successful in improving the quality of care and reducing program expenditures for



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Maryland residents, including Medicare, Medicaid, and Children's Health Insurance Program beneficiaries. Moreover, the Maryland system may serve as a model for other states interested in developing all-payer payment systems.

Maryland law specifically restricts medical providers from charging a victim of sexual assault, or their family, for a physical examination or initial assessment for the purpose of establishing and gathering information and evidence as to the alleged crime or for emergency hospital treatment, and for follow-up medical testing performed within 90 days after the initial examination.⁴¹

COMAR 10.12.02 Rape and Sexual Offenses – Physician and Hospital Charges outlines the following: 1) requirements for the collection of evidence in cases of rape, sexual offense, and child sexual abuse; 2) reimbursement to hospitals, laboratories, and physicians for the physical examination, the collection of evidence, and the emergency treatment of individuals for physical injuries directly resulting from the alleged rape or sexual assault; and 3) reimbursement to hospitals, laboratories, and physicians for an initial assessment and information and evidence collection from a victim of alleged child sexual abuse. The Sexual Assault Reimbursement Unit (SARU) is mandated to provide this reimbursement, and utilizes a combination of state general funds (90%) and federal funds from the Preventative Health and Health Services Block Grant Funding (10%).

Covered services include physician professional services for an initial assessment and a forensic evidence collection of rape, sexual assault, and child sexual abuse victims. Additional services include: 1) radiology, surgery, and emergency services consults; 2) physician and mental health professional services for psychological evaluation and parental interviews for victims of child sexual abuse; 3) ED fees; 4) laboratory testing, including, but not limited to, gonorrhea cultures, chlamydia cultures, testing for syphilis, pregnancy testing, acid phosphatase testing, hepatitis profile, herpes testing, alcohol and drug screening, including screening for date rape drugs; and 5) pharmacy charges, including, but not limited to, tetanus toxoid prophylaxis, antiemetic medications, antibiotics, analgesics, oral contraceptives, and additional medications directly related to the assault. In addition, the SARU provides reimbursement for follow-up medical testing performed up to 90 days after the initial physical examination. HIV prophylaxis/nPEP is not currently covered.

Physicians providing services to adult victims of alleged rape/sexual assault are reimbursed at a rate not to exceed \$80 for examination and collection of evidence. Physicians (or those individuals under the physician's supervision) providing services to victims of alleged child sexual abuse are reimbursed at a rate not to exceed \$80 per hour for up to five hours for a psychological assessment, a parental interview, and a pediatric

⁴¹ COMAR 10.12.02.05: Department of Health and Mental Hygiene: Adult Health: Reimbursements



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physical examination.⁴² DHMH reimburses the established rate as determined by the Health Services Cost Review Commission (HSCRC) for the use of ED or outpatient clinic and the daily in-hospital rate in case of hospitalization for physical injuries directly resulting from the alleged sexual assault or abuse. ED charges are based on the level of care and resources required and vary depending on the hospital.

DHMH reimburses the established rate as defined by the HSCRC for laboratory test necessary to establish and gather information and evidence of the crime, and for screening of the victim for pregnancy and sexually transmitted infections.

Vendors (hospitals, physicians, and laboratories) throughout Maryland submit invoices directly to the SARU for SAFEs provided to victims of rape, sexual assault, and child sexual abuse. COMAR 10.12.02 requires vendors to provide the following documentation to the SARU within the 90 day filing period: 1) a cover sheet with the vendor's name, address, federal tax identification number, victim's name, date of service, personal identification number, and the amount due; 2) an itemized bill; 3) a police complaint number, property held number, or alternate case number; 4) the physician's signature on the ED or physician's report and/or SAFE notes; 5) documentation of laboratory/diagnostic tests ordered; 6) Medical Examination and Report of Alleged Sexual Assault (Form #2923); 7) Confidential Report of Alleged Child Sexual Assault (Form #4456); 8) the victim's (or representative) signature for informed consent on Form #2923; and 9) the physician or FNE's written narrative report. Once the required documentation has been approved for reimbursement, SARU provides reimbursement directly to vendors.⁴³

In addition, providers of SAFEs may not charge the victim or the victim's family of an alleged rape, sexual offense, or child sexual abuse for those examinations. Providers are also not permitted to bill a victim's insurance for any differences between charges and DHMH reimbursement, and providers shall accept SARU's reimbursement in full.

Each year SARU provides reimbursement for over 3,000 invoices, with reimbursement provided for 3,135 in Calendar Year (CY) 2014. For the time period CY 2010 - 2014, approximately two-percent (2.1%) of total invoices received by SARU were rejected for being received greater than 90 days from the date of service. Of the total invoices rejected during that same time period, 19.2% were rejected for being received greater than 90 days from the date of service. The remaining 80.8% of invoices were rejected for various other reasons, including: 1) sexual assault occurred out of state (31%); 2) no forensic examination performed (16%); 3) invoice not related to sexual assault (14%); 4) forensic examination performed > 120 hours after sexual assault (11%); 5) duplicate invoice submitted (11%); 6) ambulance charges (6%); 7) invoice submitted by a

⁴² COMAR 10.12.02.05: Department of Health and Mental Hygiene: Adult Health: Reimbursements

⁴³ COMAR 10.12.02.05: Department of Health and Mental Hygiene: Adult Health: Reimbursements



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mobile hospital SAFE program when a victim was seen at another hospital (5%); 8) suspect case (2.5%); and 9) other (3.5%).

A. Barriers to Reimbursement

The current reimbursement rate for physicians is capped at \$80 for adult SAFEs regardless of time spent conducting the exam. The current reimbursement rate for physicians is capped at \$400 (up to five hours at \$80 per hour) for child examinations, including a child psychological interview, a parental interview, and a medical examination. Depending on the circumstances, a child may receive a SAFE. The current professional reimbursement rate was established in 1978 and has not been increased since that time.⁴⁴

It is difficult to compare the current Maryland rate with reimbursement rates in other states, as rates are often included in a global capped fee. The 2015 Medicare Reimbursement Rates for ED visits for Maryland/Baltimore City are listed in Table 3.

Table 3: 2015 Medicare Reimbursement Rates for ED Visits to Maryland/Baltimore City⁴⁵

ICD 9 Coding	Severity	Reimbursement
99281	Limited or Minor	\$42.15 /\$43.38
99282	Low to Moderate	\$21.45/\$22.04
99283	Moderate	\$63.54/\$65.46
99284	Moderate to High	\$120.87/\$124.56
99285	High	\$178.88/\$184.46

The reimbursement rate is comparable to an ED visit of moderate severity. It may be necessary to revisit this cap, as current inflation rates suggest an equivalent cost would be approximately \$300.⁴⁶

An additional barrier to reimbursement is the inability to provide reimbursement to FNEs who travel to other hospitals to perform SAFE. FNEs may be requested to travel to hospitals to perform SAFEs in cases where the victim is not able to be transported to the SAFE program. However, reimbursement to the FNE is not clearly defined. FNEs receive a salary or a capped fee per SAFE from their primary hospital; however, FNEs are not able to bill DHMH directly for the forensic medical examination (Health Occupations Article, Title 8 Nurses and Title 10, Subtitle 27 Board of Nursing). Compensation for FNEs is included as a portion of the hospital ED visit reimbursement.^{47,48} It may be pertinent to consider a

⁴⁴ COMAR 10.12.02.05: Department of Health and Mental Hygiene: Adult Health: Reimbursements.

⁴⁵ Centers for Medicare & Medicaid Services; <http://www.cms.gov/apps/physician-fee-schedule>.

⁴⁶ Inflation Calculator: Bureau of Labor Statistics (2015); http://www.bls.gov/data/inflation_calculator.htm.

⁴⁷ Personal communication, Linda Kelly, prior GBMC SAFE Program Coordinator.

⁴⁸ Finkle, S.A., Jones C., Kovner C.T. Financial Management for Nurse Managers and Executives. 4th ed. St Louis, MO: Saunders; 2012.



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consulting physician's review of case files to submit reimbursement and establish a revenue sharing system. Non-SAFE hospitals may also consider submitting it for facility reimbursement, while SAFE programs may still submit for laboratory work if performed at the SAFE facility.

When a traveling FNE is not available the costs for transporting victims of rape, sexual assault, and child sexual abuse are not covered by state regulation. COMAR 10.12.02 does not provide for reimbursement to cover transportation costs (ambulance, taxi, etc.) for victims of rape, sexual assault, and child sexual abuse. Victims may later receive extensive bills for these transportation costs. Many non-SAFE hospitals provide transport of the victim (ambulance, taxi, etc.) but are not reimbursed for this. Some hospitals also utilize the police to transport willing victims when they do not have the ability/resources to provide their own transportation. Transportation by police raises concerns about whether the victim's right to choose whether or not to report to LE is compromised.

Other States provide reimbursement for these transportation costs either directly through a sexual assault reimbursement program or by seeking reimbursement through the State's victim compensation program. The victim may be responsible for filing for this transportation reimbursement. In Maryland, victims are encouraged to work with the CICB in order to receive reimbursement for transportation costs. SARU works with the CICB to ensure these transportation costs are covered. The State may also wish to consider providing victims with vouchers to cover their transportation costs.

Another reimbursement issue is that the cost for nPEP is not covered. COMAR 10.12.02.03A (3) provides for referral to the appropriate anonymous or confidential free HIV counseling and test sites, but nPEP is not a reimbursable service. Reimbursed costs for nPEP may be considered as two distinct costs: 1) the Starter Pack which is enough medication for three (3) to seven (7) days, provided in the hospital; and 2) the remaining 21-25 day treatment.

The Centers for Disease Control and Prevention recommends initiating nPEP with Highly Active Antiretroviral Therapy when an individual seeks care within 72 hours of HIV exposure and the source is known to be HIV infected, as well as, the exposure event presents a substantial risk for transmission. When HIV status of the source is unknown and the victim seeks care within 72 hours of exposure, the U.S. Health & Human Services Department does not recommend for or against nPEP, but encourages clinicians and victims to weigh the risks and benefits on a case-by-case basis. When the transmission risk is negligible, or when victims seek care more than 72 hours after a substantial exposure, nPEP is not recommended.⁴⁹

⁴⁹ The Centers for Disease Control, MMWR, Antiretroviral Postexposure Prophylaxis after Sexual, Injection-Drug Use, or Other Nonoccupational Exposure to HIV in the US; <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5402a1.htm>.



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Other States use a variety of methods to cover the costs of nPEP, including billing the victim's private insurance (including Medicaid and Medicare), directly billing the Office of Victim Services/Crime Victim's Compensation Program, applying to special programs within the Office of Victim Services which cover the costs of nPEP beyond the initial Starter Pack, or applying for free antiretroviral medications through the medication assistance programs run by the drug manufacturers.⁵⁰

In Maryland, reimbursements for nPEP would first necessitate a revision of COMAR 10.12.02 to include reimbursement for HIV screening (including baseline testing and counseling). The current SARU program budget would need to be increased to reflect this addition of services, as well. It may also be prudent to continue to work with the CICB to provide reimbursement for nPEP for eligible victims.

IX. Deliverable #4: Examine the protocols of Emergency Medical Service providers and local Law Enforcement agencies to direct sexual assault victims to a hospital with the capability to provide a sexual assault medical forensic examination

A. Pre-Hospital Notification and Response

1. Emergency Medical Services (EMS)

There are a number of varied entry points by which victims of sexual assault may attempt to access information and services. Victims may initially contact 911, call a 24/7 sexual assault helpline, or access other national and local resources. Victims may walk into a hospital ED or clinic, visit the local police station, or be transported by EMS. Victims may make an initial report to school or campus counselors. However, studies indicate that 95% of sexual assault victims will first disclose the assault to a family member or friend.

Across the State of Maryland, there are minimal protocols for LE, EMS, and medical providers in facilitating access to SAFEs. Victims of sexual assault, their family and friends, and the community lack awareness of services and resources, as well as, the options that victims have regarding reporting, evidence collection, and care. Although each jurisdiction in Maryland has a designated SAFE program, these programs vary in their ability to maintain forensic nurses on 24/7 coverage.

Several sexual assault victims may end up at a hospital without a SAFE program or one without an available forensic nurse. The victim then must go to another hospital, often resulting in hours of delay, possible loss of critical evidence, additional costs, and difficulty

⁵⁰ <http://fairpricingcoalition.org/patient-assistance-program-and-co-pay-program-for-pep/>.



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in transporting the victim to and from facilities, as well as, violations of privacy when police are called without consent. Victims may decide to opt out of evidence collection if there are too many barriers. Victims and support persons may not be accurately informed of options regarding reporting, evidence collection, medical care, emergency contraception, and the availability of advocacy services. In these cases it is not unusual for the victim to withdraw from reporting or accessing services and care. Victims accessing the criminal justice system continue to be very limited; sexual assault is the most underreported of violent crimes.

The Maryland Emergency Medical Dispatchers (EMDs) provide call intake, medical interview, pre-arrival and post-dispatch instructions, and medical call prioritization for EMS resource allocation and management.⁵¹ EMDs follow guidelines to help determine if the victim must go to a trauma center for treatment of severe injuries. The current guidelines used by Maryland EMDs for sexual assault victims can be found in Appendix K.

The current 2014 Maryland Medical Protocols for EMS Providers (EMS protocols) offer limited guidelines for the treatment of sexual assault victims. See Appendix L. This protocol locates sexual assault under “Trauma,” indicating that EMS providers assess the level of trauma which may dictate the specific ED/ Trauma Center to which the victim is taken. It also does not clarify that the sexual assault victim should be transported to the nearest SAFE program if the victim is not assessed as having a high level of trauma and can be transported to the nearest ED.

Montgomery County EMS offered a General Order to all EMS providers dictating that medically stable victims not requiring other specialty care can bypass closer EDs to be taken directly to the county SAFE facility at Shady Grove Adventist Hospital. However, victims that have suffered traumatic injury should still be taken to the closest ED/Trauma Center, unless specialty care is required (See Appendix M).

The State of Ohio also offered guidelines to their EMS providers through specific protocol for possible sexual assault victims. While medical stabilization is the priority, all sexual assault victims not suffering from severe injury are to be transported to an appropriate facility where SAFEs are performed by a SAFE program.⁵² EMS protocol also dictates the expectation for victim safety, evidence preservation, and documentation requirements. This protocol and its resources can be found in Appendix N.

Maryland EMS protocols should include guidelines to take the victim to the nearest ED with a SAFE program (absent of other trauma needs); and should list the SAFE

⁵¹ Maryland EMS Provider Descriptions;

http://www.miemss.org/home/Portals/0/Docs/EducationCert/EMS_Provider_Description.pdf.

⁵² Ohio Department of Health, Ohio Protocol for Sexual Assault Forensic and Medical Examination (February 2011).



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programs in the “Specialty Referral Centers” section within the Maryland EMS protocol. A suggested addition to the Maryland EMS protocols to address these recommendations can be found in Appendix E.

Although some local EMS jurisdictions have guidelines in place, the current Maryland EMS protocols for sexual assault victims does not direct personnel to take the victim to the nearest ED with a SAFE program. The Maryland EMS Sexual Assault protocol only touches the surface for the treatment of sexual assault victims. The Sexual Assault protocol does not include recommendations regarding eating/drinking, notifications to the destination facility, or facility recommendations for victims who do not require trauma care. EMS may also not be fully informed or trained regarding sexual assault victims’ options regarding reporting to police, and while sexual assault victims may be transported to another hospital with a SAFE program, transportation is often arranged with police even when the victim has indicated their choice is not to report to LE. This procedure can result in potential problems in billing sexual assault victims for medical care, as well as, possibly violating the victim’s rights.

The National Emergency Medical Services Education Standards offer very limited insight into the handling of sexual assault victims. Curriculum requires a review of emotional support techniques, controlling vaginal bleeding, and methods to preserve evidence and crime scene integrity. Little to no mention of additional medical care or specific facility guidelines was made.⁵³

2. Law Enforcement (LE)

Similar to EMS, there is no consistent protocol or standard for LE response to sexual assault victims in the State of Maryland. However, there are established best practices, as well as, state laws concerning the rights of crime victims and specifically sexual assault victims. LE Officers may not be informed of best practices and may inadvertently discourage victims of sexual assault from obtaining forensic evidence collection, medical care, and access to advocacy services. In addition, some jurisdictions may not have specialized units and training for sexual assault investigations. The 911 dispatch and first responders on scene, including, officers, and investigators can play a significant role in the sexual assault victim’s willingness to participate in an investigation and his/her ability to cope with the after effects of the crime.⁵⁴

In Maryland, there are 77 Police Departments and 24 Sheriff Departments in addition to the Maryland State Police, and Federal Department of Defense Officers. Table 4

⁵³ National Highway Traffic Safety Administration: National Emergency Medical Services Education Standards; www.ems.gov/pdf/811077a.pdf.

⁵⁴ Model Policy, Investigating Sexual Assaults, International Association of Chiefs of Police, May 2005.



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outlines the twelve LE policies received by the EMS and LE Subcommittee. Please note that these policies do not distinguish between chronic (constant and longstanding abuse) and acute (urgent medical condition or severe injury) cases in children, though Child Advocacy Centers will commonly accept chronic cases.

Table 4: Law Enforcement Matrix

Local Agencies	Policy	Access to Exam	SART Team	Other
Maryland State Police	None specific to SA			
REGION I				
No Response Received				
REGION II				
Hagerstown City Police Department	No specific policy			
Washington Co. Sheriff's Office	No specific policy			
REGION III				
Baltimore City PD	Transport the victim to Mercy Medical Center unless the victim is already receiving treatment at another hospital and the transport would jeopardize the health of the victim.	If a victim is 12 years of age and younger, University of Maryland Medical Center Pediatric Emergency Room. If the victim is 13 years of age and older, Mercy Medical Center.	Yes	Victim may choose to see a doctor of their choice.
Baltimore County PD	Offer victims the opportunity for an examination at an approved medical facility when appropriate.	Closest hospital available if immediate medical attention is required. Greater Baltimore Medical Center if immediate medical treatment is not required. Franklin Square Hospital if 12 years of Age or under.	Yes	
Howard County PD	Explain the SAFE process and encourage the victim to submit to an exam.	Arrange transportation for the victim to the hospital either by ambulance or police vehicle.		



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REGION IV				
Cecil County Sheriff's Office	Only have a policy for child sex abuse, Jane Does, and prison rapes.			
Kent County Sheriff's Office	Victim is transported to University of Maryland Shore Medical Center. Detailed questions about the incident are left to primary criminal investigator.			
Ocean City PD	Inform victim that exam will be paid for by the State of Maryland.	Victims who desire to take advantage of the Jane Doe Reporting Program shall be directed to Atlantic General Hospital.		
Salisbury PD	No specific Policy	Local hospital has designated SAFE nurses.	Yes	
REGION V				
Montgomery County PD	If the victim requires immediate treatment, transport to nearest hospital. The victim has the right to choose any hospital within Montgomery County. However, SGAH is the preferred choice for a Sexual Assault Nurse Examiner (SANE) exam.		Yes	The victim has the right to request that the exam be conducted by their personal physician. The victim has the right to refuse medical treatment.
St. Mary's County Sheriff's Office	Victims are transported to St. Mary's Hospital. Assigned detective will respond to hospital and contact the victim.	Sexual assault forensic exam will be performed within 120 hours of the report. Chronic exam will be administered 72 hours from the time of report.	Yes	

All LE responders should ensure that the emergent medical needs of the victim are addressed before the investigation is started. LE should have training in Trauma-Informed response and all responders should handle cases from a non-judgmental perspective.

Communications personnel should follow standard emergency response, including evaluating and prioritizing the call, securing medical assistance, and obtaining information to locate and identify the suspect. They should also provide standard instructions regarding the preservation of forensic evidence to the victim and/or responders.

Initial officer response should make contact with the victim as soon as possible to address safety concerns and arrange for medical assistance. Every report of sexual assault should be investigated thoroughly and fairly.⁵⁵

The Maryland Victim Rights Law, states that victims should be transported to the nearest SAFE program unless the victim refuses or requests transport to a specific facility.⁵⁶ The responding officers and investigators should not dismiss paramedics or delay transporting the victim for medical care. The victim should not be taken to the police station unless medical treatment has been refused or it has been at least five days since the

⁵⁵ Training Bulletin: Police Clearance Methods, EVAWI, August 2013.

⁵⁶ MD Crim. Pro. §11-924(b)(1) .



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sexual assault. Victims of sexual assault may have serious injuries that are not visible and critical forensic evidence may be lost if care is delayed.

Officers should communicate to victims the need for a SAFE as important to investigative and apprehension efforts, but should not force victims to go to the hospital or provide urine samples for drug screening. LE should work with their jurisdiction's local sexual assault crisis center to secure advocacy services and medical accompaniment.

LE officers should be informed of a victims' options and rights. As part of the emergency response, victims of sexual assault should be treated with dignity, respect, and fairness as accorded to victims of crime. Recommended guidelines for inclusion in local LE protocols can be found in Appendix F.

The New York State Coalition Against Sexual Assault, along with the support of the New York State Department of Health, offers a "Pocket Guide for Police Response to Sexual Assault". Primary responsibilities of the first-responding officer to a sexual assault include attending to the victim's safety, educating the victim on evidence preservation, and immediately contacting the local Rape Crisis Program.⁵⁷ New York State Executive Law 642(b) requires all police departments to provide sexual assault victims, in writing, the name, address, and telephone number of the nearest Rape Crisis Program. These victim advocates are available at all times to assist with victim needs and questions.⁵⁸

The state of New Hampshire also provides EMS, LE, and dispatcher checklists that may be beneficial for Maryland's consideration (Appendix O).

X. Deliverable #5: Determine best practices on how to educate the community on where to access sexual medical forensic examination services

Lack of public education about available free sexual assault services presents another barrier. Many victims seeking services are unaware that Maryland law and regulations require DHMH to cover expenses related to receiving a SAFE and emergency medical treatment at no cost to victims. Most people become aware of these services after reaching out to a local sexual assault crisis center after an assault. Educating the general public about these services across the State is recommended.

Due to a general lack of awareness regarding the options, rights, and resources available to victims of sexual assault, it is recommended that a statewide public education

⁵⁷ New York State Coalition Against Sexual Assault (NYSCASA), *Pocket Guide for Police Response to Sexual Assault*, Spring 2011.

⁵⁸ NYSCASA (Spring 2011).



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campaign be undertaken to inform the community, including LE and health care providers of the following:

A victim of sexual assault has several options:

1. The victim may seek medical care only, without reporting to LE;
2. The victim may seek medical care with a forensic examination to collect evidence, without reporting to LE;
3. The victim may seek medical care, forensic examination, and report to LE;
4. Each jurisdiction has a SAFE program providing SAFE services. The Maryland Coalition Against Sexual Assault should continue to maintain the SAFE program listing and contact information; or
5. Each jurisdiction has a local sexual assault crisis program, as established under Criminal Procedure Article §11-923, that provides a 24/7 hotline and accompaniment at the ED. MCASA should continue to maintain the listing and contact information of local sexual assault crisis programs as established under Criminal Procedure Article, §11-923.

XI. Deliverable #6: Study and make recommendations about the optimal caseload level to maintain a high level of quality and competency among SAFE practitioners

A. Maryland Board of Nursing (MBON) Regulation – COMAR 10.27.21.03

The MBON certifies the following licenses for the State of Maryland: 1) the AC-FNE-A is a nurse that has a multistate license RN; and 2) a registered nurse practicing in Maryland with an active license. There are also adult (A) examiners and pediatric (P) examiners. In Maryland, there are currently seven (7) practicing AC-FNE-A, nine (9) RN-FNE-P, and approximately 114 RN-FNE-A. The FNE-Ps may also be listed as FNE-As, as pediatric FNE certification first requires an adult license. Since October 2014, the MBON has issued 38 new FNE-A certificates.

The MBON outlines the certification and training requirements for FNE practice. These guidelines include a MBON-approved standardized curriculum for forensic examinations, as well as, at least eighteen months of previous continuous clinical experience as a registered nurse.⁵⁹ The current curriculum can be found in Appendix P: MBON RN-FNE Training Curriculum.

Based on a review of the requirements from several States and several conversations with several SANE nurses from other States, it was determined that the

⁵⁹ COMAR 10.27.21.03: Department of Health and Mental Hygiene: Board of Nursing: Certification.



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number of examinations required by the different States varies from three to eight exams per year per examiner. All of the state protocols reviewed required some continuing education each year.

In the State of Maryland, three SAFEs per year are required for each of the adult and pediatric FNEs upon application for license renewal. For FNE-APs, a minimum of two adult and two pediatric SAFEs per year are required for renewal. Hospitals may impose more strict criteria (e.g., a greater number of exams) in order to continue to assure accuracy and to permit performance in a specific hospital, but the hospital may not permit fewer exams than that required for state licensure.

There are also very specific guidelines outlined for medical professionals who encounter sexual assault victims that seek a SAFE exam or other medical treatment without having reported the crime to LE. For example, there is no requirement to report sexual assault against a child if the perpetrator is not a family or household member or other caretaker. If the perpetrator does fall under one of the aforementioned categories, health care providers are required to report to LE and the Department of Social Services.⁶⁰ Health care providers are also not required to report rape or other sexual offenses to LE when the victim is an adult, except under the following circumstances:

1. Adults who fall under the legal definition of “vulnerable adult,” meaning an adult who lacks the capacity to care for his or her daily needs;
2. Adults with mental illness who are unable to authorize disclosure and have no legal representative to do so;
3. Adults who are developmentally disabled;
4. Residents of nursing homes and similar institutions; or
5. Those who receive injuries in certain ways, including (but not limited to) gunshot wounds, certain burns, and injury by a moving vessel.⁶¹

XII. Deliverable #7: Consider geographic differences in the State as the differences relate to the provision of sexual assault medical forensic examination services

Geographic barriers also need to be taken into account when considering access to SAFEs. Some victims in rural areas are located far from SAFE programs and/or medical facilities. Unfortunately, these types of geographic barriers exist throughout Maryland. A mobile FNE may be helpful in addressing access for many of these areas, and the Urban Institute study mentions this as a solution being implemented in some large rural areas.

⁶⁰ Maryland Coalition Against Sexual Assault (MCASA) Sexual Assault Legal Institute, *Mandatory Reporting and Forensic Nurse Examiners and Other Health Care Practitioners*, July 1, 2012. Retrieved from: http://www.mcasa.org/_mcasaWeb/wp-content/uploads/2011/01/Mandatory-Reporting-for-Medical-Providers-July-2012.pdf.

⁶¹ MCASA, Sexual Assault Legal Institute (July 2012).



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Telemedicine programs, as discussed in Deliverable #9, may also be a way to provide SAFE to those who otherwise would not have access due to geographical limitations.

XIII. Deliverable #8: Consider hospital reporting requirements regarding the number of victims who present and the actions taken

Often a sexual assault victim seeks medical care at a local ED or clinic. A sexual assault victim has the right to seek medical care and treatment without being required to report the assault to the police and without being required to participate in forensic evidence collection. In many cases, medical providers believe that they are required to contact police to report a crime of sexual violence. In fact, for medical personnel to contact police without the consent of the sexual assault victim is, in most cases, a violation of health information privacy laws. Deliverable #10 will further elaborate on sexual assault victims' rights and privacy protections.

There is currently no standard protocol for hospitals, EDs, or medical providers that are based on correct information regarding reporting to LE. The OAG, in cooperation with the MHA, should establish clear guidelines and training for hospitals regarding correct procedures in obtaining victim consent, informed guidelines on mandated reporting, and information on the rights of victims, including privacy, and the rights of victims of crime. These should include:

1. Medical providers and personnel should not contact LE without the consent of the sexual assault victim, with a few limited exceptions;
2. Medical providers should be informed on mandated reporting laws including definitions of "child abuse" and "vulnerable adult";
3. Materials on victims' rights should be made available to all sexual assault victims;
4. Medical providers should be informed of the options available to victims of sexual assault and inform them of these options;
5. Medical providers should connect sexual assault victims with the local sexual assault crisis program; and
6. Medical exams should be available to victims of sexual assault at no cost, in accordance with Maryland's Victim's Rights Law.

The benefit of having data reported from a hospital on the number of victims who present to the ED to report a sexual assault is unclear. Although this type of data collection can be done, it is difficult and most likely inaccurate. Reports can be run on a chief complaint, but the victim does not always report a sexual assault during triage: the secondary complaint may not be captured properly. Many different diagnoses would have to be entered into the hospital medical record and then medical records would have to be reviewed by hand. Victims often leave triage after a medical screening is offered, and they find that the hospital does not host a SAFE program.



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Reports can be developed for International Classification of Diseases-10 discharge codes, but it does not capture the victims admitted, the victims who report during an admission, those who left the ED prior to triage, or those who leave against medical advice. The discharge diagnosis may be combined with another diagnosis and not be captured. Some victims want the information to remain confidential, which places another nuance to the data mining and collection.

It takes a specialist in quality assurance to tease out the data. For each specialty that requires data reporting to the State and the Joint Commission, such as stroke and cardiac data, there is a coordinator assigned to that task. The numbers of victims that present to the ED for sexual assault, especially in non-SAFE hospitals, are too small to justify the need for additional staff. Reporting, if mandated, could be a financial burden on a hospital with little or no benefit. It would be simpler and more accurate to have the data collected from the SARTs. A suggested template for data collection can be found in Appendix H.

XIV. Deliverable #9: Review practices in other states that increase the availability of SAFEs

Some SAFE programs in Maryland are already working to improve access to SAFEs and services. Mercy Medical Center has a mobile unit that sends their SAFE nurses to any hospital in the city of Baltimore to do SAFEs on unstable patients. The mobile unit at Mercy Medical Center has been fully functional for the past 21 years. The funds to cover the cost of the mobile unit have always come from grants, private fundraising, and monies from the hospital. In addition, the “bmoreSafe” phone application for Mercy Medical Center is designed to provide victims of sexual assault and domestic violence with instant access to a variety of resources, including medical and police assistance, a crisis hotline, and more. Additional information can be found at <http://www.bmoresafemercy.org>.

In reviewing practices in other states that increase the availability of SAFEs, it was determined that various methods have been implemented with different degrees of success. The following list was created from information provided by the International Association for Forensic Nurses and with State experts.

Washington D.C.

For the past three years, victim advocates of sexual assault victims have been using Uber to transport victims from their location to the hospital for SAFE exams. Victims do not have to have the Uber application they can call a 1-800 number to get in contact with a victim advocate. The victim advocate manages the process of securing transportation for the victims by finding an Uber driver near the location of the victim, receiving the alert when the victim is picked up, following them in transit, and knowing when they have



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reached their destination. Uber is also used to take the victims back home. Victims are not charged for this service, though it is unclear who absorbs this cost. In addition, Washington D.C. offers a language access program. Translators are available to offer assistance during exams in five languages. These translators are trained in victim services and are not associated with the hospital.

Virginia

Virginia is working on ways to increase the availability of SAFE exams. In the Richmond area, there are two hospitals that offer a full service program covering domestic violence, workplace violence, elder abuse, sexual assault, child abuse, etc. The comprehensive centers are located within the hospital. The program operates 24/7 with two to four nurses available, depending on shifts.

Having a comprehensive program has not necessarily increased SAFE exams due to other factors such as transportation issues in mainly rural areas. The programs do have websites but most of the victims come for services based on word of mouth, LE, and local sexual assault crisis program referrals.

Delaware

As it relates to Christiana Care, forensic nurses have specialized training to provide a comprehensive approach. This comprehensive approach includes seeing different types of victims such as victims of domestic violence and the elderly. This approach indirectly increases SAFE exams.⁶²

West Virginia

West Virginia has a Mobile Sexual Assault Nurse Examiner (SANE) project designed to address the lack of SANEs in local hospitals needing a 24/7 SANE program. The mobile unit contains equipment necessary for SANEs to travel to victims throughout the region. This provides a more timely response time to the victim, as well as, more available SANEs.⁶³

⁶² Christiana Care Health System, Forensic Nurse Examiners;
<http://www.christianacare.org/forensicnurseexaminers>.

⁶³ West Virginia Mobile Sexual Assault Nurse Examiners;
http://www.ovc.gov/publications/infores/WVA_Mobile_SANE_guide/saneprogram.html.



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Texas

Houston has a population of over 2 million, and is over 8,000 square miles including three primary metro areas. The largest non-profit health system in Southeast Texas hosts a metro-mobile SAFE program that includes 13 hospitals. The forensic nurses are based at three of the hospitals and are all employees of one medical system. These nurses make up a Forensic Nurse Response Team, a specialized group of nurses that provide 24/7 care to victims of sexual assault, assault, and children experiencing physical and sexual abuse. This team provides mobile response and related court testimony to seven area counties.

As of September 1, 2015, all Texas hospitals with EDs are required to have staff trained in the basic collection of forensic evidence from sexual assault victims.⁶⁴ Since 2005, there have been designated facilities that provide primary care for sexual assault victims; however, many victims would report to a non-designated hospital where they would be medically stabilized and then transferred to a primary care facility. Evidence collection would be available at all EDs, though this standard is still much less detailed than that required of FNEs at most primary care facilities. Non-primary care facilities will still provide the option of transfer following stabilization.⁶⁵

Ohio

SANE of Butler County is a private, non-profit (501(c)3) organization that contracts with 26 medical facilities in eight counties to provide mobile forensic nurse examiner response 24/7. A forensic nurse responds within one hour to hospitals, EDs, clinics, and other sites located in a range of settings, including rural, suburban, and inner city. The organization is in the process of contracting with an additional nine facilities, as well as, college campus health centers. The program operates with 20 FNEs, a program director who serves as the “facility coordinator” for each hospital, and a Board. They also employ four per diem “law enforcement liaisons” that arrive to pick up the SAFE kit, maintain chain of custody, and take the kit to the appropriate facility. They provide over 1,000 forensic exams to sexual assault victims per year. In addition, they provide suspect exams, strangulation cases, exams of domestic violence victims with injuries, community education, and court testimony.

Canadian Mobile Forensic Units

Scotia, Canada’s smallest province of 21,000 sq. miles and population of 900,000, has two sexual assault nurse examiner teams (funded by the Department of Health),

⁶⁴ The Texas Tribune, More Hospitals to Collect Sexual Assault Evidence, 2013; <http://www.texastribune.org/2013/08/13/er-staff-must-be-able-gather-sexual-assault-eviden/>.

⁶⁵ The Texas Tribune (2013).



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serving only two of the regions in Nova Scotia. Halifax has a sexual assault nurse examiner team consisting of 15 registered nurses. The team responds to all metro hospitals within one hour of the victim reporting to triage. Antigonish has the other team, responding to six (6) hospitals in outlying areas. Unfortunately, there are reports of many gaps in service, with victims traveling distances or waiting up to three (3) days.

Community-Based Forensic Examiner Programs

In North Carolina, established in 2015 by InterAct in Raleigh, the Solace Center is the state's first community-based sexual assault forensic examination center.

In Nova Scotia the Avalon Center is one of three sexual assault crisis programs, and is the only program in the Halifax Regional Municipality. This Center operates a SANE Program, responding to four health centers including two hospitals and two community clinics, one of which is a health center for women, children, and families. The SANE program is funded by the health department. The SANE program employs a full-time SANE coordinator and a part-time administrative assistant. The program has two SANEs on-call 24/7 and 15 active on-call SANEs. The program provided 113 forensic exams in 2013-2014 with the majority of victims under age 16 being seen at the women, children, and family clinic.

Sexual Assault Medical Examination Telemedicine Center

In Massachusetts, a 2013 pilot project funded by the Office for Victims of Crime, the National Institute of Justice, and the Office on Violence Against Women established a national telemedicine center for sexual assault exams. The grant was awarded to the Massachusetts Department of Health to establish a National Sexual Assault TeleNursing Center. The Hub is located at Newton Wellesley Hospital with five pilot sites selected, including two U.S. Navy sites (Florida and California) and three additional sites will include rural, tribal, and corrections communities. The project partner, American Doctors Online/PhoneDOCTORx provided equipment and used telemedicine technology such as video conferencing, remote monitoring equipment, and electronic health records to link victims in remote areas to medical providers located elsewhere. The pilot project's objectives include increasing access to medical forensic expertise, assisting practitioners in maintaining proficiency, and increasing support to clinicians to increase retention, role satisfaction, and confidence.

Several States already use telemedicine to deliver sexual assault forensic exams to children in rural and tribal areas, with evidence of positive changes in the methods of examination and evidence collection and in the overall quality of the exams. Electronic communication uses audio and video communication and staffs the center 24/7, with at least 24 highly trained SANEs.



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Colorado Sexual Assault Response Project: Medical Forensic Exam Programs (MFEPs)

Funded by the Division of Criminal Justice and the Department of Public Safety, the Forensic Exam Best Practice Program (FEBP) is meant to increase access to trained medical forensic exams in rural areas by developing locally-based, cost-effective, sustainable, and victim-centered MFEPs. Colorado SANEs collaborate with local hospital administrators and experts from relevant disciplines to conduct training of local medical professionals to provide forensic exams. Currently, eight communities, seven of which are rural, are participating in this program. Basic training ranges from two to eight hours and covers working with sexual assault victims, state law, medical forensic exams, and courtroom testimony basics. Additional training of two to four hours includes forensic photography, drug-facilitated sexual assault, and experiential courtroom testimony. A clinical practice training program is also in development.

Sexual Assault Response Teams

Counties with SARTs can effectively meet the challenges of responding to sexual assault better than counties that do not have SARTs. SARTs can help increase the probability of a victim cooperating and staying involved in the investigation and prosecution of the case.⁶⁶ According to the Urban Institute, the conviction rates for rape cases increased dramatically in communities that formally organize a SART, indicating an increased need to continue to develop, implement, and enhance Sexual Assault Response Teams across the State.⁶⁷

A study entitled, “Testing the Efficacy of SANE/SART Programs: Do They Make a Difference in Sexual Assault Arrest & Prosecution Outcomes?” states that, “overall, the findings are quite supportive of SANE/SART programs and their efficacy as a tool in the criminal justice system. This study also states that both SANE only (those with programs similar to the SAFE programs in Maryland but without SARTs) and SANE/SART cases are reported more quickly, have more evidence available, and have more victim participation than non-SANE/SART cases. SANE/SART interventions, the study found, “significantly increase the likelihood that charges will be filed in sexual assault cases.”⁶⁸

⁶⁶ The SART Handbook (2009). Oregon Attorney General’s Sexual Assault Task Force. Retrieved from: <http://www.evawintl.org/images/uploads/Documents/SART-Handbook-Oregon-09.pdf>.

⁶⁷ Burt, M. R., et. al. (September 2001). *2001 Report: Evaluation of the STOP Formula Grants to Combat Violence Against Women*. Washington, DC: Urban Institute.

⁶⁸ Testing the Efficacy of SANE/SART Programs: Do They Make a Difference in Sexual Assault Arrest & Prosecution Outcomes?(May 2006); <https://www.ncjrs.gov/pdffiles1/nij/grants/214252.pdf>.



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To meet the needs of tribal communities, the Tribal Law and Policy Institute created a resource guide in 2008 for the creation of SARTS.⁶⁹ These guidelines discuss the importance of SARTs with meeting the needs of sexual assault victims and also provides an outline for communities to draft their own SART protocols.

Maryland SAFE programs should offer 24/7 access to a SAFE, and should work with their local SART team to ensure 24 hour coverage is maintained. SART teams should meet regularly. In areas with multiple hospitals without a SAFE program, a mobile team should be developed by the SAFE program in the region to go to the surrounding hospitals to do examinations on victims that are not stable enough to be discharged from the ED.

It may be beneficial to regionalize the different areas in the state for the purpose of customizing SAFE programs to meet the needs of each different region; however, care should be taken to protect victim access to local sexual assault crisis programs. There should be yearly training made available to the different counties for EMS, police, hospitals, and 911 operators on how to address sexual assault victims and where to transport them, in Appendix G.

XV. Deliverable #10: Develop and recommend protocols to enhance protections for sexual assault victims' rights and privacy

To protect patient confidentiality, Maryland does not have mandatory reporting laws for sexual violence, unless the victim consents, or the disclosure is required in specific cases as authorized by state law. Privacy and safety are important considerations in responding to victims of sexual assault. In addition, victims of sexual assault are victims of crime and are entitled to certain rights and protections under the law.

A challenge identified for sexual assault victims is that many victims and providers are unaware of the options and choices available to a sexual assault victim. Victims have the option of reporting to LE, the option of obtaining medical care, and the option of obtaining a forensic exam on either a reporting or anonymous basis. Many hospitals and health providers believe they must call the police if a patient reports a sexual assault. Doing so without the consent of the victim is a violation of the patient's privacy, and outside of certain exceptions, may violate local, state, and federal laws and regulations.

Sexual assault victims have many concerns about reporting to police, that often involve privacy and safety concerns. Addressing these issues, providing access to medical care, evidence collection, and engaging advocacy services on behalf of the victim are believed to encourage reporting and access to the criminal justice system.

⁶⁹ http://www.tribal-institute.org/download/SART_Manual_09_08.pdf.



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Individuals' health information is protected by state law, federal regulation, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA⁷⁰). A sexual assault victim seeking medical care and/or forensic evidence collection has the right to privacy under these regulations and laws. According to HIPAA regulations, individuals must be informed of their right to privacy, given access to their medical records, give written consent before information is released, and have recourse if privacy protections are violated. A patient has a right to obtain a copy of their SAFE record.

When reviewing hospital policies, it was found that there was no standard response protocol found for non-SAFE hospital EDs regarding victims' rights and options. This may lead to a delay in proper care and may even lead to a violation of victims' privacy rights. A sample template policy for hospitals without a SAFE program outlines mandated reporting guidelines and discusses the necessity to protect victims' rights in Appendix G.

It is important to note that FNEs and victim advocates play very different roles in the SAFE program. The International Association of Forensic Nurses supports victim-centered care that includes close and timely collaboration with victim advocates, recognizing that victim advocates and FNEs play different and important roles in patient care. While the role of an FNE is primarily to collect evidence for prosecution and provide medical treatment, victim advocates help victims during SAFE exams by providing emotional support to them and their friends and family members, referring them to services (including shelters, safety planning, counseling, legal providers, etc.), and ensuring they receive follow-up care. FNEs and other medical and LE professionals can focus on objective tasks such as collecting evidence while the victim advocates can, "offer a tangible and personal connection to a long-term source of advocacy and support."⁷¹

It is a nationally recognized best practice to have victim advocates present during the SAFE exam process. The U.S. Department of Justice's National Protocol for Sexual Assault Medical Forensic Examinations recommends that a victim advocate (as established under Criminal Procedure Article, §11-923) be contacted immediately upon initial contact with a sexual assault patient.⁷² In fact, not only will their rights be protected, but the presence of an advocate during a SAFE also leads to better outcomes overall. Victims are likely to get better medical treatment, experience less distress, and seek out more services from community professionals.

⁷⁰ The Health Insurance Portability and Accountability Act of 1996, Pub.L. 104-191, 110 Stat. 1936, enacted August 21, 1996.

⁷¹ International Association of Forensic Nurses: Position Statement Collaboration with Victim Advocates (September 2008) http://c.ymcdn.com/sites/www.forensicnurses.org/resource/resmgr/Position_Papers/IAFN_Position_Statement-Advo.pdf.

⁷² A National Protocol for Sexual Assault Medical Forensic Examinations for Adults/Adolescents (April 2013); <https://www.ncjrs.gov/pdffiles1/ovw/241903.pdf>.



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A. Privacy recommendations for health care facilities and providers:

1. When a sexual assault victim seeks medical care, the victim shall be informed verbally, in writing, and in other appropriate means of communication (such as American Sign Language) of their options concerning care, reporting, or declining to report to police, and obtaining evidence collection;
2. All hospitals and SAFE programs shall access their local designated sexual assault crisis program, (established under Criminal Procedure Article, §11-923) to provide assistance in informing sexual assault victims of their options and in navigating these options;⁷³
3. All hospitals and EMS shall adopt clear written privacy procedures concerning patients who are sexual assault victims. Privacy policies should clearly indicate that there is a presumption that victims have the right to decide whether to report to police and that reports over a victim's objections are authorized only if there is a law mandating reporting;
4. All hospitals and EMS shall provide training to employees regarding privacy, including concerns that are specific to sexual assault victims, the rights of minors to consent to examination, treatment for injuries resulting from a sexual assault, a SAFE, mandatory reporting laws, and the availability of Jane/John Doe exams;
5. All hospitals, health care facilities, and SAFE programs shall secure patient records so that:
 - a. SAFE records are stored separately from a patient's other files;
 - b. Electronic records are segregated and not accessible, absent specific authorization, a patient's other files should not indicate that separate segregated files exist; and
 - c. Authorization for access to SAFE records is granted separately and only to those who are required to have access, and only to the extent necessary;
6. SAFE programs shall obtain written authorization from the patient to release information to non-health entities, including:
 - a. LE;
 - b. Crime lab;
 - c. Toxicology lab;
 - d. Rape crisis/victim advocacy;
 - e. Prosecutor; and
 - f. Any non-health provider;
7. A general authorization by the patient to release medical records should not be accepted as a release of SAFE records, and specific authorization to release SAFE records must be provided prior to release. Any release should be written, time limited, and the patient must have the right to revoke the authorization; and

⁷³ MD Crim. Pro. §11-924(b)(1).



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8. An individual may refuse to authorize the release of health care information, and a health care provider cannot refuse to provide treatment without an authorization of release.

B. Procedures for reporting to Law Enforcement

1. LE may not be contacted unless the patient agrees to the disclosure and this consent is documented, with the following exceptions:
 - a. Mandated reporting of child abuse and neglect;
 - b. Mandated reporting of elder or vulnerable adult abuse or neglect;
 - c. Reporting by health care providers to LE mandated by certain local jurisdictions, including:
 - i. An injury caused by an auto accident or lethal weapon (applicable in eight counties); and
 - ii. An injury caused by gunshot or moving vessel of any type;
 - d. If the patient is believed to be a victim of a crime and is incapacitated and unable to provide consent, LE may be notified if the following conditions are met:
 - i. Such information is not intended to be used against the victim;
 - ii. The disclosure of information is necessary for immediate LE activity; and
 - iii. The hospital, in its exercise of professional judgment, believes the release of information to be in the best interest of the patient; and
2. Each hospital and SAFE program shall establish procedures for reporting to LE when the patient is a victim of sexual assault.

C. Procedures for releasing medical information to Law Enforcement

1. A hospital or SAFE program may release medical information to LE according to the following:
 - a. In response to a court-ordered subpoena, warrant or summons, disclosure is limited to that information specifically described in the subpoena, warrant, or summons;
 - b. In response to administrative request, subpoena, or summons issued by a federal, state, or LE agency rather than a court of law;
 - c. In response to a request from LE concerning a victim who may have been a victim of a crime, with consent from the patient for disclosure;
 - d. In the case of an incapacitated patient who may have been the victim of a crime and who is unable to give consent, including updates on the patient's condition; and
 - e. In cases involving death by criminal conduct; and



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2. Each hospital and SAFE program shall establish procedures for releasing medical information to LE when the patient is a victim of sexual assault. Any authorization to release medical records should be time limited and the patient must be able to revoke this authorization in writing.

D. The Rights of Crime Victims

The Maryland Constitution established crime victims' rights in this state in 1994. Article 47 of the Declaration of Rights mandates that crime victims be treated with dignity, respect, and sensitivity throughout the criminal justice process. In 1996 and 1997, the General Assembly passed legislation designed to implement these constitutional rights. Maryland's core victims' rights are the rights to be informed, present, and heard.⁷⁴

Crime victims' rights begin with information. When reporting a crime, victims are provided with a pamphlet entitled "Crime Victims and Witnesses: Your Rights and Services." Victims will later receive another informational brochure, "Your Rights as a Victim in the Criminal and Juvenile Justice Process," as well as, a Crime Victim Notification Request and Demand for Rights form. This form lays the foundation for enforcement of specific victims' rights under Maryland law. Many victims' rights are found in Title 11 of the Criminal Procedure Article. Some of the most important are found in Criminal Procedure Article §11-1002 and include:

1. Protection from harm or threats of harm arising from cooperation with LE;
2. Receiving information about crisis intervention, financial assistance, criminal injuries compensation, and social services;
3. Being informed in advance of court proceedings;
4. Addressing the court at sentencing or disposition; and
5. Receiving assistance negotiating with employers to minimize loss of pay or other benefits.

Other victim's rights in Title 11 and rights found elsewhere in the Maryland Code include:

1. Confidentiality of victim contact information (Criminal Procedure Article §11-205; Md. Rule 16-1009);
2. The right to attend proceedings (Criminal Procedure Article §11-104; see also Criminal Procedure Article §11-302, regarding sequestration, and Md. Rule 5-615; see also Courts & Judicial Proceedings §9-205 regarding job protection for witnesses who attend proceedings);
3. The right to file an appeal if victims' rights are violated (Criminal Procedure Article §11-103, see also *Hoile v. State*, 404 Md. 591 (2008));
4. The right to have a sentence reduction overturned if a victim did not receive notice;

⁷⁴ MD Crim. Pro. §11-924(b)(1).



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5. The right to request restitution (Criminal Procedure Article §11-601, et seq.);
6. Criminal injuries compensation (Criminal Procedure Article §11-801 et seq.); and
7. Victim impact statements (Criminal Procedure Article §11-402).

Certain victims' rights are especially important or applicable in sexual assault and abuse cases:

- Sexual assault victims may not be charged for medical care resulting from the assault (Criminal Procedure Article §11-925 and Health-General §15-127);
- Maryland law provides sexual assault victims with the right to request HIV testing of perpetrators both before and after conviction (Criminal Procedure Article §11-110); and
- A police officer, sheriff, or deputy sheriff who receives a report of sexual assault shall offer the alleged victim the opportunity to be taken immediately to the nearest designated facility, and this offer shall be made without regard for the place of the alleged assault or where it is reported (Criminal Procedure Article §11-924).

XVI. Deliverable #11: Receive public testimony from stakeholders

An on-line survey was developed by the Maryland Coalition Against Sexual Assault (MCASA) to allow for public input. The survey was used as a tool to collect public testimony. The goal was to collect stories from victims, caregivers, family members, etc. More than 30 statements were collected by MCASA. A summary of those statements that consented to public disclosure has been provided in MCASA's written testimony to the Committee.

Public testimony was received during the following 2015 Committee meetings: January 8, February 12, March 12, May 14, June 11, and July 9. The June 11, 2015 Committee meeting also provided an open testimony forum from 12 pm through 1 pm at the Columbia Gateway Building (Howard County Government Office Building) in Columbia, Maryland. The invitation to this forum can be viewed in Appendix Q.

An additional opportunity for submitting public testimony was published on the DHMH website, to which two testimonies were submitted: one from the Maryland State Council of the Emergency Nurses Association and the second from a sexual assault victim. To improve the current care provided to sexual assault victims in the State of Maryland, the Maryland Emergency Nurses Association has made the following recommendations:

1. Create a State SAFE system similar to our State Trauma system which would ensure victims get to a proper hospital and receive the appropriate care;



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2. Provide appropriate funding to ensure that all designated centers are properly staffed to provide 24/7 coverage;
3. Create a campaign to educate the public about the designated centers for SAFE; and
4. Ensure that there is proper oversight of the care provided to sexual assault victims. There must be a consistent standard of care to ensure that all victims, those who choose to have a SAFE exam, have an exam completed by an appropriately trained staff with clinical expertise.

The SAFE Committee also received several written testimonies from EMS providers and an additional submission from an FNE. All written submissions and summaries of verbal testimonies collected through the MCASA public input collection process can be found in Appendix R.

Through the submission of testimonies, the following common issues and gaps were compiled:

1. FNE recruitment;
2. FNE adult and pediatric training;
3. Maintenance of FNE required minimum cases;
4. FNE retention (investing in them);
5. On-going FNE Competency; and
6. Lack of consistent and reliable service by SAFE programs;
 - a. Inability to maintain FNEs 24/7;
 - b. Lack of staff FNEs;
7. SAFE program funding;
 - a. Lack of program funding for SAFEs (fund-raising efforts are being done currently); and
 - b. Lack of support by hospital executive leadership supporting the SAFE program and its benefit to citizens.
8. Reimbursement of sexual assault services;
 - a. Review the payer system in Maryland;
 - b. Reimbursement for performing SAFE is low and can only be received by the physician not FNE; and
 - c. FNE reimbursement for preparation, documentation required, and court time;
9. Hospital sexual assault policies and procedures;
 - a. Variability of the appropriate reporting guidelines and options for sexual assault care (Adult and Children); and
 - b. Inconsistent participation in SARTs throughout the state;
10. Delay in DNA Testing by the State with concern that rapists won't be prosecuted; and
11. Sexual Assault Victim Transportation



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- a. Variability in victim transportation to a SAFE program; Who does this, and
- b. The cost of victim transportation is not within the state reimbursement; the victim may receive bills for this.

The following recommendations were also offered to the Committee through public testimony:

1. Ensure all Maryland hospitals have a documented policy and procedure for how it responds to victims who have been sexually assaulted (SAFE or non-SAFE Hospitals);
2. Review reimbursement to hospitals for providing SAFEs to their victim and catchment area and extend the time to request reimbursement from 90 days to one year;
3. Develop a regional approach for SAFE programs (five regions in EMS within Maryland);
 - a. All EMS and LE Officers need to know where SAFE are performed;
4. Offer LE and EMS education in basic forensic principles and techniques so the evidence is not inadvertently destroyed or lost;
5. Routine transportation by EMS and LE of the victim directly to an approved hospital hosting a SAFE program for the rape examination;
6. Mobile SAFE Program with Memorandums of Understanding to cover non-hospital employee performing the rape exam;
7. Develop a community message for access to SAFE programs; and
8. All victims should have access to advocates.

XVII. Deliverable #12: Adopt recommendations that are consistent with the State's all-payer model contract approved by the federal Center for Medicare and Medicaid Innovation

At this time, COMAR 10.12.02 ensures that SAFE adhere to the rates set by the Health Services Cost Review Commission. Nothing in these recommendations will conflict with Maryland's all-payer model contract.

The physician reimbursement rate of \$80 for a SAFE has not been increased since 1978. The Committee recommends an increase of the physician reimbursement rate in an effort to account for current inflation. Current calculations estimate today's rate to be approximately \$300.⁷⁵ Regulations would need to be revised to reflect any changes made. Methods of reimbursement for traveling FNEs and interhospital transportation costs should also be considered.

⁷⁵ Inflation Calculator: Bureau of Labor & Statistics (2015); http://www.bls.gov/data/inflation_calculator.htm



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XVIII. Appendices

Appendix A: Committee Membership

Joyce Dantzler, MS, MCHES, Co-Chair
Chief, Center for Injury and Sexual Assault Prevention
Maryland Department of Health and Mental Hygiene

Carole Mays, RN, MS, CEN, Co-Chair
Director, Trauma and Injury Specialty Care Program
Maryland Institute for Emergency Medical Services
Systems

Mark Arsenault, RN, MSA
Vice-President, Bowie Health Campus
Dimensions Health Care System
Emergency and Disaster Preparedness
Domestic Violence and Sexual Assault Center

Greta Cuccia, RN
Clinical Director, Emergency Department,
Pediatrics/Trauma
Suburban Hospital

Eunice Esposito, RN, FNE A&P, SANE A&P
Forensic Nurse Coordinator
Peninsula Regional Medical Center

Christine Jackson, MD
Medical Director, SAFE Program
Mercy Medical Center

Lisae C. Jordan, Esq.
Executive Director & Counsel
MD Coalition Against Sexual Assault (MCASA)
Sexual Assault Legal Institute

Susan Kraus, CRNP-A, CRNP-PMH
Representing the Maryland Board of Nursing

Lt. Brian McGarry
Sex Offense Unit
Baltimore Police Department

Verlin Meekins, RN
Nurse Manager
McCreedy Memorial Hospital
Now serving as Director of Clinical Services
Choptank Medical Center

Detective Casey Swope
Washington County Sheriff's Office

Kathleen O'Brien, PhD
Executive Director
Walden Behavioral Health

Gail N. Reid, MSW, LCSW-C,
Director, Victim Advocacy
TurnAround, Inc.

Mary Lou Watson, MS, RN
Vice President
MedStar St. Mary's Hospital

Tiwanica Moore, MPH, DHMH Staff
Program Coordinator
Rape and Sexual Assault Prevention Program
Maryland Department of Health and Mental Hygiene

Amy Robinson, MA, MPA, EMT, MIEMSS Staff
Associate Regional Administrator, Region V
Maryland Institute for Emergency Medical Services
Systems



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Appendix B: House Bill 963

MARTIN O'MALLEY, Governor

Ch. 627

Chapter 627

(House Bill 963)

AN ACT concerning

**Hospitals – ~~Requirements~~ Protocol for Sexual Assault Medical Forensic
Examinations and ~~Reporting~~ Planning Committee**

FOR the purpose of requiring that certain hospitals ~~provide, on or before a certain date, have a protocol to provide certain access to~~ sexual assault medical forensic examinations by forensic nurse examiners ~~or physicians~~ to certain victims; ~~requiring certain hospitals to report certain information to the Department of Health and Mental Hygiene on or before a certain date each year, establishing the Planning Committee to Implement Improved Access to Sexual Assault Medical Forensic Examinations in Maryland; providing for the composition, chair, and staffing of the Planning Committee and reimbursement for expenses for members of the Planning Committee; providing for the duties of the Planning Committee; requiring the Planning Committee to submit a certain report to the Governor and certain legislative committees on or before a certain date; providing for the termination of a certain provision of this Act; and generally relating to hospitals and requirements protocols for sexual assault medical forensic examinations and reporting the Planning Committee.~~

BY adding to

Article – Health – General
Section 19–310.2
Annotated Code of Maryland
(2009 Replacement Volume and 2013 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

19–310.2.

~~(A)~~ ~~EACH~~ ON OR BEFORE JULY 1, 2014, EACH HOSPITAL THAT PROVIDES EMERGENCY MEDICAL SERVICES SHALL ~~PROVIDE~~ HAVE A PROTOCOL TO PROVIDE TIMELY ACCESS TO A SEXUAL ASSAULT MEDICAL FORENSIC EXAMINATION BY A FORENSIC NURSE EXAMINER OR A PHYSICIAN TO A VICTIM OF AN ALLEGED RAPE OR SEXUAL OFFENSE WHO ARRIVES AT THE HOSPITAL FOR TREATMENT.



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2014 LAWS OF MARYLAND

~~(b) ON OR BEFORE JANUARY 10 OF EACH YEAR, EACH HOSPITAL SHALL REPORT TO THE DEPARTMENT ON THE NUMBER OF EXAMINATIONS PERFORMED UNDER SUBSECTION (A) OF THIS SECTION FOR THE PREVIOUS YEAR.~~

SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) There is a Planning Committee to Implement Improved Access to Sexual Assault Medical Forensic Examinations in Maryland.

(b) The Planning Committee is composed of the following members appointed by the Governor:

(1) one representative of the Department of Health and Mental Hygiene;

(2) one representative of the Maryland Institute for Emergency Medical Services Systems;

(3) one representative of the Maryland Coalition Against Sexual Assault;

(4) two representatives of programs providing emergency room accompaniment to sexual assault victims and survivors, one of whom represents a rural region of the State and one of whom represents an urban region of the State;

(5) two representatives from hospitals that provide sexual assault forensic exams (SAFEs), one of whom represents a rural region of the State and one of whom represents an urban region of the State;

(6) two representatives from hospitals that do not provide SAFEs, one of whom represents a rural region of the State and one of whom represents an urban region of the State;

(7) two SAFE coordinators, one of whom represents a rural region of the State and one of whom represents an urban region of the State;

(8) two representatives of local law enforcement agencies in the State, one of whom represents a rural region of the State and one of whom represents an urban region of the State; and

(9) one representative of the State Board of Nursing.

(c) The Governor shall designate the chair of the Planning Committee from among the members of the Planning Committee.



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(d) The Department of Health and Mental Hygiene and the Maryland Institute for Emergency Medical Services Systems shall provide staff for the Planning Committee.

(e) A member of the Planning Committee:

(1) may not receive compensation as a member of the Planning Committee; but

(2) is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(f) The Planning Committee shall:

(1) review the protocols that certain hospitals are required to have under § 19-310.2 of the Health – General Article;

(2) examine the barriers to providing care for individuals seeking a sexual assault medical forensic examination;

(3) study reimbursement issues for providers that offer sexual assault medical forensic examinations to the community;

(4) examine the protocols of emergency medical service providers and local law enforcement agencies to direct sexual assault victims to a hospital with the capability to provide a sexual assault medical forensic examination;

(5) determine best practices on how to educate the community on where to access sexual assault medical forensic examination services;

(6) study and make recommendations about the optimal caseload level to maintain a high level of quality and competency among SAFE practitioners;

(7) consider geographic differences in the State as the differences relate to the provision of sexual assault medical forensic examination services;

(8) consider hospital reporting requirements regarding the number of victims who present and the actions taken;

(9) review practices in other states that increase the availability of SAFEs;

(10) develop and recommend protocols to enhance protections for sexual assault victims' rights and privacy;

(11) receive public testimony from stakeholders; and



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(12) adopt recommendations that are consistent with the State's all-payer model contract approved by the federal Center for Medicare and Medicaid Innovation.

(g) On or before December 1, 2015, the Planning Committee shall submit a report on its findings and recommendations, including any legislation required to implement the recommendations, to the Governor and, in accordance with § 2-1246 of the State Government Article, the Senate Finance Committee and the House Health and Government Operations Committee.

SECTION 2. 3. AND BE IT FURTHER ENACTED, That this Act shall take effect ~~October~~ June 1, 2014. Section 2 of this Act shall remain effective for a period of 2 years and 1 month and, at the end of June 30, 2016, with no further action required by the General Assembly, Section 2 of this Act shall be abrogated and of no further force and effect.

Approved by the Governor, May 15, 2014.



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Appendix C: Maryland SAFE Programs

Allegany County

Western Maryland Regional Medical Center
(FNE-P and FNE-A)
12500 Willow Brook Rd. Cumberland, MD 21502
(240) 964-1333 x 41333

Anne Arundel County

Anne Arundel Medical Center
(FNE-A)
2001 Medical Pkwy. Annapolis, MD 21401-3280
(443) 481-1200

North Anne Arundel County

BWMC
(FNE-P and FNE-A)
301 Hospital Dr.
Glen Burnie, MD 21061-5803
(410) 553-2927

Baltimore City

Mercy Medical Center
(FNE-A)
345 St. Paul Pl.
Baltimore, MD 21202-2102
(410) 332-9494

University of Maryland Medical Center
(Emergency Room Physician- Pediatrics under 13)
22 S. Greene St. Baltimore, MD 21201-1595
(410) 328-6335

Baltimore County

GBMC
(FNE-A)
6701 Charles St.
Baltimore, MD 21204-6808
(443) 849-3323

Franklin Square Hospital Ctr. (FNE-P)
9000 Franklin Square Dr. Baltimore, MD 21237
(443) 777-7127

Calvert County

Calvert Memorial Hospital
(FNE-A)
100 Hospital Rd
Prince Frederick, MD 20678
(410) 535-8344

Caroline County

Memorial Hospital of Easton
(FNE-P and FNE-A)
219 S. Washington St. Easton, MD 21601-2913
(410) 822-1000 x 7976

FNE-A: Individuals age 13 and older
FNE-P: Individuals age 12 and younger

Carroll County

Carroll Hospital Center
(FNE-P and FNE-A)
200 Memorial Ave.
Westminster, MD 21157-5726
(410) 871-6655

Cecil County

Union Hospital
(FNE-A)
106 Bow St. Elkton, MD 21921-5544
(410) 398-4000

Charles County

Charles Regional Medical Center
(FNE-P and FNE-A)
701 E. Charles St. La Plata, MD 20646-5930
(301) 609-4144

Dorchester County

Dorchester General Hospital
(FNE-P and FNE-A)
300 Bryn Street
Cambridge, MD 21613
ER: (410) 822-1000 x 5557

Frederick County

Frederick Memorial Hospital
(FNE-P and FNE-A)
400 W. 7th St.
Frederick, MD 21701-4506
(240) 566-3416

Garrett County

Garrett County Memorial Hospital
(FNE-P and FNE-A)
251 N 4th St. Oakland, MD 21550
(301) 533-4000

Harford County

Harford Memorial
(FNE-P and FNE-A)
501 S. Union Ave. Havre de Grace, MD 21078
(443) 843-5000

Franklin Square Hospital Ctr.

(FNE-P)
9000 Franklin Square Dr. Baltimore, MD 21237
(443) 777-7127

Howard County

Howard County General Hospital
(FNE-P and FNE-A)
5755 Cedar Ln. Columbia, MD 21044-2912
(410) 740-7890

Kent County

UM Medical Center at Chestertown
(FNE-A)
100 Brown St. Chestertown, MD 21620
(410) 778-3300

Montgomery County

Shady Grove Adventist Hospital
(FNE-P and FNE-A)
9901 Medical Center Dr. Rockville, MD 20850-3357
(240) 826-6000

Prince George's County

Prince George's Hospital Center
(FNE-P and FNE-A)
3001 Hospital Dr. Cheverly, MD 20785-1189
(301) 618-3154

Queen Anne's County

Chester River Health System
(FNE-P and FNE-A)
100 Brown Street Chestertown, MD 21620
(410) 778-3300

St. Mary's County

St. Mary's Hospital
(FNE-P and FNE-A)
25500 Point Lookout Rd.
Leonardtown, MD 20650
(301) 475-8981

Talbot County

Memorial Hospital of Easton
(FNE-P and FNE-A)
219 S. Washington St. Easton, MD 21601-2913
(410) 822-1000 x 7976

Washington County

Meritus Medical Center
(FNE-P and FNE-A)
11116 Medical Campus Rd.
Hagerstown, MD 21742
(301) 790-8300

Wicomico/Somerset County

Peninsula Regional Medical Center
(FNE-P and FNE-A)
100 E. Carroll St. Salisbury, MD 21801-5422
(410) 912-6382

Worcester/Somerset County

Atlantic General Hospital
(FNE-P and FNE-A)
9733 Healthway Dr. Berlin, MD 21811-1155
(410) 641-1100

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Appendix D: Maryland Hospital Policy Review (November 2015)

Maryland Hospital By Region	Maryland County	Sexual Assault Policy	Policy Addresses	Coverage	Collaborative Arrangement	SART
REGION I						
Garrett County Memorial Hospital *	Garrett	Reviewed	Adult / Does Not Distinguish		WMRMC	
Western Maryland Regional Medical Center *	Allegany	Reviewed	Adult & Pediatrics	Full 24/7		Yes
REGION II						
Frederick Memorial Hospital *	Frederick	Reviewed	Adult & Pediatrics	Limited		
Meritus Medical Center *	Washington	Reviewed	Adult & Pediatrics	Full 24/7		
REGION III						
Anne Arundel Medical Center *	Anne Arundel	Reviewed	Adult 13+	Limited	Pediatrics to UMMC	Yes
UM Baltimore Washington Medical Center *	Anne Arundel	Reviewed	Adult & Pediatrics		Does not cover exams at other facilities	
Bon Secours Hospital	Balt. City	Reviewed	All Ages	None	Mercy/UMMC	No
Carroll Hospital Center *	Carroll	Reviewed	Only discussed reporting of sexual assaults			
reater Baltimore Medical Center *	Baltimore	Reviewed	Adult 13+	Full 24/7	Travels to other hospitals	Yes
UM Harford Memorial Hospital	Harford	Reviewed	Adult		Upper Chesapeake	
Howard County General Hospital *	Howard	Reviewed	Adult & Pediatrics		Covers transfers if no one on call. Does not cover exams at other facilities.	
Johns Hopkins Bayview Medical Center	Balt. City	Reviewed	All Ages + Vulnerable Adults		Mercy/UMMC	
Johns Hopkins Hospital	Balt. City	Reviewed	Adults 13 +		Mercy/UMMC referrals to all programs in state	
Medstar Franklin Square Medical Center *	Baltimore	Reviewed	Pediatrics and Adults who do not want to transfer	Full 24/7	Adults transferred to GBMC	
Medstar Good Samaritan Hospital	Balt. City	Reviewed	No pediatric arrangements		Mercy/UMMC	
Medstar Harbor Hospital Center	Balt. City	Reviewed	No pediatric arrangements		Mercy/UMMC	
Medstar Union Memorial Hospital	Balt. City	Reviewed	No pediatric arrangements		Mercy/UMMC/GBMC/MFSMC	
Mercy Medical Center *	Balt. City	Reviewed	All Ages, Stable/Unstable	Full 24/7	Pediatrics to UMMC	Yes

* Refers to SAFE Program

** Domestic Violence Policy Only



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Northwest Hospital Center	Baltimore	Reviewed			Transfers all patients	
Sinai Hospital	Balt. City	None Received				
St. Agnes Hospital	Balt. City	None Received				
Union Hospital of Cecil County *	Cecil	Reviewed	Adult 13 +		Does not cover going to another facility	
University of Maryland Medical Center *	Balt. City	Reviewed	Pediatrics		Adults 13+ to Mercy	Yes
UM Midtown Medical Center	Balt. City	Reviewed	Not Clear		Not Clear	No
UM St. Joseph Medical Center	Baltimore	No Policy (DV**)	Children 0-12		Not Clear	No
UM Upper Chesapeake Medical Center *	Harford	None Received				
REGION IV						
Atlantic General Hospital *	Worcester	Reviewed	Adult & Pediatrics			
Chester River Hospital Center *	Kent	Reviewed	Adults 13+		Does not cover going to another facility	
Dorchester General Hospital *	Dorchester	Reviewed	Adult & Pediatrics		Memorial Hospital of Easton	
Edward McCready Hospital	Somerset	No Policy	None		PRMC	
Memorial Hospital of Easton *	Talbot	Reviewed	Adult & Pediatrics		Received from UM Shore Health	
Peninsula Regional Medical Center *	Wicomico	Reviewed	Adult & Pediatrics		Receive from McCready	
REGION V						
Calvert Memorial Hospital *	Calvert	Reviewed	Adults 13+	Full 24/7	St. Mary's	Yes
UM Charles Regional Medical Center*	Charles	Reviewed	Adult & Pediatrics	Limited	Does not include going to other hospitals	
Doctor's Community Hospital	Prince George's	None Received				
Fort Washington Hospital	Prince George's	None Received				
Holy Cross Hospital - Silver Spring	Montgomery	Reviewed	Adults & Pediatrics		Covers transfer to SAFE program	No
Holy Cross Hospital – Germantown	Montgomery	Reviewed	Adults & Pediatrics		Convers transfer to SAFE program	
Laurel Regional Hospital	Prince George's	None Received				
Medstar Montgomery Medical Center	Montgomery	Reviewed	Adult & Pediatrics		Transfers all patients	
Medstar Southern Maryland Hospital	Prince George's	Reviewed	Pediatrics		Covers transfer to SAFE Program	
Medstar St. Mary's Hospital *	St. Mary's	Reviewed	Adult	Full 24/7	Transfer to PGHC if necessary	
Prince George's Hospital Center *	Prince George's	Reviewed	Adult & Pediatrics	Full 24/7		Yes
Shady Grove Adventist Hospital *	Montgomery	Reviewed	Adult & Pediatrics	Full 24/7		
Suburban Hospital	Montgomery	Reviewed	Referred to SGAH		Discusses how patient will be sent	No
Washington Adventist Hospital	Montgomery	Reviewed	None			No

* Refers to SAFE Program

** Domestic Violence Policy Only



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Appendix E: EMS Protocol for Responding to Sexual Assault: Sample Template

Sexual assault patients should be given priority as emergency medical cases. Individuals disclosing a sexual assault should be quickly transported to the designated evidence exam site, promptly evaluated, treated for serious injuries, and provided access to evidence collection should they so elect. In responding to sexual assault patients, it is important to treat victims with compassion, obtain informed consent for treatment and evidence collection whenever possible, and protect the privacy of the patient.

- I. Initiate general patient care: assess the physical and mental status of the patient
- II. Presentation: Patient may present with no overt evidence of trauma or may present with the following injuries:
 - A. Abrasions, bruises, and/or bleeding
 - B. Forcible signs of restraint
 - C. Petechiae of the face and conjunctiva, secondary to strangulation
 - D. Facial injuries, including broken teeth, swollen jaw or cheekbone, eye injuries
 - E. Fractures or muscle soreness or stiffness
 - F. Vaginal or rectal bleeding or pain
 - G. Altered level of consciousness
- III. Treat injuries according to presentation
 - A. Preserve evidence and articles of clothing, if practical
 - B. Dress wounds, without attempting to clean
 - C. Do not perform a genital examination
 - D. Discourage self-treatment, such as washing, changing clothes, brushing teeth
 - E. Ask if the patient performed any of these actions
 - F. Avoid invasive procedures, such as IVs or blood draws when possible, so that medical and evidence samples can be taken at the same time at the hospital
 - G. Medical stabilization must be balanced with the need to protect rapidly deteriorating physical evidence
- IV. Provide a safe environment
 - A. Move the patient into the ambulance or private area
 - B. Explain all of your actions to the patient
 - C. Maintain a non-judgmental but caring attitude
 - D. Maintain strict confidentiality
 - E. Ask only questions necessary for the medical treatment of the patient; avoid detailed questions about the assault
- V. Preserve evidence
 - A. If responding to the crime scene, be careful where you walk and what you touch
 - B. If police are present have an officer escort you
 - C. If medical treatment is provided at the scene, do not leave materials on the scene



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- D. Do not delay treatment of transport to await police; information can be obtained from the victim at the hospital
 - E. Transport the patient to the medical facility designated to perform evidence collection, unless the patient requires transport to a specialty center due to injuries or conditions
 - F. If the patient is stable, it is acceptable to bypass the nearest ED to transport to a Sexual Assault Forensic Examination (SAFE) facility
 - G. At the hospital, provide your linens and gloves to evidence collection
 - H. Document assessment, findings, information obtained about the assault, and the patient's mental status



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Appendix F: Law Enforcement Response to Reported Sexual Assault: Sample Template

Officers and emergency communications personnel must use professional judgment and follow state law and department policies in determining the proper response to a call involving sexual assault. Officer and victim safety must always be a first priority. Law enforcement agencies should establish protocols to preserve all sexual assault calls (911 and non-emergency contacts) and computer printouts even if there was a delay in reporting. Tapes should be reviewed as part of the investigation.

(1) Dispatcher or Call Taker Response

General Protocol

- When a caller reports a sexual assault, communications personnel should elicit the initial facts of the situation and determine whether the victim or others are in life threatening danger or in need of emergency medical response
- The call taker should dispatch emergency medical assistance as necessary
- Once the caller is identified as the victim of a sexual assault, the appropriate priority rating should be applied. Victims of sexual assault should be transported quickly to the designated exam site for evaluation, treatment of injuries, and evidence collection
- Sexual assault reports should be handled as a priority even though it is common for a victim to delay reporting by hours or even days, and injuries at that point may not be life threatening. Potential evidence deteriorates over time and may be intentionally destroyed by the offender. Medical treatment for sexually transmitted infections and pregnancy are also time sensitive
- The victim will likely want to clean up (e.g., brush teeth, gargle, shower, or douche) as soon as possible. Communications personnel should instruct the caller in preserving evidence (below) and explain that it is important to preserve evidence
- Depending on the information obtained from the caller, the call taker and the first responding officer may need to coordinate multiple responses to several different locations (e.g., the location where the sexual assaults took place and any other locations where the victim and offender may have been prior to or following the sexual assault)
- Crimes may also involve more than one jurisdiction. Officers should follow agency policy concerning multi-jurisdictional case coordination
- Be advised that a victim of drug-facilitated sexual assault, voluntary intoxication, head injury, strangulation, loss of consciousness, limited cognitive functioning, or trauma may report blackouts, gaps in memory and general uncertainty as to whether or not an assault has occurred. A victim may be unable to provide a chronological narrative of events

Obtaining Suspect Information

- If the call is about a crime in progress or a crime that just occurred, the call taker should obtain information from the caller to assist in identifying and apprehending the suspect. The call taker should inquire as to whether there is a relationship between the victim and



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suspect, if there is a history of violence, whether a weapon was involved, and whether the suspect possesses any weapons

- It is important for the call taker to explain that the questions being asked will not delay the dispatch of an officer to the caller's location

Evidence Collection Issues:

- Inform the victim that in the case of a sexual assault, it is important to try to preserve all physical evidence. Instruct the victim to not bathe, brush teeth, douche, use the bathroom, eat, drink, or change clothes, and explain that this is important to evidence collection
- If the victim has already taken any of these actions, instruct the victim that it is still possible to collect forensic evidence; instruct the victim to collect and retain clothing if changed
- Ask the caller about the need to urinate; if the caller cannot wait for officers or medical personnel to respond with a urine collection container, instruct the caller to urinate in a clean jar with a lid

(2) Initial Officer Response

Law enforcement officers are often the first point of contact for a sexual assault victim. Responding officers can impact the victim's ability to respond positively to continued investigative efforts. Sexual assault investigations must focus on the medical care of the victim first and the investigation second. Officers should ensure that all victims are treated professionally and with dignity. The role of an officer responding to sexual assault includes:

- Protecting the safety and well-being of the victim
- Ensuring the victim receives prompt medical attention and access to evidence collection
- Collecting and preserving evidence, including witness statements
- Initiating an investigation
- Initiating other responders as part of a collaborative response

Emergency Response

- The first responding officer on the scene should determine the safety of the situation and should immediately connect with the victim to assure that his/her safety is a priority
- Emergency Medical Services can be summoned to assess the victim's medical needs; it is important to note the serious medical injuries may not be observable
- If EMS is not contacted, officers must transport the victim to the nearest designated facility for medical evaluation, treatment of injuries, and evidence collection if requested by the victim
- The victim has the right to decline evidence collection and medical treatment
- Additional responding officers should begin a search for the suspect when appropriate
- Additional responding officers should identify and secure the crime scene(s) per departmental protocol to ensure that potential evidence is not contaminated or destroyed
- The victim may have left the location of the assault; additional crime scene evidence and any clothing worn by the victim at the time of the assault or put on afterwards must be identified and collected



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- Responding officers should identify and isolate any potential witnesses, including corroborating witnesses to aspects of the assault, “outcry” witnesses, and those who may have left the scene
- The responding officer should assess any special needs of the victim, such as inability to speak English, language or hearing difficulties, mental or physical impairment, for example
- Family members or friends should not be utilized as interpreters
- The victim should not be left unattended in the area where the assault occurred
- Consideration should be given to the safety, dignity, and privacy of the individual reporting a sexual assault, including notification of a victim advocate to provide support and assistance
- Each department should consider the most effective team approach when evaluating possible responses, resources, and best practices

The Preliminary Interview

- In the initial response, the responding officer must first establish the elements of a crime and identify potential witnesses, suspect(s), evidence, and crime scene
- The preliminary interview is a critical point in assuring the victim that part of the officer’s function is to provide assistance and protection and in laying a foundation for respect and cooperation
- The preliminary interview should be conducted in a private area free from distraction
- The responding officer should inform the victim about forensic evidence collection and that clothing will be collected
- Consideration should be given to the use of an advocate to provide support during the process; a spouse, dating partner, or parent may not be the most appropriate support person because the victim may be hesitant to share some of the details of the assault
- Consideration should be given to any special needs identified
- The officer should obtain contact information and explain the need for follow-up interviews during the course of the investigation, either by the officer or by a detective if the agency has an investigative unit
- Be advised that a victim of drug-facilitated sexual assault, voluntary intoxication, head injury, strangulation, loss of consciousness, limited cognitive functioning, or trauma may report blackouts, gaps in memory and general uncertainty as to whether or not an assault has occurred. A victim may be unable to provide a chronological narrative of events
- Every effort should be made to use simple terminology
- In most cases, a victim should not be asked during the preliminary interview whether s/he wants to prosecute the suspect. Decisions regarding sufficient evidence, charging, and prosecution should only be made following a complete investigation
- A written report should be completed in all cases of sexual assault, including a copy of the forensic examination
- The responding officer must ensure that victims are given written notification and understand their rights as a crime victim, under state law. The victim should be provided with the crime report number as well as contact information for the reporting



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- officer (including identification or badge number) and for the lead investigator or person handling the follow-up
- A victim advocate can be helpful in providing safety planning, including shelter, protective orders, and VINE/VPO registration. This is particularly important if an arrest is not immediate or if the suspect is released shortly on bond
 - The victim has the right to be free from harassment and intimidation by the suspect(s) and should be instructed to call 911 in an emergency
 - Many victims of sexual assault postpone reporting the incident to police or anyone else, for a number of compelling reasons. While it is important to document these reasons, it should be understood that this is normal and not deter a thorough investigation. A victim may have also had an anonymous or “Jane Doe” forensic exam and evidence collection and can sign a release for law enforcement to collect the kit



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Appendix G: Sample Hospital Policy Template for ED with no SAFE Program

Department: Emergency Medicine

Title: Abuse: Alleged Sexual Assault-Adult/Adolescent and Vulnerable Adults

Purpose: To provide guidelines and procedures for the identification, management, and reporting of adult victims to the Emergency Department (ED) following an alleged sexual battery or rape.

Definitions:

1. Adult- anyone 18 years of age or older.
2. Child- anyone younger than 18 years
3. Adolescent- anyone 13 years to 17 years.
4. Vulnerable Adult- an adult who lacks the physical or mental capacity to provide for his/her daily needs.
5. Mandatory Reporting- situations in which health care providers are required by law to report to the proper authority (e.g. police, Child Protective Services (CPS), Adult Protective Services (APS)).
6. FNE- Forensic Nurse Examiner, a registered nurse examiner certified by the Maryland Board of Nursing
7. SAFE- Sexual assault forensic examination/program
8. Jane Doe Exam- A forensic evidentiary exam completed for a patient without involving the police. The patient has the ability to choose to involve the police at a later time if they chose. The evidence will be held by the forensics program for a specified amount of time (Mercy currently holds Jane Doe kits for 18 months) after which time the evidence will be destroyed if the patient does not choose to report to the police.
9. Sexual Assault- engaging in any sexual act with another person by force, threat of said force, or without the consent of the person.

Policy:

The mission of medical personnel is not to judge, defend, prosecute, or render opinions as to whether a sexual assault has occurred.

The purpose of a rape exam is two-fold:

1. Medically, to ascertain and treat actual and potential physical and psychological trauma, and
2. Legally, to provide a victim with the option of obtaining a Sexual Assault Forensic Exam (SAFE).

ED staff is directed by the following procedures:

1. If a victim wishes to report the sexual assault to police, the appropriate LE agency will be contacted. Informed, signed consent to contact LE should be obtained in order to assure that the patient's right to privacy has been protected.
2. All alleged victims of sexual assault presenting to the ED will not be referred elsewhere for evaluation until they have been registered as an ED patient, receive a medical screening examination, and are medically cleared for associated injuries (COBRA).
3. Sexual assault examinations are not done at _____. All patients desiring to have a sexual assault forensic exam (SAFE) should be offered the following three (3) options for care:
 - a) Medical Care (prophylaxis)/Evidence Collection/Report to LE-the (county, city, or jurisdiction police dispatch) will be notified to deploy an officer to determine venue of the crime. The officer will determine what agency will investigate the assault. The medical SAFE need not be performed in the jurisdiction where the assault occurred.
 - b) Medical Care/Evidence Collection only-"Jane/John Doe" cases. All "Jane/John Doe" cases are to be referred to a hospital SAFE program (name the hospital ED), no matter where the crime took place. Evidence will be held by the facility performing the exam for a minimum of one year from the date of treatment without LE involvement. This included patient who have reported to the police and have been unfounded by LE. The patient may be referred to (the SAFE hospital name) by ambulance, private vehicle, or police escort without involvement in the case.
 - c) Medical Care only- Prophylaxis and general medical screening will then be provided at this hospital without evidence collection.
4. Minors may consent to physical examination and treatment injuries related to a sexual assault and to a SAFE.
5. The ED nurse will:
 - a) Greet the patient and escort to an area of privacy, an OB/GYN room is optimal,
 - b) Convey an attitude of caring; provide the victim with the same ED nurse from the minute they present to the ED until they leave. A female nurse is preferable with a female patient.
 - c) Briefly, assess for emergent conditions which may require immediate medical intervention. If medically necessary to procure a urine specimen or if the patient must void, have the patient blot dry genitals with 2 squares of toilet tissue and place in a biohazard bag with the specimen to be kept by the patient and given to the SAFE nurse at _____.
6. Documentation of injuries is done by the attending physician and nursing staff. Document reports and referrals made.
7. If a patient prefers not to be transferred or is deemed by the medical staff to be in critical condition and unable to be transferred to _____ for evidentiary or Jane Doe examination, or if Sex Offense Unit needs immediate evidence collection, contact the ED charge nurse at _____ to activate a Forensic Nurse Examiner (FNE) to provide care at this hospital. The FNE will be escorted by LE and a consultation form will be generated by the FNE to guide medical staff in prophylaxis recommendations. The _____ FNE may be transported to this hospital to examine patients in a courtesy fashion when the venue of the crime has been committed outside the City/County or jurisdiction limits.*

* Current recommendation is to support resources for mobile SAFE programs.



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8. Contact the local sexual assault crisis center to request an advocate. Do not disclose identifying information about the victim without the victim's permission. Once a victim advocate is at the hospital, advise the patient an advocate is available.
9. A referral to a social worker will be made to provide any necessary resources or assistance to the patient. The social worker should address any safety issues the patient may have and provide the patient with information about the local sexual assault crisis center if an advocate is not involved.
10. Ensure that the patient has a safe place to go to, preferably with a friend/family member.
11. Information concerning the patient will be given only to those personnel who must know the details of the case in order to carry out their official duties regarding the situation.
12. Nearest SAFE program is _____.
13. Local sexual assault crisis center is _____.
14. If human trafficking is suspected and the patient consents, call the National Human Trafficking Resource Center 1-888-373-7888.

PROCEDURE

Patient care providers will follow the attached age specific and mandatory reporting guidelines for responding to reported or suspected sexual abuse.

REPORTING TO LAW ENFORCEMENT

To report to law enforcement, the patient care provider will call 911 and provide the needed information to dispatch [unless a different protocol with law enforcement is in place]. Law enforcement may not be notified without the patient's permission unless the case is subject to mandatory reporting laws. A report to law enforcement is not necessary to obtain a forensic examination.

HANDLING EVIDENCE

If not contraindicated by appropriate patient medical care or patient comfort please handle potential evidence in the following ways:

- *Clothing*- have the patient remain in their clothing. If not possible place each item of clothing in a separate bag preferably paper bag and keep with patient. Avoid bathing or cleaning up patient if possible.
- *Urine/Vomit*- collect first sample in a sterile cup and keep with patient.
- *Eating/Drinking*- if possible refrain from anything by mouth.
- *Urinary Catheters/Speculum Exams*- if not emergently medically indicated do not perform

Evidence should remain with the patient at all times.

120 HOUR TIME FRAME

If the reported or suspected assault occurred more than 120 hours ago, the police may still be contacted to make a report as mandated or as requested by the patient/guardian. An evidentiary forensic exam generally may not be completed at this time, though this will be evaluated on a case by case basis by consulting the nearest SAFE program.

Transportation to a SAFE/SANE program

Patients that are medically stable will be discharged from the Emergency Department and sent to the closest SAFE/SANE program that has an available FNE.*

The SAFE/SANE program will be called to verify that an FNE is available. If no FNE is available then alternate facilities will be called until a program with an available FNE is contacted.

If the patient is reporting the incident to the police the police will be called and will transport the patient to the facility with an FNE available.

If the patient chooses to be a Jane/John Doe case than depending on the police protocol the patient will either be transported by the police (with consent from the victim), a TAXI or by private car. The patient should not be sent alone to the SAFE/SANE program.

Patients that are unstable should not be sent to another facility. Call the nearest SAFE/SANE program and request that an FNE come to your facility to do the examination.

* Current recommendation is to support resources for mobile SAFE programs.



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Reporting Guidelines

REPORT	STATUTE	WHO MUST REPORT
1. CHILD UNDER 18 YEARS a. Abuse/assault is by a parent b. Abuse/assault is by a person who has permanent or temporary care or custody or responsible for supervision of a child c. Abuse/assault is by a family/household member or caregiver	Family Law §5-701(x), 5-701b	Any individual.
d. Reports of suspected abuse/neglect	Family Law §5-704	Health practitioner, police officer, educator, or human service worker that has reason to believe child has been subjected to abuse; if acting as a staff member at a hospital, public health agency, child care institution, juvenile detention center, school, or similar institution.
e. Child at substantial risk of abuse. ****not mandatory but individual may have option.	Family Law §5-704.1	Any individual may report if the individual has reason to believe that a parent, guardian, or caregiver of a child allows the child to reside with or be in the regular presence of an individual who is registered as a sex offender or poses substantial risk of sexual abuse to the child.
2. VULNERABLE ADULT (An adult who lacks the physical or mental capacity to provide for their daily needs.)	Family Law §14-302 Family Law §14-101	Health practitioner, police officer, human services worker.
3. MENTALLY ILL PERSON	Health Gen. §4-307	A health care provider shall disclose to the medical or mental health director of a juvenile or adult detention or correctional facility or to another inpatient provider of mental health services.
REPORT	STATUTE	WHO MUST REPORT
4. PERSON WITH A DEVELOPMENTAL DISABILITY	Health Gen. §7-1005	Any person who believes that an alleged individual with developmental disability has been abused shall promptly report the abuse.
5. RESIDENT OF A NURSING HOME OR RELATED INSTITUTION	Health Gen. §19-347	A person who believes that a resident of a related institution has been abused shall promptly report the alleged abuse.
6. RESIDENT OF A HOME FOR EMOTIONALLY DISTURBED CHILDREN OR ADOLESCENTS	COMAR 10.07.04.05	The center shall furnish reports covering serious injuries/unusual incidents, reports of all deaths, and any occurrences which threaten the welfare, safety or health of any resident of the center.
7. THE ASSAULT OCCURRED ON A BOAT OR MOVING VESSEL	Health Gen. §20-702	Physician, pharmacist, dentist, or nurse who treats an individual with injury that was caused or shows evidence of having been caused by an accident involving a moving vessel.
8. AN INDIVIDUAL WITH A GUNSHOT WOUND.	Health Gen. §20-703	Physician, pharmacist, dentist, or nurse who treats an individual for an injury that was caused or shows evidence of having been caused by a gunshot of any type; An individual in charge of a hospital.
9. AN INDIVIDUAL WITH INJURIES CAUSED BY AN AUTOMOBILE, LETHAL WEAPON, OR MOVING VESSEL IN SPECIFIC COUNTIES. *ONLY FOR ALLEGANY, ANNE ARUNDEL, CHARLES, HARFORD, KENT, MONTGOMERY, PRINCE GEORGE'S, SOMERSET, TALBOT AND WICOMICO COUNTIES.	Health Gen. §20-701	Physician, nurse, dentist, or pharmacist who treats someone with one of these injuries; An individual in charge of a hospital.



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REPORT	*DO NOT REPORT*
1. CHILD UNDER 18 YEARS a) abuse/assault is by a parent b) abuse/assault is by a person who has permanent or temporary care or custody or responsible for supervision of a child c) abuse/assault is by a family/ household member or caregiver 2. VULNERABLE ADULT 3. RESIDENT OF A NURSING HOME OR SIMILAR INSTITUTIONS 4. RESIDENT OF A HOME FOR EMOTIONALLY DISTURBED CHILDREN OR ADOLESCENTS 5. THE ASSAULT OCCURRED ON A BOAT OR VESSEL 6. NON-VULNERABLE ADULT WITH A GUN SHOT WOUND	1. CHILD UNDER 18 YEARS a) assailant is not a family member b) assailant is not a household member c) assailant is not a caretaker 2. NON-VULNERABLE ADULT



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Appendix H: Monthly SART Sexual Assault Data Collection Form: Sample Template

Agency	#	Notes
Police Department		
New sexual assault cases (victims 16+)		
<i>Rape/attempted rape</i>		
<i>Other sex crimes</i>		
Cases referred for prosecution		
Unfounded		
Hospital		
Adult (18+) exams (police report)		
Adult "Jane/John Doe"s		
Adult Converted		
Adolescent (13-17) exams (police report)		
Adolescent "Jane/John Doe"s		
Adolescent Converted		
Pediatric (under 13) exams (police report)		
Pediatric "Jane/John Doe"s		
Pediatric Converted		
Local Child Abuse Center		
Sexual assault forensic interviews, total		
<i>0-12</i>		
<i>13-15</i>		
<i>16-17</i>		
<i>18+</i>		
Office of the State's Attorney		
Rape & sex offenses charged		
Nolle prosequi		
STET		
Convictions		

<i>Of sex crime</i>		
Average sentence imposed in years		
Average probation in years		
Average time suspended in years		

Agency	#	Notes
Local Advocacy Organization		
Total hospital accompaniments, 18+		
<i>"Jane/John Doe"s</i>		
Total hospital accompaniments, 13-17		
<i>"Jane/John Doe"s</i>		
Police accompaniments		
Court accompaniments		
Helpline calls		
Unit-based advocates/victims assisted		
Laboratory		
Det. Requested SAFE kits received		
<i>Child Abuse Unit</i>		
<i>Sex Offense Unit</i>		
Total backlog		
No Det. Request SAFE kits received		
<i>Child Abuse Unit</i>		
<i>Sex Offense Unit</i>		
Total backlog		
SAFE cases processed/tested		



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Appendix I: Nationwide Costs and Coverage

Paid SAFE Costs

Set Maximum		Percentage of Bill	Other
Implied but no amount in statute	Delaware, Missouri, Virginia, Wisconsin (limited to exam costs)	Utah – 70% of the eligible hospital services and supplies	Arkansas will reimburse up to 65% of the medical bills, not to exceed a total reimbursement of \$10,000 (not specific to medical forensic exams)
\$80	Maryland (for examination and collection of evidence)	Vermont – 70%	
\$150	New Mexico (for medical costs not associated with evidence collection)	Louisiana – 100%	
\$300	California ¹⁶ , Utah ¹⁷	New Mexico – 100% of bills resulting from exams, evidence collection, or child sexual abuse exams	
\$350	Utah (for rent or use of an examination room or space for the purpose of conducting a sexual assault forensic exam)		
\$500	Florida, Iowa, ¹⁸ Oklahoma ¹⁹		
\$600	Michigan, ²⁰ Montana, Utah ²¹		
\$700	Texas		
\$750	Maine, Tennessee		
\$785	Oregon ²²		
\$800	New York, North Carolina ²³		Ohio will reimburse a flat fee of \$500
\$900	Connecticut ²⁴		
\$1000	Georgia, Nevada, Pennsylvania		
\$25,000	Rhode Island (not specific to medical forensic exams)		

Covered Medical Costs

Pregnancy Test	STI Test	Medications	Hospital/ER Fees	Reasonable Medical Care
California Connecticut Delaware Indiana Iowa Maine Minnesota Montana New Jersey New Mexico South Carolina Texas Utah Virgin Islands	California Connecticut Delaware Illinois Indiana Iowa Maine Minnesota Montana New Jersey New Mexico ²⁵ South Carolina Texas Utah Virgin Islands Wisconsin	District of Columbia Illinois Indiana Maine Michigan Montana New Hampshire ²⁶ New Mexico New York North Carolina North Dakota Ohio Oklahoma Pennsylvania Utah Wisconsin	Delaware Iowa Maine Maryland Montana New Jersey New Mexico New York North Carolina South Dakota Utah	Massachusetts Mississippi Rhode Island West Virginia
Emergency Contraception	Toxicology/Drug Testing	Counseling	Treatment for Injuries Related to the Sexual Assault	
California District of Columbia Maine New Jersey South Carolina Utah Virgin Islands	Connecticut Montana Texas	Indiana Vermont	Illinois Indiana Maryland Nevada New Mexico	

¹⁶AEquitas: The Prosecutors Resource on Violence Against Women, *Summary of Laws & Guidelines: Payment of Sexual Assault Medical Forensic Examinations* (February 2012).



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Appendix J: Victim Compensation

State	Regulation	Covered Services	Funding
Delaware	Del. Code Ann. tit. 11, § 9023 (2011). Payment for forensic medical examinations for victims of sexual offense. Del. Code Ann. tit. 11, § 9023 (2011). Payment for forensic medical examinations for victims of sexual offense.	MD fees for the patient history, physical, collection of specimens & treatment for the prevention of STIs; ED expenses; Lab fees, including Hepatitis B, blood typing, pregnancy testing, syphilis, wet mount, cultures for STIs.	Department of Justice, Victim's Compensation Assistance Program (VCAP). Victim's health insurance (including Medicare/Medicaid) billed first. VCAP will pay if there is no health insurance or pay the balance after insurance pays.
District of Columbia	D.C. Code § 4506 (2012). Eligibility for compensation. D.C. Code § 4507 (2012). Awards of compensation. D.C. Code § 72123 (2012). Access to emergency care for victims of sexual assault	The CVCP provides reimbursement or direct payment to providers for services necessary as a result of the crime. Access to prophylactic antibiotics for the treatment of STIs and emergency contraception for pregnancy prevention.	DC Superior Court, the Crime Victims Compensation Program (CVCP). Victim's health insurance (including Medicare/Medicaid) billed first. A maximum of \$25,000 per claim may be paid for necessary crime related services.
Pennsylvania	18 Pa. Cons. Stat. § 11.707 (2011). Awards. 42 Pa. Cons. Stat. Ann. § 1726.1 (2011). Forensic examination costs for sexual offenses. 28 Pa. code § 117.56 (2011). Information regarding payment for sexual assault emergency services. 37 Pa. Code § 411.41 (2011). Amount. 37 Pa Code § 411.42 Out-of-pocket loss. 35 Pa. Const. Stat. § 10172.3 Sexual assault evidence collection program.	MD/ARNP office or outpatient services; ED services; lab testing including STIs and pregnancy; medications directly related to the SA; forensic evidence collection kit; drug/ETOH screening; HIV testing.	PA Commission on Crime and Delinquency, Office of Victim's Services through the Victims Compensation Assistance Program (VCAP). The process for reimbursement for the Forensic Rape Exam is separate from the standard VCAP claim form, although a standard VCAP claim form may be submitted. Victim has choice to have health insurance billed for FRE. Reimbursement for the FRE is capped at \$1,000.
New York	N.Y. Exec. Law § 631 (McKinney 2011). Awards. N.Y. Comp. Codes R. & Regs. tit. 9, §525.12 (2011). Manner of payment; awards. N.Y. Pub. Health Law § 2805i (McKinney 2011). Treatment of sexual offense victims and maintenance of evidence in a sexual offense.	Forensic examiner services and facility; lab and pharmaceutical services related to the forensic exam. Unrelated medical services (suturing, broken limbs, inpatient services) are not included, although the victim can apply to OVS and/or use their insurance to cover medical care costs. The NY state facility is which the exam took place is the Billing Provider eligible to file for reimbursement, proportionately allocating expenses among service providers.	Office of Victim Services, The Medical Provider Forensic Rape Examination Direct Reimbursement Program. Victim has choice to have health insurance billed for exam. Reimbursement for forensic medical exam is capped at \$800, although victim may seek additional compensation through the OVS.
Virginia	Va. Code Ann. § 19.2165.1 (2011). Payment of medical fees in certain criminal cases; reimbursement. Va. Code Ann. § 19.2368.11:1 (2011). Amount of award.	Forensic examiner fees, including equipment and supplies; MD medical screening exam; ambulance transport fees; testing and prophylactic medication for the prevention of STIs; testing and prophylactic medication for the prevention of pregnancy. Costs not covered by the SAFE Payment Program or additional out-of-pocket crime-related expenses may be eligible for compensation through CICF.	Payment of all victim sexual assault forensic exams was transferred from the Supreme Court of Virginia to the Criminal Injuries Compensation Fund (CICF) in 2008. The SAFE (Sexual Assault Forensic Examination) Payment Program was established within CICF to process claims submitted for payment of these exams.
West Virginia	W. Va. Code § 618B16 (2011). Payment for costs of forensic medical examination. W. Va. Code § 618B15 (2011). Forensic Medical Examination Fund; training of sexual assault nurse examiners.	All reasonable, customary and usual costs of the forensic medical examination; the costs of additional non-forensic procedures performed by the licensed medical facility, including, but not limited to, prophylactic treatment of injuries, testing for pregnancy and testing for STIs, may not be paid from the fund.	The West Virginia Prosecuting Attorneys Institute provides reimbursement to licensed medical facilities performing forensic medical examinations from the Forensic Medical Examination Fund.



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Appendix K: Maryland Emergency Medical Dispatcher Guide, Sexual Assault

4 ASSAULT / SEXUAL ASSAULT

KEY QUESTIONS

1. Unconscious or Arrest (per Case Entry)
2. Is the assailant (clocker) still nearby?
3. Were weapons involved or mentioned?
4. Is there any **SERIOUS** bleeding?
5. Unconscious or Arrest (per Case Entry)
6. Is s/he **completely alert** (responding appropriately)?
7. (Assault) What part of the body was injured?
a. (Chest or Neck) Is s/he having any difficulty breathing?
8. (Sexual assault) Does s/he have any other injuries?
9. When did this happen?

POST-DISPATCH INSTRUCTIONS

a. I'm sending the paramedics (ambulance) to help you now. Stay on the line and I'll tell you exactly what to do next.

b. (Sexual assault) Do not change clothes, bathe, shower, or go to the bathroom.

* In volatile/criminal situations, refer to applicable law enforcement protocol.

DLS * Link to X-1 unless:

Danger or Crime Score

Arrest X-9
INEFFECTIVE BREATHING and Not alert ABC-1
Unconscious and Effective breathing X-3
Control Bleeding X-5
Nosebleed Control X-5a
Avulsed Teeth (w/ significant bleeding) X-6a

LEVELS	#	DETERMINANT DESCRIPTORS	A S	CODES	RESPONSES	MODES
D	1	Unconscious or Arrest		4-D-1		
	2	Not alert		4-D-2		
	3	Chest or Neck injury (w/ difficulty breathing)		4-D-3		
	4	Multiple victims		4-D-4		
B	1	POSSIBLY DANGEROUS body area		4-B-1		
	2	SERIOUS hemorrhage		4-B-2		
	3	Unknown status/Other codes not applicable		4-B-3		
A	1	NOT DANGEROUS body area		4-A-1		
	2	NON-RECENT (> 6hrs) injuries (without priority symptoms)		4-A-2		

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A2SPDST v12.2, NAE-EM, ID#W113334

POSSIBLY DANGEROUS Body Area	SERIOUS Hemorrhage	Axioms
• Abdomen • Amputation (excluding finger/toe) • Back • Chest (breathing normally) • Genitalia • Head (alert) • Hip/Pelvis • Leg, upper (obvious deformity) • Neck (breathing normally)	Uncontrolled bleeding (spurting or pouring) from any area, or any time a caller reports "serious" bleeding. NON-RECENT Six hours or more have passed since the incident or injury occurred. Rules 1. The preservation of evidence in sexual assault situations may be of much greater eventual importance to the patient than initial response and treatment of physical injuries. 2. Sexual assault patients often require a very high level of compassionate care. 3. The head-tilt is the only recognized method of airway control in the PAI dispatch environment. When presented with a TRAUMA patient described as not alert with INEFFECTIVE BREATHING, the EMD should protect life over limb and open the airway. 4. If a spinal injury is suspected in a breathing patient and PAIs are not necessary, PDIs may be enhanced by encouraging the patient not to move and by advising the rescuer to use her/his hands to stabilize the patient's head and neck in the position found. 5. Direct pressure on the wound should be avoided in the presence of visible fractured bone or foreign objects.	1. Assault complaints are generally 3rd party calls and are often received by police dispatch first. 2. On certain Protocols (3-4, 7-17, 27, etc.), an arrest may have been caused by extremely SERIOUS hemorrhage. In these cases, controlling the bleeding before initiating CPR may increase patient survival. 3. When a problem is NON-RECENT, the presence of current priority symptoms is the issue of most concern, not the location of the injuries per se. 4. Medical Dispatch should always try to obtain complete information. Even if law enforcement personnel initially request "paramedics," response should be driven by specific priority problems (see SEND Protocol).
NOT DANGEROUS Body Area • Ankle • Arm • Clavicle bone (clavical) • Elbow • Finger • Foot • Hand • Knee • Leg, lower (tibia) • Leg, upper (without deformity) • Shoulder • Toe • Wrist Problem Suffixes The suffix codes help to delineate the type of problem for specific response and safety purposes: A = Assault S = Sexual Assault		SEND Protocol (Medical Miranda Card) Secondary Emergency Notification of Dispatch (SEND) from police should include Chief Complaint, approximate age, level of consciousness, breathing status, presence of chest pain, and severity of bleeding (and opinion of need for lights and siren response).

4 ASSAULT / SEXUAL ASSAULT



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Appendix L: Current Maryland State Protocol for Sexual Assault Victims⁷⁶

QQ. TRAUMA PROTOCOL: SEXUAL ASSAULT

1. Initiate General Patient Care.

2. Presentation

Patient may present with no overt evidence of trauma, or may present with bruising, bleeding, or associated physical and/or emotional trauma.



ALL HEALTH CARE PROVIDERS ARE OBLIGATED BY LAW TO REPORT CASES OF SUSPECTED CHILD OR VULNERABLE ADULT ABUSE AND/OR NEGLECT TO EITHER THE LOCAL POLICE OR ADULT/CHILD PROTECTIVE SERVICE AGENCIES. DO NOT INITIATE REPORT IN FRONT OF THE PATIENT, PARENT, OR CAREGIVER.



3. Treatment

- a) Patient may feel more comfortable talking to someone of the same gender.
- b) Maintain non-judgmental, but caring attitude.
- c) Preserve crime scene and clothing articles, if practical.
- d) Maintain strict confidentiality.
- e) Do not perform a genital examination.
- f) Dress wounds (do not attempt to clean).
- g) Discourage any self-treatment (shower, washing, changing clothes).
- h) Treat injuries according to presentation.

4. Continue General Patient Care.

⁷⁶ Maryland Institute for Emergency Medical Services Systems (MIEMSS), 2014 Maryland Medical Protocols; <http://www.miemss.org/home/LinkClick.aspx?fileticket=RbnabALtvXg%3d&tabid=106&mid=907>



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Appendix M: Montgomery County Fire & Rescue Service General Order

**Montgomery County Fire and Rescue Service
FIRE CHIEF'S GENERAL ORDER**

No. 13-14

December 16, 2013

TO: All MCFRS Personnel
FROM: Fire Chief Steven E. Lohr 
SUBJECT: EMS Transport Destinations for Victims of Sexual Assault

MCFRS EMS providers are frequently asked by the police to transport patients who are the victim of sexual assault to Shady Grove Adventist Hospital (SGAH). Compared to other Montgomery County hospitals, SGAH does have enhanced capabilities for the forensic examination of sexual assault victims. Common sense and compassion also suggest that these patients would benefit from being treated by only one set of hospital staff, and should not be subjected to an inter-facility transport.

Therefore, if a patient who is the victim of a sexual assault is stable, and does not need referral to a specialty center due to other injuries or conditions (trauma, burns etc.), it is acceptable to bypass the closest Emergency Department to transport the patient to SGAH. If this patient is not stable, he or she must be transported to the closest appropriate receiving facility, in accordance with Maryland Medical Protocols.



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Appendix N: Ohio State EMS Protocol for Sexual Assault

(Revised 2012 by Oriana Chen, MD and Sheila Steer, MD, FACEP)

I. Introduction

- A. According to the Ohio Emergency Medical Services Incident Reporting System (EMSIRS), there have been 72 sexual assault victims transported by Ohio EMS transports in 2012 and up to 206 patients in 2010 (R. Frick, MPH, personal communication, June 29, 2012)
- B. According to the CDC, there are approx. 71,000 cases of sexual assault (nonfatal injuries) in 2010(1).
- C. Sexual assault has been defined as any form of sexual contact or conduct with another person without his or her consent, or the inability of the victim to give consent due to age, cognitive disability, incapacitated by drugs or alcohol – whether voluntarily or involuntarily. This includes unwanted genital touching, kissing or making any unwanted contact to the body, attempted or completed penetration, forced masturbation by the victim or to the assailant, and even forced participation in viewing or involvement of pornography (2, 3, 4).
- D. Rape is a legal term, and refers to any penetration of a body orifice (mouth, vagina, anus) involving force or threat of force or incapacity (i.e. young or old age, physical or cognitive disability, drug or alcohol intoxication – voluntary or involuntary), and non-consent (2,3,4).
- E. It is important to note that sexual assault is one of the most underreported crimes (2).
- F. Sexual assault is not an act perpetrated for sexual gratification, but is a form of acting out power and control over another individual, with the intention of abusing and humiliating the victim (3).

II. Objectives

- A. To provide quality emergency medical services and care to the sexual assault victim
- B. To assist in preservation of forensic material during the prehospital care of the patient

III. Recognition

A. Scene Response

- 1. Safety of the care providers comes first.
- 2. It is not the EMT's role to decide whether or not an assault has occurred (2) as compassionate evaluation and treatment of the patient is the priority.

B. Patient Evaluation

- 1. Respect ALL boundaries set by the patient during your assessment: physical, emotional and social. There is no "correct" patient response to being sexually assaulted (2, 4, 5, 6, 7).
- 2. Male and female victims both require compassionate and professional assessment and treatment.
- 3. Child sexual abuse victims require comprehensive health care to cope with the physical and mental health consequences of their experience (5).
- 4. Providing care to the patient should be non-judgmental and reassuring to the patient (2, 4, 7). Interview should be brief and injury-focused. Details of the assault other than the injuries sustained are not pertinent for the prehospital record.
- 5. Offer the patient simple choices (to sit up or recline on the stretcher, for example) to allow the patient to feel in control.
- 6. Screening for strangulation injury is important. Significant strangulation (loss of consciousness, loss of bladder or bowel function) may occur without visible injury. If strangulation has occurred, evaluate difficulty speaking, swallowing, or breathing (2, 4, 6, 7). Transporting the patient to a trauma center may be considered if airway injury is suspected (if an option in your area).
- 7. Do not ask the patient to undress on scene to collect the clothing. However if discarded items from the assault are on scene, please handle accordingly if patient is medically stable (see VII).
- 8. Screen for current pregnancy (2, 4, 5, 6).
- 9. Examine area of injury if the patient permits. In the absence of hemorrhage, there is rarely any need for visualization of genitalia by EMS.



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IV. Treatment

A. Unstable patient:

1. Medical stabilization remains the priority; local protocols for management and destination of the critically injured victim should be followed (2).

B. Stable patient:

Many victims of sexual assault may be medically treated as any assault victim with a few exceptions:

1. Bite wounds should be covered with dry sterile gauze. Do not wash wounds with saline nor water; do not place ointments over wounds. Evidence may be collected during the forensic exam if the wound is undisturbed (2, 4).
2. No food or drink should be given to the patient. Oral assault may have occurred. Patient should avoid brushing teeth or gargling until evidence has been collected by the forensic examiner (2, 4).
3. If the patient has an on scene support person, EMS should transport this person with the patient if possible.

V. Transport

- A. All sexual assault patients should be transported to an appropriate medical facility where sexual assault evidence exams are performed by the Sexual Assault Nurse Examiner (SANE) program, unless injury severity dictates otherwise. (2, 4, 6, 7)
- B. Relay information to the receiving Emergency Department that there is a concern for sexual assault so the proper resources can be mobilized.
- C. If possible, patient report to emergency department staff should be done discretely with respect for patient privacy.

VII. Documentation

- A. Patient Care Reports (PCR) are always important documents and part of the patient's permanent medical record (7). PCRs on sexual assault victims may be reviewed by many entities (medical and legal) and may be presented in court. Documentation must be accurate, succinct and pertinent. If the handwriting is difficult to read, the EMT is more likely to get called into court to interpret the PCR. Write legibly.
- B. Do not use the word "alleged sexual assault" as your impression. It is "sexual assault" if this is what the patient told you. The term "rape" may be used in quotes if you are quoting a patient statement but rape is a legal term not a medical one. "Choked" may also be used as a direct patient quote, but the medical term for external compression of the airway is "strangulation". Being accurate in your terminology reflects professionalism in your care. Quote the patient wherever necessary (7).
- C. If patient voluntarily discloses fear of being killed, being threatened with a weapon, or loss of memory of the events of assault, please include these direct patient quotes in your PCR (7). Also be sure to add something about where the assault took place if possible.
- D. Body maps of the patient may be drawn on the PCR to reflect injuries found on your assessment (4). Note any injuries and or markings in detail.

VII. Preservation and Handling of Evidence

- A. If asked to collect pertinent scene items (patient's clothing, used towels, etc.) place each item in its own paper bag and label with patient name. Plastic bags should not be used as moisture degrades important organic materials (2, 4, 6).
- B. Chain of custody must be maintained for each item to be valuable in the process.
- C. If the patient needs to urinate or vomit, the evidence should be preserved in a sterile or clean container (e.g. urine specimen container) if available (2, 4). This is especially important in drug-facilitated sexual assault (DFSA). Again, chain of custody must be maintained if these fluids are collected.



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- D. Any on scene containers the patient believes may have been used in drugging should also be collected and custody maintained.
- E. While it is most likely law enforcement that will take any evidence from the scene, if EMS is asked to do any of the above, chain of custody is most easily done by having the patient keep the bagged material in their possession until seen in the emergency department.

RESOURCES

1. Centers for Disease Control and Prevention (CDC) – Injury prevention & Control: Data & Statistics. Web-based Injury Statistics Query and Reporting System (WISQARS), Nonfatal Injury Data. <http://www.cdc.gov/injury/wisqars/index.html>. Accessed June 25, 2012.
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3. National Center for Victims of Crime. Sexual Assault, <http://www.ncvc.org/ncvc/main.aspx?dbName=DocumentViewer&DocumentID=32369>. Accessed June 25, 2012.
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6. American College of Emergency Physicians (ACEP): Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient. <http://www.acep.org/WorkArea/DownloadAsset.aspx?id=8984>. Accessed June 6, 2012.
7. EMS Response to Sexual Assault. Jimmy Futrelle. <http://theemtspot.com/2009/05/23/ems-response-to-sexual-assault/>. Accessed June 25, 2012.



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Appendix O: New Hampshire Checklists⁷⁷

Dispatcher Checklist

- Confirm victim's safety and medical needs; activate Emergency Medical Services as needed
- Check safety concerns (weapons shown, threatened or used, injuries to victim or suspect)
- Check special language/access needs
- Seek suspect information; description, direction of travel, vehicle, etc.
- Provide SANE related evidentiary advisories – not to bathe, change clothes, comb hair, brush teeth, touch any articles or furniture the suspect may have touched, etc. while waiting for officer to arrive
- If a SART trained officer is on duty, the SART trained officer will be dispatched to the scene. If a SART trained officer is not on duty, a uniform officer will be dispatched to the scene
- Dispatcher is to remain on the line with the victim, if practical, until officers arrive, especially if the victim is alone and/or the scene is not safe

First Responder Checklist

- Re-evaluate safety for the victim and any other person at potential risk
- Activate emergency medical services as needed or encourage the victim to seek medical care
- Call a crisis center advocate
- Identify the crime and the scene(s)
- Establish jurisdiction
- Preserve evidence /secure the scene(s)
- Determine if the suspect is known and their possible location(s)
- If the Responding Officer is not SART trained, contact a SART trained officer
- If the victim is an incapacitated adult, it is **mandatory** to report to the NH Bureau of Elderly and Adult Services at 1 (800) 949-0470
- Do not conduct a comprehensive interview of the victim; seek confirmation of the crime, scene and suspect information (Please refer to Conducting a Minimal Facts Interview, page 10)
- If a SART trained officer has a delayed response, work with the crisis center advocate to facilitate transportation to the hospital
- Remain with the victim until a SART trained officer arrives and the information is transferred to the investigating officer
- Promptly complete the initial incident report

⁷⁷ New Hampshire Governor's Commission on Domestic and Sexual Violence, Office of the Attorney General. A Model Protocol for Response to Adult Sexual Assault Cases, 2012 edition.



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Investigation Checklist

- Re-evaluate safety, activate Emergency Medical Services as needed
- Verify collaborative response has been initiated (crisis center advocate, SANE)
- Ascertain what disclosure has already been made and to who (initial officer, friend, family member)
- Conduct initial victim statement – short interview to determine evidence collection as requested by the victim – crisis center advocate can be present during initial and comprehensive statements (Please refer to Conducting a Minimal Facts Interview, page 10)
- Follow-up with comprehensive/complete victim interview; generally takes place after the SANE exam
- Coordinate audio/video taped statements in accordance with County Attorney's guidelines
- Determine need for search warrant(s); secure and execute if necessary
- Photograph and collect evidence from the scene(s)
- Conduct witness interview(s) – including potential disclosure witnesses
- Conduct and record suspect interview(s)
- Promptly and completely document case
- Conduct comprehensive review of case prior to sending case to the County Attorney – including reviewing all reports, evidence, obtain and review SANE documentation, statements, etc.
- Be available to provide case follow-up in consultation with the prosecutor



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Appendix P: Maryland Board of Nursing RN-FNE Training Curriculum

MBON RN-FNE Adult Curriculum

Lecture	Objectives
Overview	1. Define FNE 2. Review research findings pre and post FNE development. 3. Review the educational guidelines established by the Maryland Board of Nursing 4. Expand rate of FNE
Historical Perspective of Forensic Nursing	1. Define Forensic Nursing 2. Identify types of forensic nursing practice: a. correctional, b. death investigation, c. sexual assault d. interpersonal violence assessment, etc. • Child maltreatment • Intimate Partner Violence • Sexual Violence • Youth Violence • Elder/Vulnerable Adult Abuse 3. Discuss the development of forensic nursing with the International Association of Forensic Nurses (I.A.F.N) 4. Present the historical development of SANE programs. 5. Discuss the history and development of FNE programs in Maryland. 6. Current trends and national research
Multidisciplinary Team Concept	1. Define the multiple discipline team (SART) concept. 2. Identify members of the multidisciplinary team (sexual assault nurse examiners, law enforcement, rape crisis staff, judicial staff and adult and child protective services) 3. Discuss the roles of the members of the team.
Statistics, Myths and Barriers to Reporting	1. Demonstrate knowledge of current national and local statistics related to sexual assault. 2. Discuss misconceptions associated with sexual assault 3. Identify barriers for individuals reporting sexual assault and discuss how the barriers have been decreased due to SANE/FNE programs. 4. Discuss differences in how males and females are socialized to accept sexual assault 5. Discuss research recommendations related to forensic nursing. 6. Review the controversy of the Human Sexual Response



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Overview of the Role and Responsibility of the Forensic Nurse	1. Define the roles of the forensic nurse examiner. a. Review the IAFN Scope and Standards of Practice. b. Review the MBON Scope and Standards of Practice c. Process for obtaining informed consent 2. Discuss each component of care of the a. physical and psychosocial assessment. b. The evidentiary examination (medical/forensic interview, evidentiary collection of specimens and chain of custody) c. Expert witness testimony to court system d. Fact witness testimony e. Referrals to victims for follow up care (private MD, HMO, or clinic for follow up sexually transmitted diseases and HIV testing) f. Prevent and treat sexually transmitted diseases and pregnancy 3. Discuss the components for performing the forensic examination step by step: components include history, head to toe examination for trauma identification, detailed genital examination for trauma identification and collection of evidence 4. Identify forensic nurse examiner role with Maryland criminal code of sexual assault. 5. Discuss Maryland criminal code defining penetration.
Medical Forensic History	1. Demonstrate history taking skills a. Evaluating mental status, b. Behavioral observations and interpretation of verbal and non- verbal communication of the patient c. Reactions that the examiner may encounter from individuals that have been sexually assaulted d. Documentation of others present in the room, 2. Demonstrate how to obtain the patient's history in a non-leading manner. 3. Identify questions that need exploration during the history taking process; (decline vs. refuses, subjective vs. objective and nurses 4. Review the documentation of a sample forensic history and identify strengths and weaknesses.
Crime Lab Trace Analysis	1. Identify types of trace analysis evidence specific to sexual assault cases a. DNA b. CODIS (Combined DNA Index System) 2. Describe techniques and procedures for trace analysis evidence. 3. Discuss challenges related to the evidence gathering process, including the evidence integrity and chain of custody. a. Evidence/specimen gathering process b. Evidence/specimen labeling process c. Documentation d. Cross contamination prevention



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Police Roles and Responsibilities	1. Define the role of the uniform officer vs. the detective when responding to the sexual assault patient 2. Review the police roles in response to sexual assault cases
Forensic Photography	1. Important tool of documentation 2. Landmarks 3. Techniques a. Rule of three b. Angles c. lighting 4. Cameras a. Colposcope/mediscope/digital b. Familiarity with facility camera prior to exam 5. Documentation/labeling 6. Poor quality Vs sharp forensic photographs a. Focus/faded/shadows b. Review sample forensic photographs
Sex Offenders	1. Discuss the human sex drive 2. Discuss types of sexual assaults a. Stranger b. Acquaintance c. Date rape d. Intimate Partner e. Internet/computer crimes f. Undetected rapist 3. Define the four phases of a sexual crime: a. Antecedent/Fantasy b. Victim selection c. Commission of the crime d. Post offense behavior of the perpetrators 4. Discuss approaches commonly used by perpetrators (con, blitz, surprise) 5. Discuss Typology of sex offenders: a. Power reassurance b. Power assertive c. Anger retaliatory d. Anger sadistic e. Gang 6. Review case studies of victims and their offenders.



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Suspect Examination	1. Identify the purpose: a. Caring for the suspect as a patient. b. Examination and evidence collection 2. Consent Versus Search Warrant a. financial considerations b. medical examination c. evidence collection 3. Security/Law Enforcement a. Law enforcement presence b. Documenting all persons present in room c. Documenting personnel performing exam d. avoiding contact between victims/suspect 4. Locard's Principle 5. Trauma Identification, Evidence Collection & Preservation to include but not limited to: a. Photographs b. Body mapping
Special/Underserved Populations	1. Identify special populations of sexual assault and their special needs a. Physically or mentally challenged b. Ethnicity c. Non English speaking d. Elderly e. Male f. Same sex/transgender g. Cultural barriers h. Human sex trafficking i. Migrant/undocumented
Sexual Assault and Intimate Partner Violence	1. Define intimate partner violence (IPV) 2. Describe the dynamics of abusive relationships. 3. Identify physiological and behavioral signs and symptoms of intimate partner violence. 4. Identify barriers that prevent victims from leaving abusive relationships 5. Review of evidence collection and documentation
Drug Facilitated Sexual Assault	1. Discuss the incidence of substance abuse and relationship to sexual assault 2. Identify types of substances abused. 3. Discuss date rape drugs 4. Review current drug testing utilized. 5. Review facilities policy on collection and handling of DFSA specimens



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Continuum of Care Referrals And Discharge Instructions	1. Continuum of Care a. Review the initial sexual assault process b. Ongoing medical care c. Referrals d. Local Health Department e. Follow up with physicians f. Resource/Advocacy/ Counseling centers g. Discharge Instructions 2. Review samples of current documentation 3. Discuss civil legal services for victims
Documentation and Impact on Testimony	1. Maintaining congruency between evidence collection, documentation, and medical forensic history a. Forensic history b. Body maps/diagrams c. Injury documentation d. Photography e. Exam findings 2. Rape Shield doctrine according to Maryland Law 3. Detailed documentation process including: a. Objective vs. Subjective b. Negative documentation vs. positive documentation c. Detailed narrative vs. checklist
Courtroom Testimony and Application of the Medical Forensic and Personal Protection	1. Overview of Courtroom proceedings 2. Discuss preparation for court 3. Review of medical/forensic history taking process 4. Apply the process to the expert witness testimony in courtroom. 5. Apply the process to the fact witness testimony in courtroom 6. Apply courtroom testimony with exception to hearsay ruling for RN, FNE
Defining the Expertise of the FNE	1. Construction of FNE-CV 2. Describe the didactic and clinical components for FNE recognition 3. Describe the difference between a fact witness and an expert witness 4. Appropriate dress and presentation for Court
The Judicial System and Laws	1. Give 2 elements of crime necessary for a charge of rape 2. Discuss what constitutes sexual abuse 3. State the order of proof in a criminal trial 4. Discuss the rules of testifying as an expert witness 5. Discuss the laws specific to the protection of children reporting sexual child abuse and how they relate to the expertise of the FNE examiner



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Mock Courtroom Testimony	1. Review a simulation of actual court proceedings that include all parties involved 2. Witness and exert being cross examined
Clinical Requirements	1. Review required clinical rotations

MBON RN-FNE Pediatric Curriculum

Lecture Topic	Course Content
1. Overview of FNE	1. Define FNE-P vs. FNE-A 2. Historical view of the FNE-P 3. Training requirements 4. Maintaining your expertise a. Continuing education b. Professional reading c. Peer review d. Professional associations e. Participation with MBON – FNE/Curriculum- policy development 5. Regulations: Scope of practice and recertification requirement 6. Define child maltreatment and discuss models of care for child maltreatment in MD. a. Sexual assault/abuse b. Physical abuse c. Neglect
2. Overview of Child Maltreatment	1. Identify issues surrounding child sexual abuse/maltreatment a. Sexual Abuse Accommodation Syndrome b. Delayed disclosure c. Recantation d. Teenage high-risk behaviors (1) Age-based relationships e. Family nucleus f. Acquaintances g. Authority figures 2. Identify issues surrounding perpetrators of child offenses a. Juvenile-on-juvenile b. Adult-on-minor c. Implication of in-home abuse



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3. Physical Indicators of Concern	1. Identify physical signs and symptoms that should trigger the question of child maltreatment 2. Physical conditions that mimic or could be mistaken for child maltreatments a. Sexual assault/abuse b. Physical abuse c. Neglect d. Research regarding progression of healing vs. staging of bruises
4. Behavioral Indicators of Concern	1. Identify behavioral signs that trigger the question of child maltreatment 2. Discuss risk factors that make children vulnerable to maltreatment a. Family dysfunction b. Disability c. Impact of domestic violence d. Impact of drug use/abuse 3. Review findings of adverse childhood experiences (ACE) study (see CDC.gov/ACE)
5. Stages of Growth and Development	1. Identify the stages of growth and development through a child's lifespan from birth to adolescence a. Tanner/Sexual Maturity Ratings b. Height/weight c. Cognitive development d. Linguistic development e. Sexual development
6. Child Maltreatment Triage	1. Define Acute vs. chronic a. Sexual assault/abuse b. Physical abuse/neglect 2. Medical clearance 3. Indications for evidence collection a. Sexual assault/abuse implication for evidence collection kit b. Physical abuse/neglect c. Law enforcement involvement d. Informed consent 4. Discuss regional models of triage
7. Obtaining the Medical History	1. Regional variations in medical history protocols 2. Discuss and demonstrate history using non-leading question techniques appropriate to children 3. Discuss documentation of the history as stated by the child 4. Discuss barriers to obtaining an accurate medical history a. Presence of parents b. Range of emotional reactions



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8. The Child Maltreatment Examination Overview	1. Discuss the components of the head to toe assessment for trauma identification 2. Injury Identification a. Review of injury terminology b. Physical findings that warrant follow-up exam c. Physician consultation 3. Discuss how to do an appropriate medical/forensic sexual assault examination on a pediatric patient a. Discuss how the examination will vary depending on the development age of the child b. Utilizing appropriate components of the sexual assault kit
9. Age Appropriate Genital Exam Techniques	1. Discuss the various examination positions a. Supine lithotomy b. Supine knee/chest c. Frog-leg d. Prone knee/chest e. Left lateral decub 2. Discuss the examination techniques a. Visual inspection b. Labial separation/tension/traction c. Cotton tip applicator d. Water floatation e. Foley catheter f. Implications of speculum use in sexual assault examination for children
10. Hymen Variation and Pre-Pubescent Genital Interpretation	1. Discuss hymen and genital variations and abnormalities a. Photograph examination of normal Vs abnormal genital findings 2. Discuss the appropriate interpretation of the prepubescent genital findings a. Review defining criteria b. Schematic Vs photo examination 3. Discuss the difference between the estrogenized and non-estrogenized prepubescent genitalia a. Define criteria/morphology of estrogenized Vs non-estrogenized b. Photograph Identification
11. Anal/Penile Evaluation	1. Review of anal/penile/scrotal anatomy 2. Identify techniques for the examination 3. Interpretation & documentation



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12. Sexually Transmitted Infection: Identification and Interpretation in Children	1. Overview of STI's in the pediatric population a. Regional consideration of HIV testing and informed consent 2. Practicalities of STI testing a. Who gets tested; sampling and test selection b. DHMH regional regulations 3. Discuss the American College of Emergency Physicians Guidelines and the CDC's recommended treatment of the different sexually transmitted infections a. Prophylaxis in acute settings b. Treatment of established infections c. Overview of the side effects of medications 4. Discuss the reporting of sexually transmitted infections in the pediatric population 5. Consider possibility of pregnancy and prophylaxis for post pubescent a. Consideration of informed consent
13. Documentation	1. Documenting the assessment a. Written documentation b. Photo documentation c. Body mapping d. Simulate a written assessment with body mapping 2. Formulate the clinical impression 3. Maintaining the record a. HIPPA b. Confidentiality c. Chain of custody
14. Law Enforcement	1. Investigation of child maltreatment crime (scope and role of law enforcement) 2. Mandated reporting as it relates to law enforcement
15. Understanding the Forensic Interview	1. Define Forensic interview VS medical interview 2. Discuss principles and models of forensic interviews 3. Qualifications/recommendations for forensic interviewers 4. Identify those questions that need exploration during the history taking process
16. Child Protective Services	1. The role of CPS 2. Mandatory reporting as it relates to CPS 3. Discuss current reporting procedures



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17. Children Advocacy Center (CAC) and Similar Resources Overview	1. Discuss model of services provided to victims of child maltreatment and their families a. Forensic interviewing b. Medical evaluation c. Mental health/counseling services d. Victim advocate
18. Taking Care of You	1. Discuss secondary traumatization of care providers 2. Managing acute stress
19. Documenting Your Expertise	1. Tips to developing a professional portfolio a. Professional presentation b. Project development within facility c. Volunteer activities d. Curriculum vitae e. Committee activities with MBON – curriculum/policy development f. Tracking your court expertise
20. Preparing Courtroom Testimony	1. Review the record 2. Attorney communications 3. Discuss what to expect when you go into a courtroom 4. Consider peer review 5. Dress for success
21. Qualifying as an Expert	1. Describe the difference between a fact witness versus an expert witness 2. Discuss the laws specific to the protection of the children, the reporting of sexual maltreatment, and how these laws relate to the expertise of the FNE 3. Voir dire a. Learn how to recite educational accomplishments
22. Basic Do's and Don'ts of Testifying	1. Discuss testifying as an expert witness
23. The Judicial System and Laws	1. Legal definition of child maltreatment crimes a. Sexual offenses b. Physical abuse c. Neglect 2. Other related crimes against children, i.e. trafficking internet crime/child porn 3. State the order of proof in Criminal Vs Civil trial 4. Delayed/Anonymous reporting 5. Discuss the federal hearsay law exceptions and how it applies to courtroom testimony 6. Statute of limitations
24. Mock Courtroom Testimony	1. Conduct a simulated court proceeding



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Appendix Q: Public Testimony Invitation

Last year, the Maryland legislature heard testimony about barriers that victim/survivors face when they sought an exam after sexual assault. Advocates and survivors have reported that many women and men do not realize that only designated hospitals perform these exams. As a result, some survivors had to go from one hospital to another. Other concerns included having little information about where to go or what to do after a sexual assault has occurred, fears about costs (exams are free), not knowing if the doctors or nurses will speak the same language, long waiting times at the hospital, and transportation issues. Nurses and other medical professionals report having too few trained forensic examiners. Attorneys have emphasized the need to have stringent standards so evidence collection will stand up in court.

In response to the concerns raised, the General Assembly created the Planning Committee to Implement Improved Access to Sexual Assault Medical Forensic Examinations in Maryland to help improve the existing system. We are currently seeking input from victim/survivors of sexual violence, nurses, advocates, medical service providers, law enforcement providers, and anyone else who would like to share their experiences, suggestions, and opinions.

The Planning Committee will be receiving public testimony on Thursday, June 11, 2015 at 12:00PM. This will take place at the Howard County Government Gateway Building:
6751 Columbia Gateway Drive
Room 401
Columbia, Maryland 21046

A photo ID will be required for building entry.

If you are unable to attend or would prefer to submit your feedback privately, please contact Amy Robinson at arobinson@miemss.org.

We look forward to hearing from you.

Respectfully,

Joyce Dantzler, MS, MCHES
Co-Chair
Department of Health and Mental Hygiene

Carole Mays, RN, MS, CEN
Co-Chair
Maryland Institute for Emergency Medical Services Systems

Tiwanica Moore, MPH
Staff Member, DHMH

Amy Robinson, MA, MPA, EMT
Staff Member, MIEMSS



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	Program Attributes	Access to Exam	Best Practices	Gap/s Identified	Other Comments
REGION I					
REGION II					
June 11, 2015 Frederick Memorial Hospital (FMH)- Pam Holtzinger RN	Pam Holtzinger, FNE-AP, has been with Frederick Memorial Hospital (FMH) for approximately 1 year and works in the Forensic Nursing program, which handles patients with any reports of sexual assault, domestic violence, elder abuse, etc. Staff development and call coverage has been a difficult process. It takes 6 months to a year to get a forensic nurse examiner (FNE) fully trained and working. The structure at the hospital is for the FNEs to be on-call, though it is a casual relationship that is not beneficial to current practice. This is causing a failure to provide 24-hour resources. FMH has offered a full time position to begin addressing this issue. The majority of patients have a component or suspicion of sexual abuse/assault, but they are now also seeing child maltreatment and additional increases in responses to violence. Many programs begin with sexual assault but increase capacity to be involved in domestic violence cases, child maltreatment, etc. This program is a healthcare response to violence.	The hospital handles both adult and pediatric cases, and is collaborating with the Frederick County Childhood Advocacy Council (CAC) to develop and expand their pediatric capabilities.	Frederick County has a strong, well-engaged SART team.	By not having dedicated individuals, there is limited education among staff. When an FNE is put in place, you can do more and be available for more than just exams. Recognition skills, resources, and testing should all be available. We need to legitimize that FNEs do more than just the actual exams. This would allow for larger scale collaboration and providing greater access to expertise. Putting a nurse in place with specialty skills with the ability to manage these types of populations can provide meaningful results and better care. Having this type of staff allows facilities to make connections early on to recognize violence and provide early intervention. Regionalizing responses may move patients beyond where they are comfortable. Taking them somewhere for an exam and then referring them back elsewhere does not have as positive an impact as managing a patient within their own area (with local resources and team responses).	The current system to staff/train/recruit nurses is not sustainable. It takes hundreds of hours, additional costs for certification, and then requires the FNE to be on-call nights/weekends after already working a 40-hour work week. Pay will only be for when you come in; it's a lot of extra work with a limited money incentive. Taking less on-call hours limits the FNE's ability to stay current in practice, and getting called in is an individual responsibility where the FNE is the sole responder to handle the case. Preparation for the position takes months, and then calls must be covered; what happens when calls cannot be covered? The workforce does not exist because it is very difficult work and very emotionally challenging to maintain. There is about a 2 year turnaround; 1 year for adult training, then about 6 months for pediatric training, (sometimes more) and then soon after they are leaving due to the stress. Dedicating and legitimizing the position allows for continued skill proficiency and for the community to have a predictable workforce to respond to all types of violence cases, not just sexual assault (strangulation, domestic violence evaluation, elder abuse).



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Date, Program, and Presenter	Program Attributes	Access to Exam	Best Practices	Gap/s Identified	Other Comments
June 11, 2015 Western Maryland Regional Medical Center (WMRMC)- Debi Wolford RN	Debi works with the Allegheny County SAFE program at Washington Maryland Regional Medical Center (WMRMC), which has two forensic nurses for 24/7 coverage. Debi is a full time FNE. The domestic violence and sexual assault programs are combined for the FNE to have a full time position. They also now have a part time position so that Debi can also travel for meetings such as these. A call schedule is maintained by the hospital. We are in alliance with Meritus Medical Center and Frederick Memorial, so hopefully patients will be able to connect there if necessary. Garrett County and West Virginia patients also come to WMRMC/Allegheny. Garrett and West Virginia hospitals both have FNEs, but they do not offer on-call pay or 24/7 coverage. Victims that have been transferred have always been moved via law enforcement, never by family or EMS – the police have always volunteered. WMRMC is seeing patients from four counties, spanning an hour and a half away. The majority of patients are walk ins. Victim advocates are on- call and are always present during exams and/or transfers.	WMRMC does both adults and pediatrics.	Mobile FNEs is an exciting prospect. Patients are able to stay in their own environment and care can come to them. The one time Debi traveled to Garrett County, it was on per diem. Debi has privileges at Garrett Memorial Hospital as well, but has only gone there once for a severely ill patient. The arrangements WMRMC has with other hospitals are all informal. The SART Team meets monthly, year round. Cases are discussed.	Debi does not want ER physicians doing evidence exams, and they do not want to do them. Keeping nurses is difficult, but we do NOT want ER physicians giving exams.	



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Date, Program, and Presenter	Program Attributes	Access to Exam	Best Practices	Gap/s Identified	Other Comments
REGION III					
February 12, 2015 Greater Baltimore Medical Center (GBMC)- Laura Clary RN, Clinical Program Manager of SA and DV Programs	GBMC has a good interdisciplinary team with a lot of nurses to provide 12 hour shift coverage. The SAFE program has a Domestic Violence (DV) component. Advocates are cross trained to respond to Sexual Assault (SA) and DV. Patients may drive in or be transported by EMS or law enforcement. Most of the victims come in with someone and drive personal vehicles. When patients walk-in through the ED, the Triage nurses know they can activate the SAFE team. Patients presenting at another ED (in Baltimore County) are transferred to GBMC. Acute exams are done in the hospital. Forensic Nurse Examiners (FNE's) are paid by the hour for prep time and when they go to court. They submit invoices for reimbursement and can be paid even if they are no longer with the program. Laura is currently the only nurse FNE for pediatric cases; most of the time pediatricians do the exam. Children 12 & under go to MedStar Franklin Square Medical Center (MFSMC). There is a care and custody issue for children where an interdisciplinary team comes in. Laura takes calls at MFSMC outside of her regular FT job. Children never come to GBMC unless they are 13 and over.	When nurses travel to another hospital, they need their IDs; many times police are involved and transport the FNE to the other hospital to do the exam.	If a patient is unable to be transferred due to medical reasons, the GBMC FNEs can respond to them at the hospital where they are being cared for. There is a Baltimore County SART meeting every other month; Towson University and all other local colleges send representatives. GBMC does community outreach; Laura does presentations in schools and on college campuses.	Nurse retention is a barrier (staffing 24/7). There is high turnover in forensic nursing due to some of the following reasons: Most of the nurses have other jobs besides being a SAFE nurse; personal issues; inability to commit to amount of call time that the program required etc. Having a minimal set call time would not work for GBMC. One barrier for children is the need for more hospitals to offer exams; there is a much smaller window with how fast exams need to be done.	There could be an entire sub-committee devoted to this because there are a lot of barriers and an intersection of services (i.e. protective services, rape crisis etc.). Hospitals have procedures to make sure that persons practicing in their facilities are legit, which is one concern with having traveling practitioner (Watson). The committee is looking at hospitals and not CACs, which is the bulk of the child cases. A sub-committee should be looking at Peds if that's a part of the charge of this committee. Are MOU's with hospitals needed for the FNE to go to another hospital to provide the exam?



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Date, Program, and Presenter	Program Attributes	Access to Exam	Best Practices	Gap/s Identified	Other Comments
June 11, 2015 Howard County General Hospital (HCGH)- Joey Middleton RN	There are never enough nurses. There are no dedicated FNE positions and all FNEs already have full time jobs. Howard County General Hospital requires the FNEs to be proficient in both adult and pediatrics. There have been times when there was not a FNE available to see the patient and the patient had to be transferred elsewhere. The SAFE program is grant funded so they do not have the luxury of full time staff. Oftentimes the exam process can be lengthy. FNEs are very skilled at talking down patients to make them feel at ease, be cooperative, and not feel as if they're being assaulted all over again.	They receive patients from Baltimore County, Baltimore City, Anne Arundel, Prince George's, etc.	"Hope Works" is a local advocacy agency that provides a victim advocate for every patient. The hospital relies on them since one nurse does all the other work – photos, evidence collection, exam, information, etc. Law enforcement may also come in for an interview if it is not a Jane Doe case. HCGH has an excellent SART team. Every two months Hope Works, Child/Adult Protective Services, Law Enforcement, and the State Attorney's Office will meet with the SAFE program to discuss past and current cases.	Baltimore Washington Medical Center has been having an issue recently with a lack of pediatric certified FNEs (they currently have only 1). They are planning to train 7-9 pediatricians to do the exams if the FNE is not there. There is concern about doctors doing the training though, as FNEs are experience at working with the patients under such difficult circumstances. Documentation needs to be standardized. Information on photo technique, written documentation, etc. would be very beneficial. Current processes do not allow for clear, full documentation (i.e., paperwork does not offer enough space).	An example: A young girl attacked by multiple assailants presented to Harbor Hospital with a friend. She was told they would have to call her parents, that they didn't do exams, and that they had no further information. Later that evening she told her mother, who took her to BWMC. They did not have a nurse on call, so she was later sent to HCGH. All hospitals should know what resources are available elsewhere – what hospitals offer 24/7, pediatrics, etc.



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Date, Program, and Presenter	Program Attributes	Access to Exam	Best Practices	Gap/s Identified	Other Comments
March 12, 2015 Mercy Medical Center (Mercy)- Debra Holbrook RN	The Mercy Sexual Assault Program was founded by Dr. Christine Jackson. They see victims of sexual assault 13 years of age and older. Mercy is the only SAFE program in the city and sees over 500 victims per year. The SAFE program is expensive to maintain and it does not generate money; it “breaks-even.” There are 36 nurses working with the Mercy program and 1-2 people are on call 24/7. Grant funds support this fully mobile 24 hour a day program; they see approximately 100/year SA mobile cases. The Sisters of Mercy absorb any extra costs as this work is part of the Mercy Mission. They travel to all city hospitals and other facilities, such as nursing homes and prisons. They provide other victim services; a Strangulation Center for Baltimore City and Elder/Vulnerable Adult Abuse, Assault, Neglect and Maltreatment. The program does have MOUs (through Risk Management) with the hospitals where Forensic Nurse Examiners (FNE) are sent. The SAFE nurses use their MMC ID badges for identification. Police transport the SAFE nurses due to safety concerns, open evidence, and the transportation of expensive equipment. Arrangements exist with Baltimore City police and the Police Chief's Association (for cases where victims are brought into Baltimore). The program does not provide victim advocates; most hospitals will have their own already available (and are often who request the FNE visit).	Up until a few weeks ago, no reimbursement was provided by DHMH for mobile cases. Mercy can now submit a claim for up to \$80.00 under Dr. Jackson as a physician fee that goes into the Emergency Department (ED) cost center. Mercy still loses approximately \$200 on each case. Fundraising is necessary to cover costs. Mercy also does community education work and works closely with stakeholders, which may help ensure victims know where to go for treatment. There are relatively a small number of people transferred.	Holbrook recommends 4-5 regional programs with mobile units for Maryland. To address staffing concerns, it has to be a program that people want to work for, and nurses have to feel good about their skills. Debbie has run a successful program in rural and urban areas; the volume is different but the work is the same. Programs are held to the state standard of 120 hours. National policy is also 120 hrs. Mercy will still take cases over 120 hours though the claim may be denied if sent to DHMH/SARU.	From Debbie's perspective, every hospital should not have a SAFE program, considering staff training. It's no different from transporting a patient where the specialty is addressed (i.e. trauma). There is a concern that some hospitals that say they have a SAFE program cannot provide 24-hr. care. Pediatric FNEs handle ages 0-12 years. Mercy has pediatric FNEs, but University of Maryland has the “ownership” for pediatric victim care patients. All pediatric patients are transferred there. If a pediatric patient is admitted to Mercy, Sinai, Union, etc., they will NOT receive a forensic exam no matter the circumstances. The committee is looking at hospitals and not CACs, which is the bulk of the child cases	MCASA's concern is that nurses are not getting paid and improved access for sexual assault victims is not the same as hand surgery (Jordan). State crime lab meeting revealed that semen can be obtained from high up in the cervix for up to 10 days (Jordan). Hospitals have procedures to make sure that persons practicing in their facilities are legit, which is one concern with have a traveling practitioner (Watson).



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Date, Program, and Presenter	Program Attributes	Access to Exam	Best Practices	Gap/s Identified	Other Comments
5/14/15 University of Maryland Children's Hospital (UMCH) - Dr. Forrest Closson	The UMCH cares for child Sexual Assault victims under age 14 and see victims with "normal findings" (physical abuse or non-penetrative sexual abuse, ~90% of the cases) and sexual assaults (violent acts); approximately 225 cases each year (15-20 /month) mostly between the ages of 2 and 8 years old and 1- 3 adolescent aged children are seen each month. Children who have been sexually assaulted tend to have more findings than those who have been abused. Physician training; UMCH physician who work with child abuse victims are fellowship trained in the ED setting and have interest in child maltreatment. They receive "a" level of training. No specialized course. Review cases at QA meetings. Baltimore Child Abuse Center has Child Advocates but are not open 24/7 (mostly daytime hours).	The children are brought to the ED and Triageed with a priority status. The child is taken to a private room in the ED. Child Life Specialists/SW. Relationship with MFSMC (Dr. Krugman).	Baltimore City SART; victims taken to Mercy aged 14 and greater and UMCH 13 and under.	<u>Barriers:</u> 1). Victims coming forward; the perception is that victims have to pay for the exam. (sexual abuse/assault evaluations do not have to go through their own health insurance. 2) Financial issues such as Healthcare plans 3) Notification of parent; adolescents who request services for sexual health, abuse, or assault can receive care without parental notification or consent. Police and or parental engagement can lead to unclear situations. 4) Transportation for victims in and around the city at night (many at night, too young to drive, public transportation or walking). 5) Paucity of FNE-P in Baltimore and surrounding counties. UMBWMC has 1 FNE-P. <u>Recommendations:</u> 1) Adequate funding of FNE training 2) Better redefining of options; caregiver mandated-reported for sexual abuse. Healthcare provider discretion whether to notify the parent and providers prefer to follow guidelines exactly so that there can be no questions or ambiguity (black or white and no grey).	There are only a few pediatric cases across the state which makes it difficult for providers to maintain credentialing for the FNE-P. Pediatrician training (for those who do the SA exams) is done at UMCH by Dr. Closson. Most are child abuse specialists with special training that differs from FNE-P training. Many referring pediatricians do not feel comfortable doing the SA exams. There is no "Mobile Peds SA team".



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Date, Program, and Presenter	Program Attributes	Access to Exam	Best Practices	Gap/s Identified	Other Comments
REGION IV					
February 12, 2015 Peninsula Regional Medical Center (PRMC)- Eunice Esposito RN, SAFE Program Manager	PRMC's eastern shore location is unique. They receive some patients from Delaware and Virginia. They work with the Sexual Assault response team in VA. PRMC has 24/7 coverage for adults and children. The program is growing to encompass DV, elder abuse, gunshot wounds; not just sexual assault. PRMC has begun doing a lot of trainings "on the Shore" to keep people there and save money.	Eunice is working with Verlin Meekins on possibly establishing a SAFE program for McCready Hospital.	Nurses are paid hourly rates when they respond to a victim and when they go to court. They have a "makeshift contract" to cover 16 hrs. per week. The original hospital contract was removed. There are expectations for the nurses and verification checks are done to determine if they have completed their expectations for the SA program.	Staffing issues exist. Barriers include how many times training can be offered due to the associated cost. Pediatric SA is a separate teaching piece.	
REGION V					



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Date, Program, and Presenter	Program Attributes	Access to Exam	Best Practices	Gap/s Identified	Other Comments
STATE					
June 11, 2015 Child Advocacy Center CAC) Pam Holtzinger RN	She was on the board for development of the Frederick County Childhood Advocacy Center (CAC) and has been a nurse examiner there since its opening. The CAC model is ideally a model to bring together specialty resources and multidisciplinary team members to deal with physical and sexual abuse. Victims do not often disclose unless there is severe trauma, and when they do it is usually outside of the evidence window. The CACs are to bring together law enforcement, medical (2 days a week in Frederick, very rare in other locations), counseling services, etc. It is a holistic response to healthcare and investigation. The CAC provides the opportunity for the child/family to address the situation and handle it appropriately. They can offer STD testing and minor treatment, but often it is the opportunity to have a healthcare screening and provide proper referrals for advocacy and counseling services.	Acute care setting models typically will have a child go in during the evidentiary collection window. Most children do not present during that window, but instead weeks (or even years) later. CACs do not usually do evidence collection, but instead provide counseling services and normalization of experiences.		Not all counties have a CAC. The Child Abuse Medical Professionals in Maryland group is concerned about access. They have been trying to train pediatricians and FNEs to support CACs. Not all CACs have a medical component, either. Those that do still have relationships that are somewhat casual – staff are usually on an on-call basis and are not working dedicated hours.	



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Date, Program, and Presenter	Program Attributes	Access to Exam	Best Practices	Gap/s Identified	Other Comments
July, 9, 2015 Criminal Injuries Compensation Board (CICB)- Jessica Roman	CICB Services include payment of medical expenses up to \$45,000 for Sexual Assault. Medical bills may be submitted for: Individuals who went to facilities that not covered for SAFE exams & are transferred to other facilities, victims who seek services out of state (VA, DC, DE), co-payments, deductibles, out-of-pocket expenses, bills from DHMH SARU for providers that did not provide bills to DHMH within the designated time period or used the wrong diagnosis code, & expenses for physical injuries that occurred at the time of the assault. Individuals are eligible for up to \$5,000 for counseling services. Family members can receive up to \$1,000 per member up to \$5,000. A maximum of \$25,000 compensation for lost wages for individuals unable to work. Funding is also available when parents need to miss work to care for a child/dependent. Child abuse cases; the parent may be eligible for lost wages with certification from a doctor. Dependency maximum benefit is \$25,000 & is used in cases involving death or incarceration. Funeral/burial (up to \$5,000), and crime scene clean-up (up to \$250) can be covered; Clean up includes professional services or non-professional services if receipts are provided for cleaning products purchased. The victim's contact information is needed for applications; victim paperwork can be overwhelming, & they often need assistance to complete it. A Police report or report number is necessary to show that the crime was reported within 48 hours of the incident. There may be leeway for specific cases when reporting is delayed (i.e. child abuse over a period of time since counseling expenses can be requested up to age 25). A statement explaining the situation (i.e. fear of abuser) may allow for later compensation if there is good cause. Applications must be in office within 3 years from the incident. Min. benefit is \$100. Clients can apply for lost wages only if they meet the 2 week requirement. The crime must have occurred in Maryland, with the exception of an overseas assault or terrorist attack. The victim must have experienced physical or psychological injury and must not have contributed to the victimization. A social security number is requested to search for state indebtedness (A dummy number is used for those who do not have one).	HIV Prophylaxis-The Board is not comfortable awarding on an emergency basis. There is no set protocol. This is one of the controversial topics but has been reimbursed in some cases. CICB is in communication with other agencies to see how they can address it better. One client that paid for the drugs & was reimbursed.	CICB is the last resort, & refers clients to DHMH (SARU), private insurance, medical assistance, hospital charity care, tri care (military), MD Auto insurance, workman's comp. etc. as applicable because funding is limited.	CICB is payer of last resort. Victims may be denied because there are other resources available: Failure to avoid or contribute to the injury, Failure to report in 48 hours, Lack of cooperation with law enforcement, Changes in the victim's story during the course of the investigation can delay or result in denied compensation (Victims may request a hearing in the CICB office if this occurs), Repression of the assault delays reporting (i.e. child abuse situations or if victim was drugged), Providers may miss deadlines or provide the wrong diagnoses code for DHMH (SARU) claims, Undocumented wages cannot be reimbursed. CICB is statutory based, Relocation / lock changes are not covered. Situations are handled on a case-by-case basis (i.e. Jane Doe, pregnancy/abortion, prophylaxis etc.).	CICB can help with ambulance fees. Exams that are done on victims that go to a non-SAFE hospital can be covered if they are not eligible for the SAFE exam through said hospital. When doctors do not submit claims in a timely manner to DHMH (SARU), CICB may cover those expenses if reasoning is provided. Sexual assaults out of state are not covered, but what about assaults in Maryland where care is then provided out of state? When DHMH does not reimburse, CICB may cover it.



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Date, Program, and Presenter	Program Attributes	Access to Exam	Best Practices	Gap/s Identified	Other Comments
June 11, 2015 Children's National Health System (CNHS)- Siobhan Copeland	A large portion of our patients come from Maryland. 2,033 encounters annually – 64% are victimized in DC, 17% in Prince George's County, and 18% come from other Maryland and Virginia locations. 60% of all in-patients in the hospital are Maryland residents. Pediatric care is considered care for anyone under the age of 22. Pediatric expertise is necessary – adult models for SAFE programs should not be applied to pediatric cases. Independent or systematic victim advocates for the child are not as welcomed as family victim advocates would be. In order for a child to deal with the trauma experienced, they need the support of the family. When the families aren't healthy, CNMC helps to get the family back on track. An adult model allows for strangers to be victim advocates, while children should really have the advocacy of a family member or guardian.	We see children throughout the DC, Maryland, and Virginia area. Comprehensive examinations are conducted by physicians and nurses with forensic specialties. Treatment for STDs and counseling for maltreatment (psychologists, clinical social workers) are offered.	Every county does not have a child abuse pediatrician, so CNMC serves as a backup for many localities when patients have acute needs. It is difficult to provide referrals for resources when you are not familiar with the area the patient comes from (i.e. St Mary's Co.).	The Crime Victims Compensation Program (CVCP) is their main source for reimbursement. Medicaid doesn't pay for mental health services; if insurance doesn't cover, CNMC works with CVCP to help cover reimbursement. The DC CVCP helps with transportation, which is often a big cost, but Maryland program does not cover this. Maryland also does not assist with housing, which can be a problem for assault victims who are not safe at home and have nowhere to go. DC has safe housing.	Forensic exams for Maryland residents may be reimbursed through CVCP in DC (Maryland DHMH only covers reimbursement in Maryland facilities. DHMH has no mechanism to reimburse facilities not within the state



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Date, Program, and Presenter	Program Attributes	Access to Exam	Best Practices	Gap/s Identified	Other Comments
January, 8, 2015 Department of Mental Health & Hygiene (DHMH)- Lisa Garceau, RN, CNM, MSN, Nursing Supervisor, Sexual Assault Reimbursement Unit (SARU)	The Sexual Assault Reimbursement Unit (SARU) is a centralized statewide program administered by the Department of Health and Mental Hygiene's Center for Injury and Sexual Assault Prevention. The SARU is 90% funded with the State general funds and 10% funded with Federal funds. In Fiscal Year (FY) 2014, the SARU provided reimbursement for approximately 3,100 claims related to rape, sexual assault and child sexual abuse. The SARU FY14 budgeted totaled approximately \$1,300,000 with hospital services comprising 79% and physician services comprising 21% of the budget. The Violence Against Women Act stipulates that no state may require victims of sexual assault to participate in the criminal justice system in order to be provided with a forensic medical examination or reimbursement for charges incurred for such an examination.		Reimbursement of claims is victim-focused. It takes care of patient expenses but does not necessarily cover overhead for hospital operating costs. The nursing costs are built into the ED fee; there is no other mechanism to pay the nurses. The DHMH Sexual Assault Reimbursement Unit (SARU) pays Dr. Jackson or any physician working collaboratively with FNEs. The Violence Against Women Act and Victims of Crime Act funding is limited to approximately \$15,000 and \$30,000 for direct salary reimbursement, respectively.	Initial ambulance/helicopter transportation costs and inter-hospital transfer transportation costs (commercial air, or commercial ambulance) are not covered. Victims may receive bills.	



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Date, Program, and Presenter	Program Attributes	Access to Exam	Best Practices	Gap/s Identified	Other Comments
INTERNATIONAL					
February 12, 2015 International Association of Forensic Nurses (IAFN)- Carey Goryl & Jana Parrish RN	The International Association of Forensic Nurses (Association) is a nonprofit professional membership organization for clinicians (nurses, physicians, and physician assistants) who specialize in providing medical and forensic healthcare for victims and perpetrators of violence, and other allied professionals who support this work. The mission of the IAFN is to provide leadership in forensic nursing practice by developing, promoting, and disseminating information internationally about forensic nursing science. The Association has provided technical assistance to more than 15,000 multidisciplinary professionals who work with adult and adolescent victims of sexual violence. According to American Hospital Association, 5,724 registered hospitals exist in the United States. The Association's SANE program listing of 777 programs indicates that the majority of SANE programs (588 programs--or 70%) operate out of hospital facilities and that a much smaller percentage (20%) comprise community-based programs; the remaining 10% do not specify a setting. These numbers reveal a stark reality for sexual assault victims; only 1 in 10 hospitals have established programs where trained professionals are available to provide sexual assault care.	There is a growing trend to ensure that sexual assault victims have faster and better access to a trained provider when needing a medical forensic exam. Since the biggest growth of nurse examiner programs in the early 2000's, Emergency Departments have become even less inclined to provide a medical forensic exam without trained personnel. The Government Accountability Office has recently begun a survey to assess the quantity of training and education, the funds and resources being provided to host education, and the availability of trained forensic health providers to the average citizen.	The way to keep a program sustainable is to invest in it the way other specialty areas of healthcare have been invested in. Invest in the people, encourage advancement in education (by funding education), and have strong leadership and oversight of programs. National Sexual Assault Medical Forensic Exam Protocol- Adult/Adolescent (2013). National Sexual Assault Medical Forensic Exam Training Standards (2009). IAFN Sexual Assault Nurse Examiner Education guidelines (2013). Coming in 2016: National Sexual Assault Medical Forensic Exam Protocol- Pediatric.	The common problems found during the SANE Sustainability project site evaluations are the same as those being described in MD and listed below: Providing 24/7 coverage, recruiting & retaining nurses, addressing ongoing competency issues in practice, creating & updating policies & procedures for program operation that meet or exceed national standards, addressing personality and interpersonal conflicts among staff, handling payment/finances/billing & fundraising to support program activities & education, maintaining foundational nursing practice standards & expectations while interacting with the criminal justice system, combining professional isolation & connecting to state, national & regional resources, conducting outreach & publicity, and collaborating with advocacy organizations & other stakeholders.	Engage the greater healthcare systems to take a larger & more active role in providing care of the forensic health population. SA victims are one of the many types of patients that could benefit from forensic health care. Until forensic health care can be found at every major hospital, ensure consistent transportation between facilities that is not an added burden to victims. Ensure consistent & reliable service from existing forensic programs. Consider opportunities to support the current forensic programs to expand forensic health services. Discuss how current forensic programs can provide full-time staff and coverage to reduce sporadic availability. Invest in nurses. Review payer system in MD with healthcare systems. Consider the data archived at the DHMH as a result of its reimbursement system. Ensure that all hospitals have a documented policy/procedure to respond to patients who have been sexually assaulted. All EMS providers need to know where exams are performed. EMS and LE should be educated in basic forensic principles and techniques so evidence is not inadvertently destroyed or lost. Patients should have choices about where to go, but should be informed if there is no exam site. Keep dialogue open with the MBON.



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Maryland Rape and Sexual Assault Prevention Program



Request for Public Testimony

The 2014 General Assembly enacted a law (click [here](#) to view the law) creating the Sexual Assault Forensic Examination (SAFE) Committee. The term "forensic medical exam" means an examination provided to a sexual assault victim by medical personnel trained to gather evidence of a sexual assault in a manner suitable for use in a court of law. The SAFE Committee was instructed to look for ways to improve access to sexual assault forensic examinations (sometimes called "rape exams"). These are exams that are done at hospitals for victims of sexual assault. They are done by health care providers with specialized training in working with victims of sexual assaults, and the exams are for the purpose of treatment and collection of forensic evidence (legal evidence).

The SAFE Committee would like to hear from sexual assault survivors, nurses, sexual assault victim advocates, and others about their experiences with the current system in Maryland and suggestions for improving the system including access to a SAFE exam, interactions with health care, law enforcement, and advocates, and the handling of billing and payments.

The Maryland Department of Health and Mental Hygiene (DHMH) serves as a co-Chair of the SAFE Committee and has two options to receive public testimony, gather stories, which will be reviewed by SAFE Committee members. These testimonials will assist them in making recommendations for changes that will make the current system better for victims. If you would like to share your story, please use one of the following options:

1. Email Public Testimony– Email your written testimony to DHMH.safecommittee@maryland.gov or
2. Anonymous Direct Mail– Mail in your testimony to DHMH in an unmarked envelope to:
 - a. **Joyce Dantzler, Chief, Center for Injury and Sexual Assault Prevention/SAFE Committee Co-Chair, Maryland Department of Health and Mental Hygiene, 201 W. Preston St., Room 426, Baltimore, MD 21201**

Your testimony will be part of the public record. You do not need to provide your name unless you choose to include it. The deadline to submit public testimony is **May, 31, 2015**. Thank you for sharing your experiences and suggestions.



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Appendix R: Public Testimony and Written Comment

Testimony 1

Maryland Emergency Nurses Association – Written Testimony for SAFE Exam Access

This is the official written testimony from the Maryland State Council for the Emergency Nurses Association regarding SAFE Exam Access.

The Maryland State Council of the Emergency Nurses Association (MD ENA) represents nurses who are trained and certified as SAFE nurses, as well as nurses who provide emergency nursing care to our friends, families, and other people in our communities during their time of need.

Sexual assault and rape victims seeking care in the emergency department are an at-risk and vulnerable population. It is imperative that victims of sexual assault and rape receive appropriate and time sensitive care that addresses their complex medical, emotional, and legal needs. It is the position of MD ENA that victims of sexual assault deserve to receive highly specialized care by appropriately trained and certified Sexual Assault Forensic Examination (SAFE) nurses and other team members in the already established designated centers throughout the state. However, it is also the opinion of MD ENA that improvements in the current system are warranted.

Presently, there are 24 sexual assault designated centers throughout the state of Maryland staffed by SAFE nurses, who use special equipment to conduct the forensic medical exam. On average this exam takes 3 to 4 hours due to the informed consent process, evidence collection, maintenance of chain of custody of evidence, patient counseling, written and photographic documentation, collaboration with a sexual assault advocate, law enforcement and judicial officers, and if needed, other members of the medical and nursing team. These medical and forensic exams take time and resources to assure that the patient is medically and physically safe, and that the victim's discharge instructions and legal options are fully explained.

SAFE nurses develop excellent professional relationships with advocacy networks, law enforcement, and district attorney's offices to assure that victims have safety plans, options for psychological counseling, medications and treatment for injuries. The designation SAFE centers and regionalization of resources have become the national standard of care for sexual assault victims, because the emergency department setting does not always lend itself to having the equipment, certified staff, space or uninterrupted time that is required to provide the appropriate standard of care to victims of all ages and genders 24 hours a day and 7 days per week. In this regard, it is akin to the establishment of trauma centers that provide efficient and effective specialty care to trauma victims.

It is important not to dilute the expertise, competency, and relationships these specially trained nurses have as a result of working in designated centers. Maryland has over 50 hospitals and to



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require these hospitals to have the same resources as the currently designated centers would be a financial burden that many hospitals cannot afford. In addition, training and finding nurses willing to performing these exams would be difficult and costly. Proposals to mandate that all hospitals provide sexual assault forensic examinations would not improve the care of victims in Maryland. While the Maryland Board of Nursing provides oversight for certification of SAFE nurses, no one organizational body oversees the operations of the 24 SAFE centers, and as a result there is not a consistent standard of care or processes. MD ENA also recognizes that the current system of designated centers are understaffed and underfunded. Training nurses, maintaining competency through ongoing education, and maintaining and purchasing state-of-the-art equipment is costly for any organization who sponsors a designated sexual assault center. According to the Maryland Board of Nursing, as of June 2, 2015, the State of Maryland has a total of 215 active certified SAFE nurses, who they name as "Registered Nurse-Forensic Nurse Examiner" or "RN-FNEs." The numbers are detailed below:

- AC-FNE-A (Active Compact - Forensic Nurse Examiner - Adult) = 7
- RN FNE-A-P (Registered Nurse - Forensic Nurse Examiner - Adult & Pediatric) = 58
- RN FNE - A (Registered Nurse - Forensic Nurse Examiner - Adult) = 122
- RN FNE - P (Registered Nurse - Forensic Nurse Examiner - Pediatric) = 8

We need to create a system throughout the state that provides coordinated and appropriate medical care for all victims of sexual assault and rape. This includes coordination and situational awareness of SAFE resources available to health care and law enforcement communities. When trauma injuries occur we ensure that patients are transported to the most appropriate facilities and we must do the same for victims of sexual assault and rape.

To improve the current care provided to sexual assault victims in the State of Maryland, MD ENA is making the following specific recommendations:

- Create a State SAFE Center System similar to our State Trauma System which would ensure victims get to a proper hospital and receive the appropriate care.
- Provide appropriate funding to ensure that all designated centers are properly staffed to provide 24 hour a day, 7 days a week coverage.
- Create a campaign to educate the public about the designated centers for SAFE exams.
- Ensure that there is proper oversight of the care provided to sexual assault victims. There must be a consistent standard of care to ensure that all patients who would like to have a SAFE exam completed by staff with the appropriate clinical expertise can get one.

Patients needing a SAFE exam are a vulnerable population. They deserve timely access to care, and support by a variety of agencies and organizations. MD ENA supports initiatives and legislation that facilitates sexual assault victims receiving the appropriate care, in the appropriate location, by staff with the appropriate clinical expertise.

We thank you for your time and look forward to the opportunity to improve the quality and access to SAFE exams throughout the state of Maryland.



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Testimony 2

The responder conveyed that she felt blamed for her rape and for not reporting it or receiving a rape kit by therapists, hospital ER staff, and social workers. She feels African American women face a stigma and that is the reason why rapes go unreported due to racial stereotyping. She has reviewed her circumstances with various agencies to help her resolve her issues and protect her privacy.



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MCASA Public Testimony Survey Tool

The Maryland Coalition Against Sexual Assault (MCASA) would like to hear from you about your experiences, suggestions, and opinions about rape kit examinations (formally known as “sexual assault forensic exams” or SAFEs). These exams collect evidence that can be used in sexual assault prosecutions.

Last year, the Maryland legislature heard testimony about barriers that victim/survivors face when they sought an exam after sexual assault. Advocates and survivors have reported that many women and men do not realize that only designated hospitals perform the exams. As a result, some survivors had to go from one hospital to another. Other concerns included having little information about where to go or what to do after a sexual assault has occurred, fears about costs (exams are free), not knowing if the doctors or nurses will speak the same language, long waiting times at the hospital, and transportation issues. Nurses and other medical professionals report having too few trained forensic examiners. Attorneys have emphasized the need to have stringent standards so evidence collection will stand up in court.

In response to concerns raised, the General Assembly created the Planning Committee to Implement Improved Access to Sexual Assault Medical Forensic Examinations in Maryland to help improve the current system. MCASA is part of this committee, and we are seeking input from victim/survivors of sexual violence, nurses, advocates, service providers, and anyone else who would like to share their experiences, suggestions, and opinions.

We invite you all to participate in this effort. You may provide your personal information or complete this Request for Public Testimony anonymously. Thank you for taking the time to share your stories and experiences with MCASA and the Planning Committee to Implement Improved Access to Sexual Assault Medical Forensic Examinations in Maryland. Your voice is very important to us and we want to make sure it's heard.

1. The information you share will be provided to the Committee to Implement Improved Access to Sexual Assault Medical Forensic Examinations and will be submitted as part of a public record.

☐ Yes, I understand that the information I provide is not confidential.

2. You have the option of providing your contact information, such as your name, phone number, or email address. Please choose how you want your information to be used:

☐ I give permission to share my contact information as part of the public record.

☐ I give permission to share my contact information with MCASA only

☐ I prefer to not disclose my contact information.

3. Please tell us about your experiences, suggestions, or opinions regarding medical examinations or medical care received after a sexual assault. Many people refer to these exams as “rape kits” or a “sexual assault forensic exam (SAFE)”, but you do not need to have had a forensic exam to provide input. Your story may be as detailed or general as you would like. You are not required to disclose personal information, such as your name, gender, location, etc. and should feel free to use initials or other names to protect privacy.

Please include any information about problems you (or someone you know) encountered or concerns you have about seeking an exam after a sexual assault (often called a rape kit exam or SAFE). We are interested in your experiences whether or not you actually had an exam. For instance, if you decided not to wait for a forensic nurse, decided you didn't want to have an exam, nor had medical treatment without having evidence collected, please let us know.

You should feel free to use this tool if you are an advocate, work with a sexual assault program, or simply would like to express your view on this issue.

Thank you again for taking the time to share your experiences. Your voice is very important to us and we want to make sure it's heard.



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Methodology

From April 6, 2015, to June 30, 2015, MCASA collected statements from victim/survivors of sexual violence, nurses, advocates, service providers, and anyone else who wanted to share input about rape kit examinations. Input was solicited via emails to Maryland rape crisis centers, colleges, SARTs, FNEs, and MCASA's list of over 2000 individuals interested in ending sexual violence. MCASA will supplement its testimony if additional statements are received.

MCASA accepted testimony through an online survey tool and by email, and also encouraged people to testify in person at a Planning Committee meeting or submit documents directly to the Department of Mental Hygiene. The following testimonials were collected from the online survey tool and emails sent directly to MCASA.

All respondents were told that the information they shared would be provided to the Committee to Implement Improved Access to Sexual Assault Medical Forensic Examinations and would be submitted as part of a public record. Respondents had the option to share their contact information as part of the public record, to share their contact information with MCASA only, or to not disclose their contact information. Most respondents chose not to share their contact information with the Committee; contact information for those that did wish to share contact information is included with their statements.

MCASA provided the following prompt in its online tool:

Please tell us about your experiences, suggestions, or opinions regarding medical examinations or medical care received after a sexual assault. Many people refer to these exams as “rape kits” or a “sexual assault forensic exam (SAFE)”, but you do not need to have had a forensic exam to provide input. Your story may be as detailed or general as you would like. You are not required to disclose personal information, such as your name, gender, location, etc. and should feel free to use initials or other names to protect privacy. Please include any information about problems you (or someone you know) encountered or concerns you have about seeking an exam after a sexual assault (often called a rape kit exam or SAFE). We are interested in your experiences whether or not you actually had an exam. For instance, if you decided not to wait for a forensic nurse, decided you didn't want to have an exam, or had medical treatment without having evidence collected, please let us know. You should feel free to use this tool if you are an advocate, work with a sexual assault program, or simply would like to express your view on this issue. Thank you again for taking the time to share your experiences. Your voice is very important to us and we want to make sure it's heard.



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MCASA Public Testimony Report



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Access to Sexual Assault Medical Forensic Examinations in Maryland

Testimony to the Planning Committee to Implement Improved Access to Sexual Assault Medical Forensic Examinations

June 29, 2015

For every 100 rapes, 2 will lead to a felony conviction.¹ According to the 2010 National Survey of Intimate Partner and Sexual Violence, women are frequent victims of sexual assault.² In Maryland, 1 in 5 adult women (about 466,000 adult women) have been victims of rape some time in their lifetime.³ Furthermore, Maryland women have the third highest lifetime prevalence of sexual violence other than rape, totaling an estimated number of 1,248,000 women, or about 54.9% of the female population in the state.⁴

In 2013, 1,169 forcible rapes were reported to the police in Maryland.⁵ However, the National Crime Victimization Survey shows that in 2013, 34.8% of rape and sexual assault victimizations were reported to the police, while the percentages for other violent crimes such as robbery and aggravated assault were 68% and 64.3%, respectively.⁶

Sexual Assault Medical Forensic Examinations collect evidence of sexual violence from a victim/survivor's body and increase the rates of investigation and prosecution.⁷ Prosecution of a

¹ Justice Department, *National Crime Victimization Survey: 2008-2012*; FBI, *Uniform Crime Reports, Arrest Data: 2006-2010*; FBI, *Uniform Crime Reports, Offenses Cleared Data: 2006-2010*; Department of Justice, *Felony Defendants in Large Urban Counties: 2009*.

² Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. (2011). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

³ Ibid.

⁴ Ibid.

⁵ 2013 Uniform Crime Report. Maryland Governor's Office of Crime Control and Prevention. Retrieved from <https://www.mdsp.org/LinkClick.aspx?fileticket=Ynu0iNFwsVE%3D&tabid=429&mid=3218>. A number of other degrees/types of sex crimes such as forced anal or oral penetration were not included in this number.

⁶ Truman, J., Langton, L. (September 2014). *Criminal Victimization, 2013 Bulletin*. Department of Justice.

⁷ Campbell, R., Patterson, D., Bybee, D. (2012). Prosecution of adult sexual assault cases: a longitudinal analysis of a sexual assault nurse examiner program. *Violence Against Women*, 18(2), 223-244 (finding increased rates of investigation and prosecution with SANE programs).



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sex offender may help a survivor seeking justice, but also helps to protect the community from future assaults the perpetrator may have committed. The victim/survivors who undergo forensic exams deserve the community's support and respect.

Maryland's current system for providing forensic examinations places unnecessary burdens on sexual assault survivors. Only one hospital in each county provides sexual assault forensic exams (SAFEs).⁸ Few hospitals have forensic nurses on staff or provide any sort of career opportunities for forensic nursing. Hospitals without SAFE programs are inconsistent in their responses to survivors. Survivors are expected to be transported from one hospital to another, have received bills for forensic services, and experience long waits.

A victim advocate working for a rape crisis center gives this overview:

As an advocate, I have witnessed many survivors sitting in exam rooms for hours before a SAFE exam is offered to them. I have had survivors state to me that they had gone to the hospital closest to them waited for a few hours to be seen, only to be told they had to go to another hospital to get the exam, when they reached the correct hospital they again wait for hours before having the exam completed. All of this time they are kept waiting without being allowed to eat or drink anything, or go to the bathroom.

In 2014, the Maryland General Assembly recognized that Maryland's system is not supportive of sexual assault survivors and enacted HB963. This law requires all hospitals to have a protocol addressing how to respond to sexual assault survivors and created the Planning Committee to Implement Improved Access to Sexual Assault Medical Forensic Examinations. The Maryland Coalition Against Sexual Assault (MCASA) is a designated member of this Committee. This written testimony is submitted as part of the public record and for consideration as the Committee's report and recommendations are developed.

MCASA is a non-profit membership organization that includes the State's seventeen rape crisis centers, law enforcement, mental health and health care providers, attorneys, educators, survivors of sexual violence and other concerned individuals. MCASA includes the Sexual Assault Legal Institute (SALI), a statewide legal services provider for survivors of sexual assault. MCASA represents the unified voice and combined energy of all of its members working to eliminate sexual violence in the State of Maryland.

As a member of the Planning Committee to Implement Improved Access to Sexual Assault Medical Exams, MCASA collected statements from victim/survivors of sexual violence, nurses, advocates, service providers, and anyone else who wanted to share input about rape kit examinations. Statements could be provided on-line or via email and could be made confidentially or anonymously.⁹

⁸ An exception is Anne Arundel County, which currently has two hospitals providing SAFEs (though an advocate from that county reported that SAFE staff at both is so limited that victims often still have to travel to another hospital). Baltimore County also has two sites that can provide SAFEs, but one only sees children 12 and younger.

⁹ MCASA's methodology for collecting these statements can be found later in this document.



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Summary of Online Statements

MCASA received statements from survivors, advocates, service providers, medical professionals, and other concerned individuals. Though some shared positive experiences, the overwhelming majority expressed frustrations with the current system.

As reflected in the statements below, getting a SAFE exam is inherently traumatic and emotionally difficult for victims. The process itself, along with any other medical attention the victim may need, can take hours. Victims cannot bathe, go to the bathroom, smoke, eat, or even drink water so as to preserve evidence of the assault. They must interact with multiple nurses, doctors, advocates, police officers, and sometimes other professionals before, during, and after the exam, some of whom are experts at working with survivors and others who have little or no training about how to deal with their specific needs.

Unfortunately, flaws in the current system are causing this experience to last longer and be more difficult for victims than it needs to be. Victims in some jurisdictions often have to travel to a different hospital than the one closest to them in order to find a SAFE program and get an examination. Additionally, victims who self-present at a hospital that does not provide SAFE exams have been told they must find their own transportation to a different facility. Even when they do manage to get to the “right” hospital, victims often wait hours for a forensic nurse examiner (FNE) to arrive. Though the exams are now required by law to be free, victims are still receiving medical bills for ancillary services.

Additional Issues

In addition to collecting statements electronically, a number of witnesses provided statements to the full committee. MCASA wishes to highlight the following points from those presentations:

SAFE program participants. In addition to sexual assault forensic nurses, it is a nationally recognized best practice to have advocates as a part of SAFE programs. Advocates are rape crisis center staff or volunteers who provide critical support for survivors during the forensic exam, and also are able to connect survivors with resources beyond the SAFE. When an advocate is present during a sexual assault forensic exam, survivors are likely to get better medical treatment, experience less distress, and seek out more services from community professionals.¹⁰ SAFE programs should be connected and in close communication with local Rape Crisis Centers to ensure that an advocate is always present when a survivor undergoes a SAFE.

SARTs. Sexual Assault Response Teams (SARTs) are multidisciplinary teams that provide specialized responses for sexual assault victims while encouraging victim participation in the criminal justice system and improving safety for the general public. A SART is also described as an intervention model for sexual violence that includes a core group of disciplines working together, formally or informally.¹¹ Generally, counties with SARTs can effectively meet the challenges of responding to sexual assault better than counties that do not have SARTs, and they can help increase the probability of a victim cooperating and staying involved in the investigation

¹⁰ Campbell, R. (2006). Rape survivors' experiences with the legal and medical systems: Do rape victim advocates make a difference? *Violence Against Women*, 12(1), 30 – 45.

¹¹ Report on the National Needs Assessment of Sexual Assault Response Teams (March 2006). National Sexual Violence Resource Center. Retrieved from: http://www.nsvrc.org/sites/default/files/file/Projects_SART_Report-on-the-National-Needs-Assessment-of-SART.pdf.



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and prosecution of the case.¹² In fact, according to the Urban Institute, the conviction rates in rape cases increase dramatically in communities that formally organize a Sexual Assault Response Team (SART), indicating an increased need to continue to develop, implement, and enhance Sexual Assault Response Teams across the State.¹³ A study entitled, “Testing the Efficacy of SANE/SART Programs: Do They Make a Difference in Sexual Assault Arrest & Prosecution Outcomes?” states that “overall, the findings are quite supportive of SANE/SART programs and their efficacy as a tool in the criminal justice system.”¹⁴ This study also states that both SANE- only (those with programs similar to the SAFE programs in Maryland but without SARTs) and SANE/SART cases are reported more quickly, have more evidence available, and have more victim participation than non- SANE/SART cases. SANE/SART interventions, the study found, “significantly increase the likelihood that charges will be filed in sexual assault cases.” Ideally, SAFE programs should participate in local SARTs in order to maximize the benefits of both. When survivors have to travel far from their community to access a SAFE exam, it makes it less likely the SAFE program that sees them will participate in the survivor’s local SART.

Local Connections, Local Services. Several of the expert witnesses, committee members, and statements provided show the importance of local connections for sexual assault survivors. While other medical specialties may make use of a regional approach (for example, the designated trauma center system in Maryland) the response to sexual assault survivors is not solely medical. A survivor who chooses to use the criminal justice system will benefit from a forensic program with local prosecutors and law enforcement. Each jurisdiction is served by rape crisis centers which can provide advocates, counseling, information, referrals, and support. MCASA strongly supports SAFE responses that can maintain and strengthen community-based connections for survivors.

Nursing Staff. Another consistent theme from experts was the need to update the staffing model for nurses at SAFE programs and for forensic nursing generally. A handful of successful Maryland programs have one or more SAFE nurses on staff and then supplement with on-call nurses for hours when there is not staff coverage. However, many SAFE programs currently utilize only on-call nurses and are often short-staffed. SAFE program coordinators and other medical professionals noted a high burnout rate for nurses who become certified to perform SAFEs, with some nurses only remaining in the program for two years after completing the training, due not only to the stressful nature of the work, but to the on-call model that did not provide enough incentives to continue in the programs. The International Association of Forensic Nurses and others noted that forensic nursing is broader than sexual assault-related exams, and supports creating programs and career tracks for forensic nurses. MCASA is devoted to responding to sexual assault survivors, however, we believe this approach falls in line with the adage that a rising tide lifts all boats and development of general forensic programs merits support as a long term goal.

Oversight. MCASA is concerned about the lack of statewide oversight for SAFE programs and encourage policymakers to consider carefully where this oversight should be housed. Though forensic exams include medical components, the purpose of a forensic examination also includes collection and preservation of evidence. As mentioned above, investigation, arrest, and

¹² The SART Handbook (2009). Oregon Attorney General’s Sexual Assault Task Force. Retrieved from: <http://www.evawintl.org/images/uploads/Documents/SART-Handbook-Oregon-09.pdf>.

¹³ Burt, M. R., et. al. (September 2001). *2001 Report: Evaluation of the STOP Formula Grants to Combat Violence Against Women*. Washington, DC: Urban Institute.

¹⁴ Nugent-Borakove, M., Fanflik, P., Troutman, D., Johnson, N., Burgess, A. & Lewis O’Connor, A. (2006). *Testing the Efficacy of SANE/SART Programs: Do They Make a Difference in Sexual Assault Arrest & Prosecution Outcomes?* American Prosecutors Research Institute.



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prosecution rates increase when SAFE programs are effectively implemented.¹⁵ An agency familiar with law enforcement, prosecution, and litigation may be best positioned to oversee SAFE programs generally, with medical issues continuing to be addressed by the appropriate medical boards.

MCASA looks forward to working with the Planning Committee and incorporating these comments and concerns into its recommendations to implement better access to SAFE exams in the state of Maryland.

Statements Received Online

Statement #1

To MCASA, the experience I had with the Safe Kit is all the people one must go through to receive one. You have to speak to a Police Officer, hospital staff, the Doctor on call at the ER, & then the Safe Kit staff and then all the Counselors. I had one performed in late July of 2014 & still haven't been able to get any results yet. Not from the Officer or hospital staff that performed the testing. Still today being violated in the new apartment that I moved to & already called the Police for the same things that took place before. What is this world coming to when a person work to pay their rent just to be violated?

Statement #2

I hear three things that continue to be problems—lack of privacy—too many staff in asking questions and police are too aggressive—need to get rape kit down first and then talk to police. Also, problems with hospital billing since this is use of an ER—many insurances coverage insufficient and left with large debt. Thank you for all your work.

Statement #3

In Anne Arundel County, there is very limited availability of pediatric SAFE nurses. Both AACo hospitals have such limited SAFE staff that most of our victims have to travel to Howard General Hospital or Mercy Hospital in Baltimore City.

Statement #4

In all of our efforts, Victims are First. More Sexual Assault Medical Forensic Examination Access Sites are needed, especially in outlying areas. Keep up the GOODWORK.

Statement #5

My wife experienced being molested as a child as well as her daughter being molested by her father. In both cases, examinations were impersonal and very clinical. We realize it is necessary but would suggest empathy for the experience is taking into consideration as well.

Statement #6

As a service provider, my biggest concern is that we only have one hospital in the county that performs SAFE exams. When clients report to the other hospital they are told they need to find their own way to the SAFE exam hospital.

Statement #7

Many times victims wait for hours for a SAFE nurse to do the SAFE exam. Often times victims are transferred to a different hospital as no SAFE nurse is available.

¹⁵ See *supra*, notes 7, 13 & 14.



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Statement #8

The SAFE exam has been a useful tool for my clients and have been educated of what the exam is used for. Most did not know about this exam until they were informed what the test was for and how it could help with police investigation.

Statement #9

I work in Baltimore, and the SAFE program in our jurisdiction *very frequently* sees victims from Anne Arundel County. I understand there are "SAFE programs" in both Annapolis and Glen Burnie, but they are not staffed by FNEs 24/7. As an Anne Arundel County resident myself I find this very problematic; AA Co is a large area and to be transported from Annapolis to Baltimore for a SAFE seems absurd and burdensome. Many of the victims express a lot of frustration about this, and understandably so. I have wondered through the years if the AAMC and BWMC programs might merge so that they can actually offer a 24/7 local response.

Statement #10

As an advocate, I have witnessed many survivors sitting in exam rooms for hours before a SAFE exam is offered to them. I have had survivors state to me that they had gone to the hospital closest to them waited for a few hours to be seen, only to be told they had to go to another hospital to get the exam, when they reached the correct hospital they again wait for hours before having the exam completed. All of this time they are kept waiting without being allowed to eat or drink anything, or go to the bathroom. If the victim chooses to eat or drink or go to the bathroom, I have witnessed some nurses make the survivor feel that the exam is a waste now because some of the evidence cannot be correctly collected. I have also seen wonderful SAFE nurses who explain things in a comforting manner and offer the survivor choices in the decisions without any judgement or pressure.

Statement #11

As a SAFE advocate, I know that the SAFE process can often be long and emotionally exhausting for survivors. A patient may be at the hospital anywhere from 3 to 8+ hours (start to finish) to complete an exam. Sometimes, the victim and I will be waiting around for long periods of time, which often has more to do with waiting on other hospital staff (like doctors, getting medications/discharge paperwork, etc.), but occasionally on forensic nurses and law enforcement. Additionally, the process of getting HIV prophylaxis is very unclear and often tedious for survivors/advocates.

Statement #12

1. During the narrative part of the SAFE exam, victims most often share what happened, but not necessarily their sensory responses. Even sensory details can assist in establishing evidence that will hold up in the courtroom.
2. Many SAFE programs take pride in touting how they can perform the Rape Kit Exam in record time. At first blush, this seems like a good way to keep the victim from having to spend more time in the hospital than they would like. But it's far more important to cross every "T" and dot every "I", but this, of course, takes more time. The extra time taken can often make the difference in the courtroom between establishing credible evidence and shoddy evidence collection, which could ultimately deprive the victim of an air-tight case.
3. FNEs are often times so focused on the sexual assault that they miss the opportunity to define the existing relationship between the offender and the victim as one of domestic or dating violence. I'd like to see a push educating FNEs on understanding the dynamics of the intimate partner violence-connect, so they can see the relationship through another lens as they work with victims.



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4. Volunteer victim advocates are essential to the victims' first step on their journey to healing. There have been studies confirming this.

Statement #13

Overall, I didn't have much trouble with having the SAFE. I had initially called the police, and they sent two female officers to my home that then drove me to a local hospital where we waited for a female forensic nurse. The two female officers were respectful to me. However, the nurse said something odd about how it appeared that I had been wiping myself (with toilet paper) too hard. I thought that a SAFE was a highly inappropriate event during which to critique my bathroom wiping skills, and I like she was calling me a fake and a liar and that I didn't deserve to have a SAFE. Other than that one comment, the overall experience was mostly how I might have expected: somewhat clinical and impersonal. I was thankful to have the two female officers who were supportive and who didn't say accusatory things to me or treat me like a liar.

Statement #14

the process takes a very long time. I am an advocate...

if the victim is "lucky" enough to go to a hospital that provides the exam, AND they have available staff, it can still take a very long time for things to happen. It takes time to get the advocate there, then to get the FNE on site, the exam itself takes a long time and then the time to get processed out of the hospital takes time. it is nothing for a victim to be at the hospital for 6 -12 hours. They want to shower, go home, go anywhere other than there talking to police, FNE etc... So it is a very emotionally and physically difficult time. To then get a bill for anything related to the exam deters victims is horrible! everything should be covered by the state... it shouldn't have to go through insurance or private pay. they don't need the additional stress of getting an ambulance fee etc.... in some ways it would be nice if each county had its own center... a one stop shop where a victim could go for care and forensic exam. So there was never a question of where to go, and there would be staffing guaranteed. Of course the challenge to that is if the victim is hurt and needs medical care too... there are no easy answers but access to exams is terrible and victims are put through a lot! Honestly I don't think I would go through it if I was sexually assaulted. I would just get medical treatment and counseling.

Statement #15

Sexual assault victims need choices in terms of which hospitals they would like their forensic exams to be conducted. It should not be for the convenience of a Rape Crisis program, Police or Nurse. Each County or jurisdiction should have a roving team of forensic nurses that are specially affiliated with all local hospitals so that if a rape victim shows up at their local or favorite hospital they are not turned away and told to go to another facility. Some victims are injured and should not travel. Also some victims are forceful in their opinion that they will not go to a certain hospital and choose not to collect evidence. Exams are now taking too long because the few nurses are on call and they may be coming from a long distance away. Even though sexual assault outreach volunteers and Rape Crisis programs would have to establish AGAIN relationships and working agreements with many area hospitals still this is all about what is best for the rape/sexual assault survivor, not what is convenient for us. Additionally, some hospitals do not want to do this task because they say it is costly and they do not want to lose money. The State should figure out how to financially assist so that all hospitals are capable. Can a roving team of nurses carry all they need with them to provide the state of the art exams that are needed? Can each hospital provide a comfortable, safe and welcoming environment where rape victims can be prioritized and not have to spend hours waiting for an exam? Victims are not allowed to drink if there was oral penetration, they can't go to the bathroom



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because it might destroy evidence, they can't brush their teeth until all the exams are finished, so the response time from nurses and hospitals need to get better. Additionally it is very important for forensic exams to take place BEFORE police investigations are conducted. I know detectives want to interview victims very quickly because of recall, however the health, safety and wellbeing of the victim should come always first.

Take the nurse experts to the victims, wherever hospital they are located. Some jurisdictions are not even using hospitals any more....

Statement #16

I know a woman in my program for domestic violence that was sexually assaulted by her husband. She is intellectually limited, not quite in a normal range and Spanish-speaking. I know that not all situations can be foreseen and assistance offered, she did not understand what happened to the forensic findings after the exam and her right to the information. I suggest closer attention be given to insure an examinee understands her or his rights regarding the exam.

Statement #17

SAFE nurses are not always available, in which case some patients are sent to Children's National Medical Center in DC for the child abuse team/SANE program. While we are pleased to help these families, we do not get any financial support from the State of Maryland for the forensic medical services provided by our team. More importantly, young patients acutely sexually assaulted have difficulty receiving the appropriate medications for HIV prophylaxis, which is critical in this high prevalence area.

Statement #18

My sexual assault occurred 25 years ago so I'm hoping that the tools have changed since then. I was a minor at the time, around eight-years-old, and I was taken into a room with a male doctor and my mother. I don't remember him using a speculum. However, I remember stating that I didn't feel comfortable with him examining me, especially since I was assaulted by a man. He didn't have much of a bedside manner. I didn't tell anyone that the man's son had also violated me but he may have noticed something in my anal area if he had examined that area as well. I feel guilty about not saying anything then.

Statement #19

The local hospital ED at Western Maryland Health System has 2 very qualified Forensic Nurses who are always available in case of a sexual assault. There is no cost for this service so that is not a barrier. They also provide follow-up exam in 5-6 weeks at no cost which is often not utilized. The problem with some students on the FSU campus is transportation to the facility, which is approx. 15 minute drive. There is no public transportation that can take them directly there. Taxi service costs about \$25 one way. They often have to try to find a friend with a vehicle to transport them. There is also a great need to educate students about the value of the forensic exam. There have been situations where students were actually talked out of the exam by well-meaning friends or sorority sisters.

Statement #20

Only certain hospitals like Mercy Hospital in Baltimore offer SAFE exams- also, often it can take up to an hour for a SAFE nurse to come and do the exam, which is difficult for the patient. I would try to increase SAFE kit access and SAFE nurse numbers.



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Statement #21

As an ER advocate for SA victims I recently saw a victim whose memory was very foggy as to what had happened. She is from out of town & had been in Baltimore for work related job training. She remembers being at a bar & having a few beers. The next thing she remembers is waking up the next day in her hotel room with bruises, a very sore/stiff neck & vaginal pain. Myself & her co- worker that accompanied her to the ER suspect she may have been drugged & that is why she does NOT remember what happened. For fear of her employer finding out that she may have been raped, or having her husband in another state find out, she wanted the rape kit to be kept anonymously. The SAFE nurse informed her that the rape kit would just sit on a locked shelf & not actually be processed until she chose to do so. She wanted to determine if she had been drugged and the nurse told her that she would have to process the rape kit under her name & collect the evidence in order to determine that information. This seems very unfair as this woman is married & the mother of 2 small children. She needed immediate answers before going back home to her husband & kids.

Statement #22

Adam Burston, adbur001@mail.goucher.edu

Many survivors of sexual assault experience these examinations as intrusive. Therefore, medical practitioners should be as warm and comforting as possible to mitigate the experience of further bodily intrusion. I know this as a trained advocate and a friend to those who have been sexually assaulted.

Statement #23

I am a victim advocate in Maryland. I have had many experiences where individuals who had just been raped are left to sit in the "family room" for up to 4 hours until the forensic nurse came. I think that this type of waiting is extremely discouraging and often makes individuals question themselves and what they are doing in the hospital. However, once the SAFE nurse comes, I have heard very positive feedback about having what is happening described to them in detail by the nurse as well as just overall friendly and positive care.

Statement #24

In another state, a response team was created to include a SANE nurse, advocate, and law enforcement which all responded to the hospital when a victim arrived at any ER in the area. This was a joint effort and agreement between all the parties and hospitals which housed an exam room on standby. This allowed for a swift collection and support of the victim and their family. Here in Maryland, there are so many 'holes' that prevent and deter victims from reporting starting from the barrier to receiving a rape kit. Only select hospitals or individual doctors that aren't even publicly known to individuals to secure one. Allowing an individual to respond to their closest hospital for care and examination is best and should be advocated for their best interest in terms of health concerns and the public's for collection of evidence.

Statement #25

Had a victim discouraged from getting the exam, and basically told that it wouldn't make a difference and her case was not something that could be prosecuted (by a police officer).

Statement #26

I was very young when I was raped (13) and too embarrassed to tell anyone. I was terrified of going to a hospital. I just wanted to forget it ever happened. I was ashamed as if I had caused it. Even if I had been brave enough to go to a hospital and I had to be sent somewhere else or had to wait for a nurse, I would have left. It was so traumatic. The thought of having to go through a big



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deal just to have strangers poke and prod at your most vulnerable parts that have just be so violated still makes me sick to stomach.

Statement #27

From working in this field, I have seen and heard many things regarding care after a sexual assault. One thing that I noticed, is that both hospitals in the county where I am from do not provide the same level of treatment for sexual assault. What this means is that one hospital provides SAFE exams, while the other does not. This makes the situation extremely difficult and extra stressful for the client who is involved in the sexual assault. He/she needs to find their own transportation from the hospital to the other hospital where they can then receive treatment. I have also found that at night, some of the staff does not provide the same level of compassion that clients/patients may receive in the afternoon or daytime.

Statement #28

Fatima Burns, 301-314-9383, fburns1@umd.edu

Students who seek support from campus sexual assault programs can pursue resources both on and off campus. In our experience at UMD College Park, students generally anchor to on-campus resources and have very seldom sought out a SAFE exam at the local hospital. Our experience has been that females who are impacted by sexual assault usually seek an appointment at the campus health center and males who are impacted by rape generally do not seek medical attention. While a SAFE exam may be more accessible to survivors if they are facilitated at the campus health center, health centers are not equipped to handle the complexities of the examination process. Additional considerations must be given to opening and accessing the health center after hours since most report their assault happening after the health center closes. Our health center will not be able to handle medical emergencies that extend beyond the scope of the exam administered by the SAFE nurse and a survivor may ultimately be referred to the ER for more comprehensive care. Unfortunately campuses are not ready to take on this task effectively.

Statement #29

Wendy Lane, wlane@epi.umaryland.edu

I am a child abuse pediatrician who provides medical evaluations for children who have been sexually abused and sexually assaulted. I do acute evaluations at MedStar Franklin Square Medical Center and non-acute evaluations at the Howard County Child Advocacy Center. I am also a CHAMP faculty member. CHAMP provides training and peer review to physicians and nurses who conduct medical/forensic evaluations for children with suspected sexual abuse, physical abuse, and neglect. From my perspective as a provider, I see a fairly disjointed system throughout the state. While some jurisdictions have good resources and services, many struggle to fund their hospital and/or CAC based programs and to maintain a pool of experienced providers. Most FNEs and pediatricians do this work part time - while sexual assault occurs frequently, the need for someone to do a forensic exam is somewhat sporadic, especially in smaller counties. Fortunately, there isn't enough work to sustain a full-time position, in most jurisdictions. However, that means that providers are paid to take call and to come in to the hospital or center when an exam is needed. While FNEs are paid to do call coverage, they often aren't paid to participate in the extremely important follow-up work - e.g. participating in SART meetings. Given the part-time nature of the work, the difficulty of the work, and the need for other sources of income, many FNEs are unable to do this work for extended periods of time, so there is frequent job turnover, gaps in coverage, and loss of experienced providers. For both nurses and physicians, peer review is recommended by our professional societies. Peer review is required for FNE licensure. However, there is no formal system in place for how peer review is conducted. For physicians, there is not even a formal requirement for peer review. The state's payment system for



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these exams contributes to the difficulties with program sustainability. Currently DHMH provides reimbursement of \$80/hour for sexual abuse/assault evaluations, to cover all services. This amount was established in statute when the payment system was created at least 20 years ago, and has never been increased. A more sustainable system would provide excellent training, and support to physicians and nurses, and would provide compensation for the time spent doing both the medical and forensic work, and the necessary follow-up care to ensure that women and children who are victims of sexual abuse and assault receive the appropriate follow-up services.

Statement #30

I work for a non-profit which provides a hospital companion to victims of sexual assault/domestic violence. I have been to several calls where a victim has undergone a SAFE exam, during which I was present, or outside the room. I have always had "good" experiences in these situations. Harford Memorial Hospital has an amazing program and great nurses. They have a separate wing of the hospital, and a coded-lock room, to use for SAFE exams. As well as a private bathroom with a shower for the victim. The nurses are all extremely accommodating to the victims, as well as the companions. They allow the victim to take their time, and also allow the companion to speak with the victim alone if they wish. They are also very good about respecting my organization's confidentiality policies.

Statement #31

I assist victims of rape and sexual assault. Even though the "rape kits" are supposed to be free to the victim (paid for by the MD DHMH), we have had numerous instances where either the hospital or one of the medical providers hounds the victim for payment and in some cases gets a collections agency to go after the victim. This invariably happens because the hospital and/or the provider is not following proper procedures to be reimbursed for the SAFE exam and related expenses by the state, and it is usually difficult to get the error straightened out. The providers need to establish a proper procedure for getting their reimbursement so that the victim does not have to be further victimized by being hounded, or, in some cases, having their credit wrongfully ruined.

Statement #32

Title IX Coordinator

A sexual assault situation was referred to me. The victim had a developmental/intellectual disability. I spoke with the caregiver about the process and the nearest location, courtesy of the MCASA list of sites. She and the victim were referred to a northern Anne Arundel County hospital that professed to have a SAFE trained nurse. They arrived at the ER and there was no SAFE nurse on duty. Their plan was to transport the victim to Mercy. Our local police intercepted to transport and support them. Reported difficulties included navigating 3 hospitals. Staff and local police being impatient with working with the victim - the victim regressed substantially once an exam was going forward. The guardian was disappointed with how the procedure was handled at GBMC. An advocate did accompany the victim & guardian, however the advocate seemed to not understand that when the family member wanted to leave campus with the victim, we were unable to compel them to stay - there were no papers, guardianship or PoA, that prompted them to act against "I want to go home" - even though the campus wanted to support the victim. They continued with Special Olympics prep. The alleged perpetrator was banned and trains elsewhere. These folks should not have had to drive all over MD for the exam. Examiners should come to them if they are not already on staff. Training on working with victims with intellectual/developmental/mental disabilities should be expanded.



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Statement #33

Recently, in our area, Cecil County, Union Hospital an ER physician came into the examining room and questioned the victim of "why she was not willing to press criminal charges against her perpetrator". This victim was cut up by a sharp object and was not able to identify her perpetrator. The rape advocate witnesses the victim's reaction as she shut down totally for any services. In conclusion, the medical doctors need to be reminded that the criminal portion is the rights of the victim. Our FNE nurses have been very supportive and quick to have the victim's medical needs assessed prior to any SAFE exam.

Statement #34

I have worked at the YWCA of Annapolis and Anne Arundel County for 4 years. During this time, I have been to the hospital several times on hospital calls where some of the issues that I have noticed consist of not having enough forensic nurses, having to transfer victims/survivors from one hospital to another, and having to wait for a nurse until the morning.

Statement #35

I have found that the Calvert Memorial Hospital forensic nurses are very thorough and compassionate. My concern is the lack of clothing in extended sizes for women to wear home. I also found this to be a problem in P.G. County while accompanying a friend to the hospital.

Statement #36 Michele Corley

I have never been a victim but respond to the hospital to offer support to victims. I've never had someone complain about the exam to me and in fact, they've made comments about how nice and supportive the nurses doing the exam are.



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Appendix S: Maryland State Police Victim Sexual Assault Evidence Collection Kit

AFFIX ENCLOSED BIOHAZARD LABEL AFTER SPECIMEN/EVIDENCE COLLECTION	 MARYLAND DEPARTMENT OF STATE POLICE VICTIM SEXUAL ASSAULT EVIDENCE COLLECTION KIT	AFFIX ENCLOSED "ANONYMOUS COLLECTION" STICKER IF APPLICABLE
FOR HOSPITAL PERSONNEL		
HOSPITAL: _____ VICTIM'S NAME: _____ EXAMINER'S NAME: _____ PROPERTY HELD NUMBER: _____ OTHER CASE NUMBER: _____ POLICE CASE NUMBER: _____ TYPE OF OFFENSE: _____		
OFFENSE DATE _____ TIME: _____ am/pm EXAM DATE _____ TIME: _____ am/pm PLACE KIT IN SECURED STORAGE AREA PLACED BY: _____ DATE: _____ TIME: _____ am/pm (Please Print)		
FOR POLICE PERSONNEL CHAIN OF CUSTODY		
RECEIVED FROM: _____ DATE: _____ TIME: _____ am/pm RECEIVED BY: _____ DATE: _____ TIME: _____ am/pm RECEIVED BY: _____ DATE: _____ TIME: _____ am/pm		



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MARYLAND DEPARTMENT OF STATE POLICE VICTIM SEXUAL ASSAULT EVIDENCE COLLECTION KIT INSTRUCTIONS

This kit is designed to assist the medical staff in the collection of evidentiary specimens for analysis by Maryland Crime Laboratories. The hospital is not encouraged to analyze any of the specimens collected in this kit. Any specimens required by the hospital are to be collected with hospital supplies and **AFTER** crime laboratory evidence is taken.

STEP 1 **MEDICAL EXAMINATION AND REPORT OF ALLEGED SEXUAL ASSAULT FORM**

Complete the form for all requested information. The victim and witness must sign and date, where indicated. The white copy is given to the investigating officer; the canary copy is given to DHMH (for reimbursement); pink copy is maintained at the hospital.

STEP 2 **HISTORY AND MEDICAL REVIEW**

Perform medical interview of the victim and obtain a narrative of the events related to the assault. (Use the enclosed form: Medical Narrative Notes.) Give pertinent details such as: oral, rectal, vaginal penetration, digital penetration or use of a foreign object, oral contact by the assailant, oral contact by the victim, ejaculation, and location of such.

STEP 3 **CLOTHING AND UNDERWEAR**

Collect victim's outer clothing if worn during the time of the assault and place each item into a separate paper bag. Collect victim's underwear and place in the underwear bag. Close and seal all bags and complete the requested information on the bag labels.

- Note:
- 1) Wet or damp clothing **MUST** be air-dried before packaging.
 - 2) If victim is not wearing the clothing worn at the time of the alleged assault, **collect only those items that are in direct contact with victim's genital area.**
 - 3) If victim has changed clothing after the assault, inform the investigating officer so that the clothing worn at the time of the assault may be collected by the police.
 - 4) **Do not** cut through any existing holes, rips or stains on victim's clothing.
 - 5) **Do not** shake out victim's clothing as microscopic evidence may be lost.
 - 6) If necessary, have the victim stand over a sheet or blanket to prevent loss of microscopic evidence. This can then be folded and packaged appropriately and separately for the police.

STEP 4 **DEBRIS COLLECTION** (Collect only if applicable)

Remove one of the paper folds provided in the Debris Collection envelope. Unfold and place on a flat surface. Collect all foreign material found on victim's body (leaves, fibers, hairs, etc.) and place in center of the fold. Refold paper in manner to retain debris. Return the fold to Debris Collection envelope and seal the envelope. Complete the requested information on the outside of the envelope.

STEP 5 **BITEMARK/LICKING SWABS (2)** (Collect only if applicable)

Remove the set of swabs from the Bitemark/Licking Swabs envelope. Moisten one swab with distilled water and thoroughly swab the area. Use the second dry swab to absorb any remaining moisture around the bitemark/licking area. Allow both swabs to air dry, then return to the Bitemark/Licking Swabs envelope and seal the envelope. Complete the requested information on the outside of the envelope. **Note: Have the victim attempt to pinpoint the area in question and concentrate the swabbing to that area.**

STEP 6 **ORAL SWABS (2)** (Always collect)

Remove the set of swabs from the Oral Swabs envelope. Using one swab, rub the inside of **left** cheek and **left** gumline (inside under the tongue and outside). Using the other swab repeat on the **right** side of the mouth (**right** cheek and **right** gumline). Allow both swabs to air dry and return to the Oral Swabs envelope and seal the envelope. Complete the requested information on the outside of the envelope.

STEP 7 **PULLED HEAD HAIRS** (Total of 25 hairs)

Pull, **DO NOT CUT**, a minimum of five full-length hairs from each of the following scalp locations: center, front, back, left side and right side for a total of **25 hairs**. Place in Pulled Head Hairs envelope and seal the envelope. Complete the requested information on the outside of the envelope. Make sure the hairs are not protruding from the envelope.

STEP 8 **PUBIC HAIR COMBINGS**

Remove the paper towel and comb provided in Pubic Hair Combing envelope. Place the towel under victim's buttocks and using the comb provided, comb pubic hair using downward strokes so that any loose hairs and/or debris will fall onto the paper towel. Fold towel in a manner to retain both the comb and any evidence present. Return to the Pubic Hair Combing envelope and seal the envelope. Complete the requested information on the outside of the envelope.

STEP 9 **PULLED PUBIC HAIRS** (Total of 25 hairs)

Pull, **DO NOT CUT**, a minimum of 25 full-length pubic hairs from various locations and place in the Pulled Pubic Hairs envelope and seal the envelope. Complete the requested information on the outside of the envelope. Make sure the hairs are not protruding from the envelope.



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STEP 10 FIRST VAGINAL SWAB (1)

Prior to the speculum exam and use of toluidine, use the swab provided and carefully swab the vaginal pool and walls. Air dry the swab, package in the First Vaginal Swab envelope and seal the envelope. Complete the requested information on the outside of the envelope. **Note: If hospital policy requires that you make a slide (the MDSP will not provide a slide), make the hospital slide after the collection of the evidence swabs. Do not use any of the first 4 swabs to make a slide. If making a slide and it is submitted to the MDSP Forensic Sciences Division, make sure the slide is properly labeled. THE MDSP FORENSIC SCIENCES DIVISION DOES NOT ENCOURAGE THE MAKING OF ANY SLIDES.**

STEP 11 VAGINAL/CERVICAL SWABS (3)

Using two swabs simultaneously, carefully swab the vaginal pool, walls and cervix. Repeat the same procedure using the remaining swab. Allow the swabs to air dry, return to the Vaginal/Cervical Swabs envelope and seal the envelope. Complete the requested information on the outside of the envelope. **Note: It is not necessary to collect more than 4 vaginal/cervical swabs. The MDSP recommends that if the exam occurs within 5 days of the assault, vaginal/cervical swabs should be collected.**

STEP 12 ANAL SWABS (Collect only if applicable)

Using the two swabs simultaneously, carefully swab the anal cavity. Allow both swabs to air dry and then return them to the Anal Swabs envelope. Complete the requested information on the outside of the envelope. **Note: If drainage has occurred from the vaginal cavity, designate one of the swabs as "external or perianal," allow to air dry and place the paper fold provided over the tip of the swab and return it to the Anal Swabs envelope and indicate the origin of the swabbing. Use the second swab to collect an anal cavity sample.**

STEP 13 FINGERNAIL SCRAPINGS (Collect only if the victim claims to have scratched the assailant or doesn't remember)

Left Hand: Remove one of the paper folds and fingernail scrapers provided with envelope. Hold the victim's left hand over the open paper and scrape under all five fingernails allowing any debris present to fall onto the paper. Place the used scraper in the center of paper and refold to retain the debris and scraper. Mark the paper fold "Left Hand."

Right Hand: Follow the same procedure for the right hand and then place both folds in the Fingernail Scrapings envelope and seal the envelope. Complete the requested information on the outside of the envelope.

STEP 14 KNOWN BLOOD SAMPLE

****The expiration date of the kit refers to the blood collection tube, if expired replace with an in-date EDTA purple-top tube.**

Using acceptable medical procedure and the blood collection supplies provided, collect a blood sample from the victim. Invert the tube several times to mix the blood with EDTA. **Label the blood tube with the victim's full name (at a minimum).** Place the filled and labeled blood tube into the plastic screw-top tube and place into the ziplock bag. Complete the requested information on the outside of the bag. Discard the blood collection supplies as required by OSHA and hospital guidelines. **Note: If the hospital has established a procedure to place the liquid blood sample onto a stain card (this is not required by MDSP Forensic Sciences Division), proceed to label the stain card (full name and collector's initials at a minimum) and using the provided disposable pipette, fill the circles located on the stain card with the blood sample from the EDTA tube. Allow this to air dry undisturbed and place into the provided #5 1/2 coin envelope. Label the envelope with the victim's full name and collector's initials (at a minimum). Place the coin envelope into the ziplock bag and complete the requested information on the outside of the bag. Please discard blood tube after spotting.**

STEP 15 MISCELLANEOUS COLLECTION (2 Swabs and 1 Paper Fold)

This envelope is to be used when there are unusual circumstances in a case. If additional samples are needed, swabs and a paper fold are provided in this envelope. (Ex: Skin swabs for semen, penile swabs for a male victim, vaginal drainage, external genitalia, etc.). It may be necessary to wet the swabs (with sterile water) slightly prior to swabbing the skin. If used, ensure that the envelope is properly sealed and labeled with an indication as to source/reason for collection.

STEP 16 PHYSICAL EXAMINATION AND COLLECTION OF EVIDENCE OF RAPE/SEXUAL ASSAULT FORM (DHMH-2347)

Complete ALL information requested on the form, sign and date where indicated. ALWAYS give the canary copy to the Crime Lab (enclose in the kit when sealed) with a narrative of the event (Step 2).

STEP 17 CRIMINAL OFFENDERS-HIV TESTING-VICTIM NOTIFICATION FORM

This form should be completed by the examiner and given to the victim.

FINAL KIT INSTRUCTIONS BEFORE SUBMITTING TO THE FORENSIC SCIENCES DIVISION

- Seal all collection envelopes.
- Complete the requested information on the outside of the envelopes.
- Return all items (except for clothing bags) to the outer kit envelope, along with Physical Exam and Medical Narrative Form (Step 16 and Step 2). If unused envelopes are returned, indicate on the envelope why the item was not collected.
- Affix the provided police evidence tape over the closed flap of the envelope to completely seal the opening. Initial across the seal onto the kit in one continuous motion.
- Complete the requested information on the outside of the kit under "For Hospital Personnel".
- Affix the enclosed biohazard label to the front of the kit, where indicated.
- Hand the sealed kit and other evidence to the investigating officer or place into an appropriately secure storage area.
- Indicate on the outside envelope if the blood sample has been spotted and the date it was spotted.



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STEP 17

CRIMINAL OFFENDERS - HIV TESTING - VICTIM NOTIFICATION
(CRIMINAL PROCEDURE ARTICLE SECTION 11-107-107 THRU 11-117)

THE LAW PROVIDES FOR:

- A VICTIM OF AN OFFENSE WHICH MAY HAVE RESULTED IN AN EXPOSURE MAY REQUEST, IN WRITING, TO THE OFFICE OF THE STATE'S ATTORNEY, A HEARING TO DETERMINE IF PROBABLE CAUSE EXISTS FOR THE COURT TO ORDER A PERSON CHARGED, WITHIN ONE (1) YEAR FROM THE DATE OF THE OFFENSE TO SUBMIT A BLOOD SAMPLE TO TEST FOR THE PRESENCE OF HIV (HUMAN IMMUNODEFICIENCY VIRUS).
- IF THE PERSON CHARGED WITH AN OFFENSE IS CONVICTED OR GRANTED PROBATION BEFORE JUDGEMENT (PBJ), IN COMPLIANCE WITH CRIMINAL PROCEDURE ARTICLE SECTION 6-219 THRU 6-222 (ACM), THE COURT ORDER SHALL ORDER A BLOOD SAMPLE TO BE TAKEN FOR THE PURPOSES OF TESTING FOR STATE'S ATTORNEY.
- A VICTIM WHO IS NOTIFIED OF THE TEST RESULTS MAY ONLY DISCLOSE THE RESULTS TO PROTECT THE HEALTH AND SAFETY OF: THE VICTIM, THE VICTIM'S FAMILY, OR THE VICTIM'S SEXUAL PARTNER.
- ANY VICTIM OR OTHER PERSON WHO IS AWARE OF THE RESULTS OF SUCH TESTING, AND KNOWINGLY DISCLOSES THOSE RESULTS OTHER THAN TO PROTECT THEIR HEALTH AND SAFETY, IS GUILTY OF A MISDEMEANOR AND UPON CONVICTION, IS SUBJECT TO THE PENALTY OF: NOT MORE THAN NINETY DAYS IN JAIL, A FINE OF NOT MORE THAN \$5,000.00, OR BOTH.

THE FOLLOWING ARE DEFINED FOR THE PURPOSES OF THIS LAW:

OFFENSE: ANY PROHIBITED ACTIVITY INVOLVING A SEXUAL ACT OR ANY OTHER CRIMINAL OFFENSE OR COMMISSION OF A DELINQUENT ACT WHICH MAY HAVE CAUSED OR RESULTED IN AN EXPOSURE.

EXPOSURE: CONTACT BETWEEN THE VICTIM AND THE PERSON CHARGED BY MEANS OF:
1) PUNCTURE WOUNDS WITH CONTACT OF BLOOD OR BODY FLUIDS;
2) MUCOSAL FLUID WITH CONTACT OF BLOOD OR BODY FLUIDS;
3) ANY OPEN WOUND (INCLUDING DERMATITIS, CHAPPED SKIN, OR LESIONS) WITH CONTACT OF BLOOD OR BODY FLUIDS FOR A PROLONGED PERIOD; OR
4) AMOUNTS OF BLOOD OR BODY FLUIDS FOR A PROLONGED PERIOD.

VICTIM: THE VICTIM OF THE OFFENSE AND INCLUDES:

- 1) PARENT(S) OF THE VICTIM WHO IS A MINOR;
- 2) THE LEGAL GUARDIAN OF A VICTIM; OR
- 3) A FAMILY MEMBER PERMITTED TO GIVE A SUBSTITUTED CONSENT FOR THE VICTIM.

POLICE CASE #: _____ DATE: _____

OFFICER: _____ TELEPHONE #: _____

THIS FORM IS TO BE GIVEN TO THE VICTIM



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PHYSICAL EXAMINATION

(Please print with ball point pen)

#7

Victim's Name	Address	Phone	DOB	Age
Sex	Race	Type of alleged assault	Date & time of alleged assault	Date & time police notified
Date & time of examination	Location of examination	Requesting Officer	Assignment	

Date of last consensual intercourse _____ Condom Used? Yes _____ No _____

Condom used during assault? Yes _____ No _____ Unknown _____ Lubricant used during assault? Yes _____ No _____ Unknown _____

PLEASE USE ENCLOSED MSP NARRATIVE NOTES FORM

Description of Assault (as related to examiner): by victim _____ other _____

Give description of pertinent details of the assault: oral, rectal, vaginal penetration; digital penetration or use of a foreign object; oral contact by assailant; oral contact by victim; ejaculation and location of such, if known by victim.

Suspect ejaculated: Vaginally _____ Orally _____ Anally _____ Body area (specify) _____

No ejaculation _____ Unknown if ejaculation occurred _____

Last menstrual cycle: _____ Currently on menses? Yes _____ No _____

Since assault, victim has: Douched _____ Bathed _____ Showered _____ Urinated _____ Defecated _____ Brushed teeth _____

GENERAL APPEARANCE

Condition of clothing: (Describe if observed) Undamaged _____ Torn _____ Soiled _____
Victim changed clothes _____ Victim nude _____

Victim demeanor: Calm _____ Agitated _____ Flat Affect _____ Tearful _____ Other (describe) _____

Physical trauma: Check for positive findings such as: Scratches, Bruises, Bites, Lacerations, Fractures

Head _____ Face _____ Chest _____ Back _____ Abdomen _____ Buttocks _____ Arms _____ Legs _____

No Physical Trauma Noted _____

Gynecological trauma: Check for positive findings such as: Bruises, Abrasions, Lacerations, Swelling, Tenderness

External Genitalia _____ Vulva _____ Hymen _____ Vaginal Cavity _____ Perineum _____ Posterior Fourchette _____

Fossa Navicularis _____ Cervix _____ Other _____ No Gynecological Trauma Noted _____

Describe positive findings: (physical and gynecological) _____

Signs of Anal/Rectal Trauma? Yes _____ No _____ Describe _____

Signs of Sperm or Seminal Fluid? Yes _____ No _____ Describe _____

Foreign Substance Recovered? Yes _____ No _____ Describe source and type _____

PLEASE PACKAGE ALL IN PAPER ENVELOPE - NOT PLASTIC

DHMH-2347
revised Jan/2002

WHITE: Police

CANARY: MSP Rape Kit

PINK: Hospital



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VICTIM'S NAME: _____

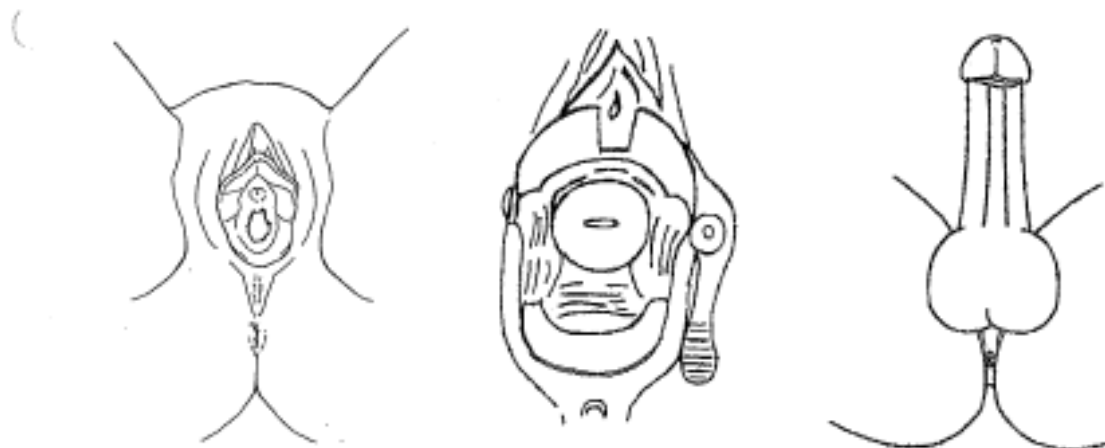
POLICE CASE #: _____

Check if collected and sent to the police laboratory:

Copy of Physical Examination Form	Included in kit?	Yes ☐ No ☐	
Victim's Underwear		Yes ☐ No ☐	
Victim's Clothing		Yes ☐ No ☐	
Debris Collected	(If indicated)	Yes ☐ No ☐	
Bite mark/Licking Swabs	(If indicated)	Yes ☐ No ☐	
Saturated Oral Swabs (2)		Yes ☐ No ☐	
Pulled Head Hairs		Yes ☐ No ☐	
Pubic Hair Combs		Yes ☐ No ☐	
Pulled Pubic Hairs		Yes ☐ No ☐	
Saturated Vaginal/Cervical Swabs (4)		Yes ☐ No ☐	
Saturated Anal Swabs (2) - perineal/anal	(If indicated)	Yes ☐ No ☐	
Fingernail Scrapings	(If indicated)	Yes ☐ No ☐	Victim scratched assailant? Yes ☐ No ☐
Victim's Blood Sample		Yes ☐ No ☐	Label tube with victim's name
Miscellaneous Collection	(If indicated)	Yes ☐ No ☐	
Photographs:	Yes ☐ No ☐	Video: Yes ☐ No ☐	By whom: _____

HOSPITAL TESTS:

RPR (Blood)	Yes ☐ No ☐	N. gonorrhea (GC)	Yes ☐ No ☐	Wet Prep	Yes ☐ No ☐
Pregnancy test	Yes ☐ No ☐	Urine Toxicology	Yes ☐ No ☐	Other	Yes ☐ No ☐
Blood Alcohol	Yes ☐ No ☐	Chlamydia	Yes ☐ No ☐	Describe	_____



I hereby certify that this is a true and correct copy of the official record concerning the examination of the above named individual.

Examiner: _____ / _____ Date: _____
(Signature) (Print Full Name)



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MEDICAL EXAMINATION AND REPORT OF ALLEGED SEXUAL ASSAULT

STEP 1

Hospital Name: _____ Police Case #: _____ Brought by: _____

Name of Victim: _____ DOB: _____ Age: _____ Sex: _____ Race: _____

Address: _____ Zip: _____ Phone: _____

Date/Time of Incident: Police Notified: Admitted to ER: Examination:

Date: _____ Date: _____ Date: _____ Date: _____

Time: _____ Time: _____ Time: _____ Time: _____

Requesting Officer (Name, District, Telephone): _____

Authorization for medical examination, collection of evidence and release of information:

I hereby authorize _____ and _____ to collect any
(Hospital) (Physician/Examiner)
blood, urine, tissue or other specimen (including clothing) necessary during the physical and gynecological examination of
my person. I further authorize the transmittal of copies of all medical reports (including any laboratory reports) to the Police
Department, DHMH, and, if I elect to prosecute, to the Office of the State's Attorney having jurisdiction. This permission and
release includes the taking of photographs and/or video, if such is indicated in the judgement of the examiner.

Signed: _____ / _____ Date: _____
(Reasonable Party) (Print) (Signature)

Witness: _____

PLEASE USE BALL POINT PEN FOR COMPLETION