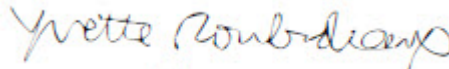


BACKGROUND

The purpose of this Transmittal Notice (TN) is to transmit a copy of the Part 3, Chapter 29, "Sexual Assault," *Indian Health Manual* (IHM). This chapter establishes a uniform standard of care for sexual assault victims (adults and adolescents) seeking clinical services at an Indian Health Service (IHS) hospital, to ensure their care is culturally sensitive, patient-centered, their needs are addressed, and the community response is coordinated.



Yvette Roubideaux, M.D., M.P.H.  
Director  
Indian Health Service

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MATERIAL TRANSMITTED

Part 3, Chapter 29, "Sexual Assault," IHM

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MATERIAL SUPERSEDED

None

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MANUAL MAINTENANCE

Insert the attached copy of the revised Part 3, Chapter 29, "Sexual Assault," IHM, including the chapter Table of Contents, in its place after Part 3, Chapter 28, IHM. Log and file this TN in sequential order.

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Distribution: IHS-wide

Date: March 23, 2011

PROFESSIONAL SERVICES

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SEXUAL ASSAULT

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Manual Exhibit 3-29-A, The Operation of a SART

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3-29.1 INTRODUCTION

- A. Purpose. This chapter establishes a uniform standard of care for sexual assault victims (adults and adolescents) seeking clinical services at an Indian Health Service (IHS) operated hospital, to ensure their care is culturally sensitive, patient-centered, their needs are addressed, and the community response is coordinated. The policies also aid evidence collection for possible use in the criminal justice system response.
- B. Background. In 2008, the Centers for Disease Control and Prevention indicated that 39 out of 100 American Indian/Alaska Native (AI/AN) women and 19 out of 100 AI/AN men have been victims of intimate partner violence at some point in their lives - the highest rates for women and men in the United States (U.S.). An AI/AN woman's risk of sexual assault is 2 ½ times higher than for women in the general U.S. population. Social stereotypes and stigmas associated with rape contribute to under reporting of rape, particularly by males. The health outcomes for sexual assault victims include depression, post-traumatic stress disorder (PTSD), addiction, suicide, chronic medical conditions, and chronic pain, among others.
- C. Authorities.
- (1) The Indian Law Enforcement Reform Act, 25 *United States Code* (U.S.C.) 2801 et seq, as amended
  - (2) The Indian Health Care Improvement Act, 25 U.S.C. 1601 et seq, as amended
  - (3) The Violence Against Women Act of 1994, Public Law (P. L.) No. 103-322, as amended
  - (4) The Health Insurance Portability and Accountability Act, P.L. 104-191, as amended and 45 C.F.R. Parts 160 and 164
  - (5) The Indian Child Protection and Family Violence Prevention Act, 25 U.S.C. 3201 et seq
  - (6) The Snyder Act, 25 U.S.C. 13
  - (7) The Transfer Act, 42 U.S.C. 2001

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(3-29.1C – continued)

- (8) National Protocol for Sexual Assault, Medical Forensic Examinations Adults/Adolescents, September 2004, Department of Justice

<http://www.ncjrs.gov/pdffiles1/ovw/206554.pdf>

D. Policy. It is the policy of the IHS that:

- (1) All IHS operated hospitals must provide adult and adolescent patients who present themselves for a sexual assault examination, with access to a sexual assault medical forensic examination by a trained Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE). Access may be provided on-site or by referral. If patients are transferred off-site for services, all transfers must comply with the Emergency Medical Treatment and Active Labor Act (EMTALA).
- (2) All IHS operated hospitals that provide on-site SAFE or SANE services must collaborate with the Tribe, other Federal and State agencies (e.g., law enforcement, prosecution, etc.), the victim advocate and the hospital SAFE or SANE with the objective of creating a community Sexual Assault Response Team (SART).
- (3) All IHS operated hospitals must create a hospital sexual assault response policy that:
  - a. Is in compliance with applicable laws;
  - b. With appropriate consent, provide victim with sexual assault medical and forensic examinations, as requested;
  - c. Identifies whether the sexual assault medical forensic examination is provided on-site or by referral;
  - d. Identifies the name and location of the off-site provider;
  - e. Requires transport of the victim to the referral provider within two hours of the victim's presentation to the hospital;

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(3-29.1D(3) – continued)

- e. Requires the hospital to offer the victim the services of a victim advocate before, during, and after the sexual assault examination;
- f. Requires that victims be offered prophylactic medications against sexually transmitted infection (STI); immunizations; pregnancy testing; prophylactic treatment for pregnancy prevention, and follow-up medical, behavioral health, or victim advocacy services as needed;
- g. Requires that HIV post exposure prophylaxis be offered to the patient if the sexual assault was within the past 72 hours;
- h. Identifies the required methods and procedures for the handling and storage of all documentation of the sexual assault and the forensic evidence as follows:
  - (i) Secure (locked) refrigerated storage for wet biological evidence (e.g., urine) according to jurisdictional policy;
  - (ii) Secure storage of the digital photographic records that is separate from the patient's medical records;
  - (iii) Secure storage of all other documentation of the sexual assault that is separate from the patient's medical record;
  - (iv) Secure storage of all other forensic evidence until it is transferred to law enforcement; and
  - (v) Compliance with chain of custody for all those involved in handling, documenting, transferring, and storing evidence.
- i. Identifies how, from whom, and under what circumstances the hospital obtains and releases the sexual assault evidence kits;
- j. Requires patient-centered care including priority treatment of sexual assault victims whether they present to the Emergency Department (ED), or out-patient service; and,

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(3-29.1D – continued)

k. Is congruent with the hospital's domestic violence policy or alternatively, revises and updates the existing policy for congruence with the sexual assault response policy. Hospitals must create domestic violence policies if comprehensive local domestic violence policies and procedures do not exist.

(4) Adult victims must not be required to report the sexual assault to law enforcement in order to have access to a sexual assault medical forensic examination.

E. Definitions.

- (1) Adolescent. In general, an adolescent is an individual who has entered puberty but is below the age of full majority (18 years of age). A child is an individual who has not yet reached adolescence. This policy generally identifies adolescents as minors. See also the definition of "minor." If a child presents with evidence of sexual abuse, refer to the IHS child abuse policies and procedures for treatment. (See Part 3, Chapter 13, Section 8, "Sexual Abuse," *Indian Health Manual*.)
- (2) Anonymous Sexual Assault Evidence Collection Kit. An Anonymous Sexual Assault Evidence Collection Kit (anonymous evidence kit) is a kit that is used in the event that the sexual assault victim either declines to report to law enforcement, or is undecided about reporting at the time of exam, and chooses to remain anonymous. The sexual assault evidence kit is identified with a unique alpha-numeric identifier. Victims can use this code number to identify themselves if they choose to report the sexual assault to law enforcement at a later time.
- (3) Assistant United States Attorneys. The Assistant United States Attorneys (AUSA), also known as Federal prosecutors, represents the U.S. Federal government in U.S. District Court and the U.S. Court of Appeals. One AUSA is assigned to each of the judicial districts. Each AUSA is the chief Federal law enforcement officer within his or her particular jurisdiction. The AUSA and their offices are part of the Department of Justice (DOJ).

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(3-29.1E – continued)

- (4) Behavioral Health Providers. Behavioral health providers include psych-mental health nurse practitioners; licensed clinical social workers; marriage and family counselors; licensed professional counselors; psychologists; and psychiatrists (Medical Doctor and Doctor of Osteopathy).
- (5) Chain of Custody. Chain of custody refers to the chronological documentation which shows the collection, custody, control, transfer, analysis, and disposition of evidence. Because evidence is used in court to convict persons of crimes, it must be handled in a scrupulous manner to avoid later allegations of tampering or misconduct. The chain of custody requires that from the moment the evidence is collected, every transfer of evidence from person to person be documented and that it be provable that nobody else could have accessed that evidence. The transfer of evidence must be kept to a minimum.
- (6) Coordinated Community Response. This term refers to immediate and longer term community response to sexual assault that is coordinated among involved agencies and their staff. While IHS provides medical and forensic examination services and interventions according to IHS-specific policies, IHS also works with Tribal, State, and Federal agencies (e.g., law enforcement, prosecution, etc.) and various disciplines to ensure a coordinated response. The desired result is a collective response to victims and offenders that is appropriate, streamlined, and as comprehensive as possible.
- (7) Confidentiality. Under Federal law, all information revealed to a health care provider is private and has limits on how and when it can be disclosed to a third party, i.e., a health care provider must hold confidential all information relating to a patient, unless the patient gives consent permitting disclosure except where required by law to report. Confidentiality is intricately linked to the scope of patients' consent. Information included in the IHS Privacy Act System of Records Notice 09-17-0001 Medical, Health, and Billing Records that contains medical, public health nursing, mental health, and social service records must be

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(3-29.1E(7) – continued)

handled in accordance with the Privacy Act (5 U.S.C. 552a) and the HIPAA Privacy Rule (45 CFR 164). Substance abuse and alcohol treatment records are subject to additional confidentiality regulations at 42 CFR Part 2.

- (8) Consent for Sexual Contact. The age of consent for sexual contact is defined by State statute and varies by age and marital status. Adolescents below the age of 18 may or may not be able to consent for sexual contact. (Sexual intercourse with a person under the age of consent [as defined by statute], regardless of whether it is against that person's will, is considered statutory rape.) Hospitals must consult their Regional Office of General Counsel (OGC) for State specific consent requirements.
- (9) Disability. For the purpose of this policy, this term includes physical, sensory, or mental disabilities, or a combination of disabilities. Physical disabilities may result from injury (e.g., spinal cord injury and amputation), chronic disease (e.g., multiple sclerosis, rheumatoid arthritis, and diabetes), or congenital impairments (e.g., developmental conditions such as cerebral palsy and muscular dystrophy). Sensory disabilities include hearing or visual impairments. Mental disabilities include developmental conditions (e.g., mental retardation), cognitive impairment (e.g., traumatic brain injury), or mental illness.
- (10) Domestic Violence. Domestic violence is abusive behavior involving intimate partners or family members or household members that is used to gain or maintain power and control over another intimate partner or family member or household member. Domestic violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone.
- (11) Emergency Medical Treatment and Active Labor Act. The Emergency Medical Treatment and Active Labor Act (EMTALA) is a Federal law that imposes patient transport regulations upon hospitals that participate in the Medicare program as follows: Before a patient can be transferred for off-site care, the patient must be screened for emergency conditions and if an emergency condition exists, the patient must be stabilized.

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(3-29.1E – continued)

- (12) Health Care Provider. The term health care provider is defined in Section 160.103 of Title 45 CFR. Section 160.103 defines health care provider as a provider of services (as defined in section 1861(u) of the [Social Security] Act, 42 U.S.C. 1395x(u)), a provider of medical or health services (as defined in section 1861(s) of the Act, 42 U.S.C. 1395x(s)), and any other person or organization who furnishes bills or is paid for health care in the normal course of business. For example, the term health care provider includes, but is not limited to, nurses and advanced practice nurses, physicians and physician assistants, behavioral health and social services providers, paramedics and emergency medical technicians, and IHS hospitals and other clinical health care delivery sites.
- (13) Indian Country. For purposes of 18 U.S.C. 1169, (the mandatory reporting of child abuse in Indian Country), the the definition of “Indian Country” is as follows:
- a. All lands within the limits of any Indian reservation under the jurisdiction of the U.S. Government, notwithstanding the issuance of any patent, and, including rights-of-way through the reservation.
  - b. All dependent Indian communities within the borders of the U.S. whether within the original or subsequently acquired territory thereof, and whether within or without the limits of a State, and
  - c. All Indian allotments, the Indian titles to which have not been extinguished, including rights-of-way running through the same.
- (14) Informed Consent. Informed Consent is the process by which a fully informed patient can participate in choices about his or her health care. The patient must be given all relevant information prior to the medical procedure. This includes information about the impact of declining a procedure, which may negatively affect the quality of care and usefulness of evidence collection. In order for the patient’s consent to be valid, he or she must be considered competent to make the decision at hand and the consent must be voluntary. Informed consent includes a discussion of the following elements:

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(3-29.1E(14) – continued)

- a. The nature of the decision/procedure.
  - b. Reasonable alternatives to the proposed intervention.
  - c. The relevant risks, benefits, and uncertainties related to each alternative.
  - e. Assessment of patient understanding.
  - f. The acceptance of the intervention by the patient.
- (15) Jurisdiction. The term jurisdiction is defined as the power, right, or authority to interpret and apply the law; the authority of a sovereign power to govern or legislate; the power or right to exercise authority; or the limits or territory within which authority may be exercised.
- (16) Law Enforcement Personnel. Law enforcement personnel may include patrol officers, officers who process crime scene evidence, and investigators.
- (17) Mandatory Reporting. Federal laws may mandate the reporting of sexual assault of minors. State or Tribal laws may impose additional reporting requirements. Consult with the Regional OGC and the DOJ AUSA on specific reporting requirements.
- (18) Minor. The term “minor” refers to an individual (a “minor” or an “adolescent”) who has not reached full legal age. Full legal age is generally the age of 18 years. For reporting purposes, Federal and State definitions vary. Consult with the Regional OGC attorney or your AUSA on State specific reporting requirements.
- (19) Office of General Counsel. The OGC is the legal team for the Department of Health and Human Services (HHS) and the agencies within HHS including the IHS.

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(3-29.1E – continued)

- (20) Prosecutor. Different types of prosecution offices exist at the local, Tribal, State, and Federal level (e.g., Tribal prosecutor's office, county prosecutor's office, district attorney's office, State attorney's office, U.S. Attorney's office). Any of these offices could be involved in responding to sexual assault cases. In addition, some offices may have personnel with specialized education and experience in sexual assault prosecutions. In this policy, attorneys from prosecution offices will be referred to as "prosecutors" unless more specificity is required.
- (21) Sexual Assault Nurse Examiner. A Sexual Assault Nurse Examiner (SANE) is a registered nurse specially trained and credentialed to provide care to sexual assault patients. The SANE conducts sexual assault medical forensic examinations and can serve as an expert witness. The SANE can be credentialed by the International Association of Forensic Nurses to conduct examinations on adults, adolescents and children. A SANE-A is credentialed to provide care to adult and adolescent sexual assault victims. A SANE-P is credentialed to conduct an acute sexual assault examination of pediatric patients who are prepubertal. A SANE works as part of a team and may also work closely with a multidisciplinary SART to ensure that the patient's needs throughout the medical and legal process are met.
- (22) Sexual Assault. Sexual assault is sexual contact without consent. A person cannot give consent to sexual contact if she or he is forced, threatened, coerced, drugged, inebriated, and unconscious, has certain disabilities, or is a minor. The age of consent for sexual contact varies by State, and may or may not include adolescents. Contact the Regional OGC for specific State requirements.
- (23) Sexual Assault Evidence Collection Kit. The sexual assault forensic evidence collection kit is used during a medical forensic examination and includes materials used to collect the forensic evidence.
- (24) Sexual Assault Forensic Evidence. Sexual assault forensic evidence collected as a part of the sexual assault examination includes the patient clothing and underwear; foreign material dislodged from clothing; foreign material on the patient's body including blood, dried secretions, fibers, vegetation, soil or debris; fingernail scrapings and/or cuttings; material

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(3-29.1E(24) – continued)

dislodged from the mouth; swabs of suspected semen, saliva; hair including hair that is plucked from the head, matted hair cuttings; vaginal/cervical swabs and smears, penile swabs and smears, anal/perianal swabs and smears; oral swabs and smears; body swabs, and a buccal swab; and photographs of genital and non-genital injuries.

- (25) Sexual Assault Forensic Examiner. A Sexual Assault Forensic Examiner (SAFE) is a physician or physician assistant who is trained and credentialed in sexual assault examination, conducts sexual assault examinations, and refers patients for needed services. The SAFE works as part of a team which might include a SANE, a physician, a behavioral provider, a social worker and a victim advocate. The SAFE also works closely with a multidisciplinary SART to ensure that the patient's needs throughout the medical and legal process are met. The SAFE is considered a sexual assault expert and can testify in court.
- (26) Sexual Assault Medical Forensic Examination. This is an examination of a sexual assault patient by a SAFE or SANE comprising two components:
- a. The forensic component includes gathering information from the patient for the medical forensic history, examination, documentation of biological and physical findings, collection of evidence from the patient, and follow-up as needed to document additional evidence.
  - b. The medical component includes coordinating treatment of injuries, providing care for STIs, assessing pregnancy risk and discussing treatment options, including reproductive health services, and providing instructions and referrals for follow-up medical care. Within this policy, this examination will be referred
- (27) Sexual Assault Response Team. The SART is a community-based team organized to promote a coordinated response to sexual assault. A SART may be a part of an existing Multidisciplinary Team. Members of the SART include a:
- a. SAFE or SANE;

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(3-29.1E(27) – continued)

- b. representatives of relevant law enforcement agencies;
  - c. victim advocate; and a
  - d. representative from the prosecutor's office.
- (28) Victim Advocate. A victim advocate is an individual who may work in the criminal justice system including Tribal, State, or Federal law enforcement or prosecution, for the Tribal Health Department, or for private nonprofit advocacy groups such as domestic violence or sexual assault organizations. Victim advocates are trained to support the victim of crime by providing crisis intervention services including emotional support, information, and counseling. Victim advocates support the victim before, during and after the medical forensic examination process. If the victim chooses to report the sexual assault to law enforcement, the advocate can support and guide the victim throughout their involvement with the criminal justice system. The SART always includes a victim advocate.
- (29) Violence Against Women Act. One provision of the VAWA specifically provides that victims of sexual assault are not required to cooperate with law enforcement or participate in the criminal justice system in order to be provided with a sexual assault examination.
- (30) Vulnerable Adult. A vulnerable adult is any person older than age 18 that has a substantial mental or functional impairment which renders them temporarily or permanently incompetent to provide consent. Mental or functional impairments may include among others certain developmental or mental disabilities, severe mental illness, psychosis, unconsciousness, drug or alcohol intoxication, and other cognitive conditions.

### 3-29.2 RESPONSIBILITIES

- A. Director, IHS. The Director, IHS, is responsible for:
- (1) Directing Area Directors and Service Unit Chief Executive Officers to identify and ensure that the resource needs are met to implement this policy.

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(3-29.2A – continued)

- (2) Approving or denying an IHS employee's release to testify in Tribal or State sexual assault or domestic violence prosecutions.
  - a. The Director may choose to delegate this authority.
  - b. The Director or designee will consult with the affected Tribal programs, for those Federal employees assigned to Indian Self-Determination and Education Assistance Act contract and compact programs, for testimony in Federal, State, or Tribal sexual assault or domestic violence prosecutions.
  
- B. Indian Health Service Headquarters Chief Medical Officer. The IHS Headquarters CMO is responsible for developing, publicizing, and assisting in the implementation of this policy.
  
- C. Area Director. The Area Director is responsible for:
  - (1) Ensuring that administrative support and the necessary funds are made available at IHS hospitals in his or her Area to implement this policy.
  - (2) Ensuring that every IHS hospital in their Area has made available all other resources necessary to implement this policy.
  
- D. Area Chief Medical Officer. The Area CMO is responsible to work with the IHS hospital Medical Director or Clinical Director to ensure the availability of physician consultation to the SAFE or SANE, and the SART by telephone.
  
- E. Indian Health Service Hospital Medical Director or Clinical Director. The Hospital's Medical Director or Clinical Director is responsible for:
  - (1) Ensuring the victim is treated with dignity and respect while he or she is a patient in the IHS hospital.
  - (2) Ensuring the victim's safety and privacy while he or she is a patient in the IHS hospital.
  - (3) Ensuring the victim is offered the services of a victim advocate before, during and after his or her sexual assault examination.

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(3-29.2E – continued)

- (4) Ensuring the victim is provided with social services, behavioral health services, and if referred off-site, transportation to the off-site location and back to the IHS hospital.
- (5) Ensuring the SAFE or SANE follows the chain of custody when handling the forensic evidence, and documents the transfer of custody in the patient's medical record.
- (6) Ensuring the hospital has secure storage for biological samples (urine, DNA, etc) according to jurisdictional policy. This may require a locked refrigeration unit, and a locked cabinet.
- (7) Ensuring the hospital has secure storage for digital photographic evidence and the sexual assault forensic examination report that is separate from the patient's medical record.
- (8) Assisting in the development of the hospital's sexual assault response policy.
- (9) Ensuring the hospital or clinic has developed domestic violence policies and procedures in accordance with applicable law.

F. Indian Health Service Hospital Chief Executive Officer. The Hospital CEO is responsible for:

- (1) When notified by an IHS employee that he or she has received a subpoena or request to testify in court or an administrative proceeding, the CEO, or his or her designee if the CEO is not immediately available, must scan and email the subpoena or request to testify to the Regional OGC.

Note: All IHS employees must obtain prior approval from the IHS Director or his or her designee before providing testimony in any administrative or judicial proceeding.

- (2) Approving and ensuring the hospital's sexual assault response policy is fully implemented;

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(3-29.2F – continued)

- (3) Ensuring the hospital has a domestic violence response policy that is congruent with the sexual assault response policy;
- (4) Ensuring that the hospital has a policy for obtaining the patient's informed consent, and that the policy follows applicable laws and policies for obtaining consent for treating minors and vulnerable adults;
- (5) Ensuring the hospital has adequate SAFE or SANE staff to provide 24 hour per day, 7 day per week access to a trained examiner, and that this access can be sustained over time subject to applicable pay and compensation policies;
- (6) Ensuring compensation of the SAFE or SANE staff for the sexual assault examinations they conduct during their off-duty hours;
- (7) Ensuring the hospital has the necessary equipment for conducting a sexual assault examination;
- (8) Ensuring the hospital has the required secure (locked) storage capacity for the wet biological evidence, the photographs, the other documentation of the sexual assault, and the forensic evidence;
- (9) Coordinating with the Tribe, and other Federal and State agencies (e.g., law enforcement, prosecution, etc.), the hospital's Medical and/or Clinical Directors, the hospital SAFE or SANE, and the victim advocate to create a community SART.
- (10) Ensuring that all employees and contractors working with children have been cleared pursuant to Agency regulations at 42 CFR Subpart K.

G. Medical Records. Medical Records is responsible for:

- (1) Providing secure (locked) storage and maintenance of the photographic records. Storage of photographic images must be separate from the medical record.

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(3-29.2G – continued)

- (2) Providing secure (locked) storage and maintenance of all written and electronic medical record documentation of the sexual assault. Storage of the medical records documentation must be separate from the patient's main medical record.

H. Behavioral Health and Social Services. The behavioral health provider or the social worker is responsible for:

- (1) Evaluating the behavioral health needs of victims and providing them with counseling, follow-up care, or referring for specialty care as needed.
- (2) Providing victim advocacy services as needed.
- (3) In cooperation with law enforcement, establishing patient safety during the examination.

I. SAFE or SANE. The SAFE or SANE is responsible for:

- (1) Conducting the sexual assault examination and referring patients for additional follow-up care.
- (2) Participating in the development, and serving as a member, of the community SART.
- (3) Participating in the development of the hospital's sexual assault and domestic violence response policy.
- (4) Treating all victims of sexual assault and domestic violence with dignity and respect.
- (5) Ensuring patient confidentiality.
- (6) Coordinating with the victim advocate to ensure that patients are offered crisis intervention, support and advocacy before, during and after the examination process, and encouraging the use of other victim services.
- (7) Coordinating with the hospital CEO to contact the law enforcement agency of jurisdiction as needed and as appropriate.

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(3-29.2I – continued)

- (8) Obtaining informed consent. There are two essential but separate consent processes; one for the medical evaluation and treatment, and another for the sexual assault examination and for the forensic evidence collection. The SAFE or SANE must be familiar with applicable laws and IHS and hospital policies governing informed consent, including in the case of minors or vulnerable adults. The SAFE or SANE must describe the examination and all procedures and their purpose prior to initiating the examination or procedure, seeking the patients' permission to proceed, and respecting their right to decline any part of the examination. For more information, please refer to Part 3, Chapter 3, Indian Health Manual, Section 3-3.13 and 3-3.14 and the IHS Risk Management Manual, Chapter 6 and consult with the service unit or Area risk manager regarding local informed consent policies.
- (9) Providing comfort and pain management measures as per hospital protocol.
- (10) Providing information and prophylactic treatment for sexually transmitted infections; screening for pregnancy; discussing, and if the patient chooses, providing prophylactic treatment for pregnancy prevention.
- (11) Providing information and referral for available behavioral health care.
- (12) Maintaining the chain of custody.
- (13) Releasing all forensic evidence including the medical forensic record, photographs, clothing, etc. to law enforcement.
- (14) Following up with patients for medical and forensic purposes.
- (15) Engaging in the peer review process for the purpose of improving documentation and discussion of SAFE or SANE program successes, failures, and needs.
- (16) Immediately notifying his or her supervisor and the hospital CEO that he or she has received a subpoena or request to testify in court or an administrative proceeding. The hospital CEO or his or her designee if the

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(3-29.2I – continued)

CEO is not immediately available, will then scan and email the subpoena or request to testify to Regional OGC. The Regional OGC will review the request or subpoena for legal sufficiency and then forward the request or subpoena to the appropriate IHS approving official. In the event that an employee receives a verbal request for testimony, IHS staff must provide his or her supervisor and hospital CEO with the name and contact information of the caller and the hospital CEO or designee will immediately convey that information to the OGC regional attorney. All IHS employees must obtain prior approval from the IHS Director or his or her designee before providing testimony in any administrative or judicial proceeding.

- J. Sexual Assault Response Team. The members of the SART are responsible for coordinating a community response to sexual assault that supports a victim-centered approach. All SART members are responsible for coordinating within and among their agencies (see SART definition) to reduce re-traumatization of victims through the use of medical forensic examiners. The SART members are also responsible for supporting victim-centered care, improving the quality of forensic evidence, promoting evidence collection that meets applicable standards and promotes successful prosecution, and improving the victim's access to justice. (See Manual Exhibit 3-29-A)
- K. Victim Advocate. The victim advocate is responsible for informing victims about their rights before, during, and after the examination process, ensuring the victim's interests are represented and that their wishes are promoted. They assist victims in addressing related legal and other issues. Included on the SART, victim advocates must be experts in how to provide sensitive, appropriate, and coordinated interventions. All IHS behavioral health providers and registered nurses who are trained as victim advocates may provide victim advocacy services and may participate as a member of the SART.
- L. Office of General Counsel. The OGC is responsible for supporting the development and implementation of HHS and IHS programs by providing legal services to the Secretary of HHS and the agencies within HHS including the IHS. The OGC attorneys support the Director, IHS, by reviewing and providing legal advice on proposed policies, legislation, IHS employee subpoenas and other matters.

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3-29.3 UNIFORM STANDARD OF CARE

- A. Patient-Centered Care of the Sexual Assault Victim. Patient-centered care is characterized by care that is compassionate and preserves patient dignity and respects their individuality. The following are procedures required to safeguard victim privacy, confidentiality, and dignity:
- (1) Sexual assault patients must be given priority as emergency cases.
  - (2) Patient privacy and confidentiality must be ensured. Sexual assault patients must be provided with a private treatment room. Arrangements must be made so that sexual assault patients will not have to wait in the main waiting area.
  - (3) Prior to the sexual assault examination the victim must be offered the services of a victim advocate. If the victim accepts, and the victim advocate is available, arrangements must be made for a victim advocate to accompany the patient during the examination. Patients have the right to accept or decline advocacy services at any time.
  - (4) Patients must receive a full explanation of the scope of confidentiality during the examination process and during communication with the victim advocate.
  - (5) Every effort must be made to accommodate the patients' request for a SAFE or SANE of a specific gender.
  - (6) The SAFE or SANE must follow standardized clinical guidelines in offering prophylactic prevention or treatment of STIs, emergency contraception, and treatment of injuries.
- B. Informed Consent Adults/Adolescents. See the *National Protocol for Sexual Assault Medical Forensic Examinations; Adults/Adolescents*, pages 39-40. An informed consent procedure must be developed for each hospital using the following guidance:
- (1) Health care providers and other responders are required to seek the informed consent of patients as appropriate throughout the exam process. There are two consent processes: one for medical evaluation and treatment

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(3-29.3B(1) – continued)

and one for the forensic exam and evidence collection. Patients should understand the full nature of their consent to all procedures. This includes what the procedure entails, possible side effects, and potential impact.

- (2) It should be clarified whether policies and statutes regarding consent for medical evaluation and treatment encompasses consent for the forensic component of the examination. If not, additional guidance from the appropriate AUSA and the Regional OGC is needed to develop the appropriate policies. Also, jurisdictional statutes regarding mandatory reporting to law enforcement or protective services of a minor or a vulnerable adult sexual assault victim must be observed.
- (3) Informed consent may be either “express” or “implied.” Express consent is given in writing or verbally. Express consent should, as required by policy, often be written but may also be verbal and must be noted in the record. Presentation to the hospital for the medical evaluation can be considered implied consent, but it is necessary for the examiner to assess patients’ legal capacity to provide consent.
- (4) Informed consent for medical evaluation and treatment typically includes, but is not limited to the following:
  - a. General medical care.
  - b. Pregnancy testing and prophylaxis.
  - c. Prophylaxis for STIs.
  - d. HIV prophylaxis.
  - e. Permission to recontact the patient for medical purposes.
  - f. Release of medical information.
- (5) Informed consent for the sexual assault examination and evidence collection is typically needed for:
  - a. Photographs, including colposcopic images.

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(3-29.3B(5) – continued)

- b. Notification to law enforcement or other authority (depends upon reporting requirements).
  - c. The examination itself and evidence collection.
  - d. Toxicology screening.
  - e. Release of information and evidence to law enforcement.
  - f. Permission to recontact patients for reasons related to their criminal sexual assault case.
- (6) Hospitals must develop policies on seeking informed consent from specific populations, including minors and vulnerable adults. It is important for examiners to assess patients' ability and legal capacity to provide informed consent. Consult the Regional OGC for guidance on laws governing the consent of minors and vulnerable adults.
- (7) Methods to inform patients and seek their consent vary significantly across jurisdictions and among individuals requesting consent. It is important that the IHS hospital, in coordination with Regional OGC and relevant authorities, ensure that clear guidelines are developed for staff regarding when written consent is necessary and how it should be sought. These guidelines should include appropriate checklists and forms to facilitate obtaining written consent in a consistent manner. Patients should understand the full nature of their consent to each procedure, whether it be medical or forensic (e.g., what the procedure entails, possible side effects, and potential impact).
- C. Informed Consent - Minors. Depending upon applicable Federal, State, or Tribal laws, a sexual assault examination of a minor may require the consent of a parent or guardian. However, some jurisdictions recognize situations where parental consent may not be required, for example, where the health care provider suspects the child has been subject to abuse or in an emergency situation. Questions regarding applicable informed consent laws may be directed to the OGC Regional Attorney. In addition, facilities should consult with their Service Unit or Area risk manager regarding local informed consent policies.

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(3-29.3C – continued)

Finally, pursuant to the Indian Child Protection and Family Violence Prevention Act, 25 U.S.C. 3201 et seq., a sexual assault examination may be allowed without parental consent if the local child protection services or law enforcement agency has reason to believe a child has been subject to abuse. Law enforcement or child protective services officials may be allowed to interview and examine the minor without first obtaining the consent of the parent, guardian or legal custodian.

- D. Additional Information. For more information, please refer to Part 3, Chapter 3, *Indian Health Manual*, Sections 3-3.13 to 3-3.14, and the *IHS Risk Management Manual*, Chapter 6. Hospital staff should also consult with their Service Unit or Area risk manager regarding local informed consent policies. Some Service Units have treatment specific informed consent or general informed consent policies. When there are questions, hospital staff should consult with the risk manager or their OGC Regional Attorney.
- E. Confidentiality. The SAFE or SANE is responsible for being aware of the scope and limitations of confidentiality related to information they gather during the examination process. Confidentiality is intricately linked to the scope of patients' consent. The SAFE or SANE, other members of a SART, and other collaborating responders are responsible for informing victims of the scope of confidentiality and must be cautious not to exceed the limits of the victim's consent to share information in each case.
- F. Confidential Medical Information. The IHS must make reasonable efforts to limit the disclosure of patient health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request and to those persons or classes of persons to which access is needed. The sexual assault victim's confidential medical information may be shared in private interagency, interdisciplinary conferences for the purposes of establishing a diagnosis, formulating a treatment plan, and monitoring the plan whenever those conferences are not open to the general public and participants in the conference are required to keep conference proceedings confidential. Information may be shared with local social service and law enforcement personnel responsible for the investigation as required by 45 CFR 164.512(f)(3) as it relates to victims of a crime. The information in the records may be shared in these circumstances, but they are not to be copied and turned over to these agencies without an appropriate court order. If substance abuse and alcohol treatment records are involved, a specific court order is required, in accordance with regulations at 42 CFR Part 2.

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(3-29.3F – continued)

Information included in the IHS Privacy Act System of Records Notice 09-17-0001 Medical, Health, and Billing Records that contains medical, public health, nursing, mental health, and social service records must be handled in accordance with the Privacy Act (5 U.S.C. 552a) and the HIPAA Privacy Rule (45 CFR 164). Substance abuse and alcohol treatment records are subject to additional regulations at 42 CFR Part 2. When medical records and other protected health information (PHI) are needed for purposes not authorized by Federal law, the express written consent of the patient must be obtained. When a request for medical records is received, contact the Regional OGC. No records shall be released except pursuant to the service unit specific directives developed by the OGC and the AUSA pursuant to applicable Federal, State, and local rules.

G. Mandatory Reporting Requirements.

- (1) Federal Law. Two Federal laws require the reporting of sexual assaults of minors.
  - a. Federal law requires persons engaged in a professional capacity or activity on Federal land or in a Federally-operated (or contracted) facility to report suspected abuse to the local law enforcement or child protective services agency if they learn of facts that give reason to suspect that a minor has suffered an incident of sexual abuse or exploitation. This requirement applies to nurses, physicians, health care practitioners, dentists, medical residents or interns, hospital personnel and administrators, chiropractors, osteopaths, pharmacists, optometrists, podiatrists, emergency medical technicians, ambulance drivers, alcohol or drug treatment personnel, persons performing a healing role or practicing the healing arts, psychologists, psychiatrists, mental health professionals, social workers, licensed or unlicensed marriage, family, and individual counselors, among others. 42 U.S.C. 13031
  - b. In addition, Federal law imposes reporting requirements when ‘child abuse’ is suspected in “Indian Country.” Federal law requires certain persons to report to child protective services or law enforcement if they have knowledge or reasonable suspicion that a minor was abused in Indian Country or actions are being taken, or are going to be taken, that would reasonably be expected to result

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(3-29.3G(1) – continued)

- c. in the abuse of a minor in Indian Country. “Abuse” includes any case in which a minor is subjected to sexual assault, sexual molestation, sexual exploitation, sexual contact or prostitution. This requirement applies to nurses, physicians, surgeons, dentists, podiatrists, chiropractors, dental hygienists, optometrists, medical examiners, emergency medical technicians, paramedics or health care providers, psychiatrists, psychologists or psychological assistants, and licensed or unlicensed counselors or person employed in the mental health professions. 18 U.S.C. 1169
  - (2) State and Tribal Law. State and tribal law may impose additional reporting requirements, such as mandatory reporting of a sexual assault of an adult involving a weapon. Consult with the OGC Regional Attorney and/or DOJ AUSA on applicable reporting requirements. All IHS providers must comply with applicable reporting requirements, even if the victim chooses not to cooperate with law enforcement.
- H. Sexual Assault Response Team. A SART coordinates immediate interventions and services, including victim support, medical care, evidence collection and documentation, and the initial criminal investigation.
  - (1) Membership. Members of the SART must understand the needs and concerns of the AI/AN community being served. Individual SARTs should reach out to agencies that serve these populations so that team members can promptly access their services if needed. A SART is composed of professionals involved in immediate response to disclosures of sexual assault. The core SART team commonly includes the SAFE or SANE, one or more law enforcement representatives, a representative from the prosecutor’s office, and a victim advocate. Forensic scientists may be involved, but more as consultants than as first responders.
  - (2) Roles. Broad roles for SART members include:
    - a. Victim advocates may be involved in initial victim contact (via 24-hour hotline or face-to-face meetings), offer victims advocacy, support, crisis intervention, information, and referrals before, during, and after the exam process, and help ensure that victims have transportation to and from the exam site. They often provide

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(3-29.3H(2)a – continued)

follow-up services designed to aid victims in addressing related legal and non-legal needs. Behavioral health providers are often trained as victim advocates and may be a member of the SART in their role as a victim advocate.

- b. The SAFE or SANE assesses the health status of the victim, provides for acute medical care, stabilization, treatment, and consultation. The SAFE or SANE performs the medical forensic exam, gathers information for the medical forensic history, and collects and documents forensic evidence from patients. They offer information, treatment, and referrals for STIs and other non-acute medical concerns, assess pregnancy risk and discuss treatment options with the patient, including reproductive health services, and testify in court if needed. They typically coordinate with advocates to ensure that patients are offered support crisis intervention, and advocacy during and after the exam process and encourage use of other victim services. They may follow up with patients for medical and forensic purposes. Other health care personnel that may be involved include, but are not limited to, emergency medical technicians, staff at IHS hospital emergency departments, gynecologists, surgeons, and/or Tribal personnel.
- c. Law enforcement representatives (e.g., 911 dispatchers, patrol officers, officers who process crime scene evidence and investigators) respond to initial complaints, work to enhance victims' safety, arrange for victims' transportation to and from the examination site as needed, interview victims, conduct the crime scene investigation, coordinate the collection and delivery of evidence to designated labs or law enforcement property facilities, and otherwise investigate the alleged sexual assault.
- d. Forensic scientists analyze forensic evidence and provide results of the analysis to investigators and/or prosecutors.
- e. Prosecutors may participate on a SART and provide important information and technical assistance on a variety of issues. Ideally they are available to consult with members of the SART as needed.

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(3-29.3H(2) – continued)

- f. All SART members should be able to explain to victims the roles of other team members. Depending on the case and jurisdictional policies, other professionals or agencies may also be involved in immediate interventions and service provision. They need information about the SART and its procedures to guide their responses and facilitate coordination of activities with the SART. The SART members also need information about those professionals and agencies, their roles in response, and how to contact and interact with them.
  
- (3) Victim-Centered SART Response. The SART must consider and plan for modifications to the examination process to address specific needs and concerns of victims. In order to respond to non-English speaking victims, team members must be able to speak their language or promptly arrange for interpretation. For a minor or vulnerable adult victim, team members must know who to contact for assistance and ensure they receive the same access to services that other victims would obtain. In addition, procedures must be in place to ensure that the response to minor victims follows Federal, State, and Tribal laws. Some victims may request advocates and other responders of a specific gender or from specific cultures. All SARTs should be prepared to deal with multi-jurisdictional coordination issues that may arise when assaults occur on Tribal lands. Involving regional OGC and relevant agencies as soon as possible according to agreed-upon procedures may help quickly determine who has jurisdiction over a case and how to best assist each victim.
  
- I. The Violence Against Women Act. The Violence Against Women Act provides that adolescent and adult victims of sexual assault are not required to cooperate with law enforcement or participate in the criminal justice system in order to be provided with a sexual assault examination, be reimbursed for charges incurred on account of such an examination, or both. Therefore, IHS hospitals must ensure that adolescent and adult victims have access to a sexual assault examination that is free of charge or with full reimbursement, even if the victim chooses not to report the crime to the police or otherwise cooperate with the criminal justice system or law enforcement authorities.

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(3-29.3 – continued)

- J. Spiritual or Religious Consultation. The SAFE or SANE must be aware of local traditional, Tribal, or faith-based healing practices and ask patients if they wish to use such practices at some point before, during, or after the examination. Care must always be culturally sensitive.
- K. Refusal to Cooperate with Law Enforcement. Medical providers are required and responsible for reporting sexual assault to law enforcement in accordance with applicable laws. However, the victim retains the ability to choose not to cooperate with law enforcement or the criminal justice system and receive a forensic examination. Each SAFE or SANE must be familiar with the applicable laws that address patient confidentiality. Native communities are small and victims often feel vulnerable. Therefore victims often desire that knowledge of the sexual assault be kept as private as possible.
- L. Disabled. Special needs victims and their families shall be given the highest priority and allotted additional time for assessment, examination, and collection of evidence. The difficulty of providing adequate responses to the sexual assault victim can be compounded when the person is disabled:
- (1) Some special needs sexual assault victims have limited mobility and cognitive defects which impair physical and perceptual abilities.
  - (2) Some are affected by impaired and/or reduced mental capacity to comprehend questions or limited language/communication skills which may impact their ability to relay what happened in the event of a sexual assault.
  - (3) Under Section 504 of the Federal Rehabilitation Act of 1973, any Agency (including hospitals and law enforcement) that directly receives Federal assistance or indirect benefits from such assistance must be prepared to offer a full variety of communication options in order to ensure that hearing impaired persons are provided effective health care services. This variety of options must be provided at no cost to the patient, and include an arrangement to provide interpreters who can accurately and fluently communicate information in sign language.
  - (4) Criminal acts committed against the disabled (physically, cognitively, mentally) are often unreported.

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(3-29.3L – continued)

- (5) Special needs victims may be confused or frightened, unsure of what has occurred, or they may not understand that they have been exploited and are victims of a crime.
- (6) Referrals to specialized support services and reports to law enforcement agencies are particularly needed for the developmentally and physically challenged who may need protection, physical assistance, and transportation for follow up treatment.

M. Elderly. The elderly male or female sexual assault victim may experience extreme humiliation, shock, disbelief, and denial. The attendant feelings of fear, anger, or depression can be especially severe in the older population, who may be disabled or isolated. In general, the elderly are physically more fragile than the young, and injuries sustained from assault are potentially more life threatening. Besides possible pelvic and genital injuries and sexually transmitted diseases, the older victim may be at higher risk for tissue or skeletal damage and exacerbation of existing illness or injury. The recovery process for the elderly tends to be lengthier than for those who are younger.

Physical conditions such as hearing impairment, diminished eyesight or memory loss, may make it difficult for an elderly victim of crime to relay a history of the assault, or make his or her needs known. Law enforcement, advocacy, and healthcare responders must be careful not to confuse distress and fear with dementia or advanced age. Healthcare, counseling, and social services follow up must be made easily accessible to older victims, or they may be unable or unwilling to seek or receive assistance. Without encouragement and assistance in locating services, elderly victims may be reluctant to proceed with the prosecution of offenders.

N. Lesbian, Gay, Bisexual, and Transgender. Lesbian, gay, bisexual, and transgender (LGBT) individuals are more likely than heterosexual individuals to be sexually assaulted by both same sex and heterosexual individuals. Due to homophobia, LGBT individuals are also at greater risk for sexual assault by strangers. Most LGBT individuals are less likely to report sexual assault due to the lack of awareness of same-sex sexual assault, the fear of skepticism or people “taking sides” within the LGBT community, and a lack of understanding that women are not socially seen as sexual perpetrators.

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3.29-4 PROCEDURES

- A. Chain of Custody. All staff involved in handling, documenting, transferring, and storing evidence must be trained in properly preserving evidence and maintaining the chain of custody.
- (1) Handling Evidence. The SAFE or SANE and all other staff who handles sexual assault forensic evidence (including the forensic evidence collection kit, the victim's clothing, photos, etc.) is responsible for securing the chain of custody by documenting the collection, custody, control, transfer, analysis, and disposition of the forensic evidence.
  - (2) Evidence Integrity. The SAFE or SANE shall protect the integrity of the evidence and guard the chain of custody by properly drying, packaging, labeling, and sealing all evidence collected, including photographs and clothing, particularly the clothing worn closest to the genitals (such as undergarments, pants, and shorts).
- B. Storage. All sexual assault forensic evidence (paper or medical documentation and photos; clothing; biological evidence such as fluids, liquids and other perishables) must be stored at the proper temperature and in a secure location, until it is transferred to the police. Proper storage requirements will vary by jurisdiction.
- (1) All photographs must be stored separately from the medical record. The photographs will be transferred to two disks: one disk will be transferred to law enforcement and the other disk will be kept as part of the patient's permanent medical record and stored in a secure (locked) filing cabinet under the control of the Medical Records Manager.
  - (2) Each hospital must develop and approve a policy for the maintenance and secure storage of photographic evidence, and which includes the requirement that all IHS staff, including Medical Records staff, must comply with the chain of custody methods and procedures.
- C. Medical Records and Documentation. Documentation must include the time and place the evidence is gathered, and the name of the person handling (gathering, securing, transferring) the evidence.

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(3-29.4C – continued)

- (1) The SAFE or SANE must follow jurisdictional policies for documenting examination findings, the medical forensic history, and the patient's demeanor/statements; and packaging, labeling, and securing the documentation and the evidence.
  - (2) The photographic evidence will be secured and stored separate from the medical record.
  - (3) Medical Records will determine where written documentation of the sexual assault forensic exam will be secured and stored prior to transfer to law enforcement. Storage of the sexual assault forensic exam report must be separate from the patient's medical record.
  - (4) A law enforcement officer will sign for receipt of the evidence, transfer the sexual assault evidence kit and other examination documentation and evidence from the hospital to the appropriate crime lab or other designated storage site such as a law enforcement property facility.
- D. Anonymous Evidence Kit. Some patients may refuse the involvement of law enforcement and choose to remain uninvolved in the criminal justice process.
- (1) All IHS hospitals offering on-site sexual assault examination must have a process that allows medical providers to notify law enforcement of the sexual assault without identifying the adolescent or the adult victim or the suspect (if permissible under applicable law).
  - (2) In this case the report to law enforcement must avoid providing any identifying information, and the evidence kit must be identified as an "anonymous forensic evidence kit." Instead of the victim's name, the hospital must identify the anonymous forensic evidence kit with a unique alpha-numeric identifier that cannot be traced back to the victim, thus not triggering the process of investigation and processing of evidence.

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(3-29.4D – continued)

- (3) Local law enforcement may not be familiar with the requirements of the Violence Against Women Act in terms of the “anonymous forensic evidence kit”. They may not be comfortable storing the kit for several months without assigning a case number to it, thus requiring victim identification. They also may not be comfortable holding the forensic evidence without taking action. Law enforcement training may be required.
- E. Emergency Medical Treatment and Active Labor Act. A Federal law that imposes four requirements upon hospitals that participate in the Medicare program:
- (1) When a patient comes to the emergency department and a request is made on that person's behalf for examination or treatment for a medical condition, the hospital must provide an appropriate medical screening examination to determine if an emergency medical condition exists.
  - (2) If the hospital determines that an emergency medical condition does exist, it must either provide the treatment necessary to stabilize the emergency medical condition or comply with the third requirement.
  - (3) A hospital may not transfer an individual with an unstable medical condition unless one of the following conditions is met:
    - a. The person (or legally responsible person acting on his or her behalf) makes a written request for transfer after the hospital has informed the patient of the risk of transfer and the hospital's obligations under EMTALA to provide further evaluation and treatment;
    - b. An advanced practice nurse, a physician or a physician assistant has signed a certification summarizing medical risks and benefits of the transfer and certifying that based upon information available at the time of the transfer, the medical benefits reasonably expected from the provision of treatment at the other medical facility outweigh the increased risks associated with effecting the transfer; or

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(3-29.4E(3) – continued)

- c. If a physician is not physically present in the emergency room when the transfer decision is made, a qualified medical person, as defined in Federal regulations, signs the certification after a physician, in consultation with the qualified medical person, and determines that benefits of transfer outweigh the risks.
- (4) The law outlines what constitutes an appropriate transfer, including:
- a. The transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health;
  - b. The receiving facility has available space and qualified personnel for the treatment of the individual, and has agreed to accept transfer of the individual and to provide appropriate medical treatment;
  - c. The transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented; and
  - d. The transfer is affected through qualified personnel and transportation equipment, as required.

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3-29.5 SEXUAL ASSAULT RESPONSE TRAINING, CERTIFICATION, CREDENTIALING, AND PRIVILEGING

- A. SAFE or SANE Training, Certification, Credentialing, and Privileging. The Area Director will make certification of SANE's a top priority and ensure that the Service Unit CEO makes access to and funding available for approved hospital employee for SAFE/SANE training, and clinical preparation. The Service Unit CEO, in consultation with the clinical or medical director, will make determinations regarding appropriateness and eligibility of employees for SAFE/SANE training. Training must include didactic classroom instruction and enough supervised clinical experience for the provider to be deemed competent to conduct sexual assault examinations. All SANE training must conform to the SANE educational requirements of the International Association of Forensic Nurses. The costs of related certification for approved IHS employees will be covered by the IHS hospital.
- (1) Registered Nurses. The training requirement for Registered Nurses and Advanced Practice Nurses can be met through 40 hours of SANE training or certification as a Sexual Assault Nurse Examiner-Adolescent/Adult (SANE-A), Sexual Assault Nurse Examiner-Pediatrics (SANE-P), Forensic Nurse Examiner (FNE), Sexual Assault Forensic Examiner (SAFE), or a Sexual Assault Examiner (SAE). Sufficient supervised clinical experience must be obtained and the individual deemed competent in SANE practice. Competence will be determined by a certified SANE-A or SANE-P. All SANE trained nurses must be certified through the International Association of Forensic Nurses as a SANE-A or a SANE-P. The cost of SANE certification will be covered by the IHS.
  - (2) Physician Assistants. The training requirement for physician assistants can be met through 40 hours of didactic SANE training, Sexual Assault Examiner (SAE) training, or Sexual Assault Forensic Examiner (SAFE) training. Sufficient supervised clinical practice must be obtained until the individual is deemed competent in SAFE practice, and has acquired privileges to perform the sexual assault medical forensic examination.
  - (3) Physicians. The training requirement for physicians cannot be assumed to have been met through medical school or a medical residency. The training requirement for all physicians is didactic training and supervised clinical experience sufficient to acquire privileges to perform the sexual assault medical forensic examination.

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(3-29.5A(1) – continued)

- (4) Supervised Clinical Experience. In order to achieve clinical competence in conducting sexual assault medical forensic examinations, any IHS hospital provider who has completed didactic SAFE or SANE training must receive enough supervised clinical experience to be deemed competent in conducting sexual assault medical forensic examinations by a trained and credentialed SAFE or SANE. If the hospital has no credentialed SAFE or SANE, the clinician must be sent to a high volume SAFE or SANE Program for supervised clinical experience. This supervised clinical experience will result in the clinician receiving privileges to conduct the sexual assault medical forensic examination. If the IHS hospital has a SAFE or SANE program, advanced practice nurses, physicians, and physician assistants who are proficient in performing pelvic exams, have completed didactic SAFE or SANE training, and may receive their supervised clinical experience on-site.
  - (5) Continuing Education. The continuing education requirement for SANE and SAFE providers is biennial attendance at the National SART Conference funded by the Department of Justice, Office on Victims of Crime.
- B. Credentialing and Privileging. By December 31, 2012, the training specified in this policy will be part of the privileging process within IHS hospitals. By December 31, 2012:
- (1) All SANE-A and SANE-P providers at IHS hospitals must be credentialed and privileged according to IHS Circular No. 95-16, “Credentials and Privileges Review Process for Medical Staff.
  - (2) All physicians at IHS hospitals who will be providing SAFE services must be credentialed and privileged as SAFEs according to IHS Circular No. 95-16, Credentials and Privileges Review Process for Medical Staff.”
  - (3) All physician assistants at IHS hospitals who will be providing SAFE services must be credentialed and privileged as SAFEs according to IHS Circular No. 95-16, “Credentials and Privileges Review Process for Medical Staff.”

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(3-29.5 – continued)

- C. SART Training. The Area Director will ensure that the Service Unit CEO will make access to funding for IHS hospital employee SART training a top priority.
- (1) The purpose of SART training is to expand the capacity of community SARTs to:
- a. Respond to sexual assault;
  - b. Promote the health and healing of sexual assault victims;
  - c. Hold sex offenders accountable for their crimes;
  - d. Promote the prevention of further sexual violence in Tribal communities; and
  - e. Help meet the goal of a sustainable and high functioning SAFE or SANE Program within IHS hospitals, and a functioning SART in Tribal communities.
- (2) SART training is best accomplished when the entire team can participate in the SART training. By training together, SART members can gain knowledge and motivation to jointly assess the effectiveness of their current efforts, consider ways to overcome barriers, and plan positive changes.
- D. Victim Advocate Training. The Area Director will ensure that the Service Unit CEO must make access to and the funding available for victim advocacy training for IHS hospital behavioral health providers or registered nurses a top priority.

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3-29.6 SEXUAL ASSAULT MEDICAL FORENSIC EXAMINATION

- A. Equipment and Supplies. Although not all of the equipment and supplies will be needed in every examination, the SAFE or SANE must know how to use all equipment and supplies necessary for the sexual assault examination. The SAFE or SANE must stay current on the latest research on the use of equipment and supplies used in the medical forensic examination. What is appropriate in each case will depend upon the circumstances of the assault and the medical and forensic attention called for, the patients' needs, and the patients' consent to utilize equipment and supplies. The following equipment and supplies must be readily available for the examination, according to jurisdictional policies:
- (1) Standard Examining Room Equipment. Standard examining room equipment for a physical assessment and pelvic examination including a medical examination table with stirrups; an independent light source to aid in visualizing potential biological evidence on the patient's clothing, marks and injuries on the patient's body; vaginal speculum, rectal anoscope; paper for the examination table; exam gloves.
  - (2) Examination Protocol. A copy of the most current examination protocol used by the jurisdiction obtained from local law enforcement. This protocol may be the instructions included in the jurisdiction's sexual assault forensic evidence kit.
  - (3) Comfort Supplies. Comfort supplies for patients which may include clean replacement clothing; toiletries; food and drink after the completion of the exam; and a phone or easy access to a phone in a private location. It is also important to help patients obtain items they may request related to their spiritual healing, (e.g., items used for Tribal traditional healing practices.)
  - (4) Sexual Assault Evidence Collection Kits. Sexual assault evidence collection kits and related supplies (see 3-29.6C below for minimum guidelines for contents). Related supplies include tweezers, tape, nail clippers, scissors, dental floss, collection paper, saline solution, distilled water, extra swabs, slides, containers, envelopes, paper bags, tape, pens, and pencils.

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(3-29.6 - continued)

- (5) Forensic Drying Cabinet. Drying evidence is critical to preventing the growth of mold and bacteria that can destroy its value as an evidentiary sample. Forensic-drying cabinets, or evidence-drying cabinets, provide a safe environment in which to dry wet biological specimens such as blood, semen, or other DNA samples. Forensic-drying cabinets also protect forensic evidence specimens from contamination.
- (6) Digital Camera and Related Supplies. Use the most up-to-date digital camera possible for forensic photography during the initial and follow-up examinations. Related supplies will include a tape measure or ruler for size reference, and additional picture cards or discs depending upon whether the hospital has a disc reader.
- (7) Testing and Treatment Supplies. Testing and treatment supplies needed to evaluate and care for patients medically. Testing supplies may be needed for forensic purposes that are not included in the evidence collection kit. For example, supplies for toxicology testing are often not in the kit.
- (8) Medications. Medications such as antibiotics, emergency contraception, and comfort measures are to be available and administered per established
- (9) Colposcope. A colposcope with photographic capability may be used. Although injuries can be detected visually by examiners without the use of a colposcope, the colposcope is an important asset in the identification of microscopic trauma.
- (10) Microscope. In jurisdictions that require wet-mount evaluations of vaginal or cervical secretions for sperm, a phase-contrast microscope and stain must be readily available.
- (11) Toluidine Blue Dye. The dye is used to assist in identifying recent genital and perianal injuries.
- (12) Alternate Light Source. An alternate light source, e.g., a Woods Lamp, must be available to examine patients' bodies, hair, and clothing. The alternate light source is used to scan for evidence, such as dried or moist secretions, fluorescent fibers not visible in ambient light, and subtle injury.

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- (13) Wet Mounts. Wet mounts may be used to identify certain types of vaginitis such as yeast, Bacterial Vaginosis, or Trichomoniasis, as well as the presence of sperm.
  - (14) Information Packets. Written information materials for patients.
- B. Sexual Assault Evidence Collection Kit. The sexual assault evidence collection kit (evidence kit) generally includes:
- (1) An instruction sheet or checklist to guide examiners in collecting evidence and in maintaining the chain of custody;
  - (2) Forms that facilitate evidence collection and analysis including patients' authorization for collection and release of evidence and information to the law enforcement agency;
  - (3) The medical forensic history; and
  - (4) Anatomical diagrams.
- C. Evidence Collection and Packaging. Most items gathered during evidence collection are placed into the kit after being dried, packaged, labeled, and sealed according to jurisdictional policy. Bags are typically provided for more bulky items that will not fit in the container (e.g., clothing). Some jurisdictions provide large paper bags to hold the container and additional evidence bags. These kits may vary from one another in types of samples collected, collection techniques, materials used for collection, and terms used to describe categories of evidence.
- The kit container must be labeled and include identifying patient information except when the patient chooses not to report; then the kit must be labeled according to jurisdictional policy for evidence kits.
- D. Instruction Sheet. An instruction sheet or checklist is used to guide examiners in collecting evidence and maintaining the chain of custody.

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- E. Forms. Forms that facilitate evidence collection and analysis, including the patients' authorization for the collection and release of evidence and information (including electronic or paper records and photographs) to the law enforcement agency; the medical forensic history; and anatomical diagrams.
- F. Collecting and Preserving Evidence. The following materials must be collected and preserved, as evidence according to jurisdictional policy.
- (1) Foreign materials on patients' bodies, including blood, dried secretions, fibers, loose hairs, vegetation, soil/debris, fingernail scrapings, and cuttings, matted hair cuttings, material dislodged from mouth using dental floss, and swabs of suspected semen, saliva, and areas highlighted by alternate light sources.
  - (2) Patients' clothing and underwear and foreign material dislodged from clothing.
  - (3) Hair evidence including head and pubic hair samples and combings.
  - (4) Vaginal or cervical swabs and smears.
  - (5) Penile swabs and smears.
  - (6) Anal/perianal swabs and smears.
  - (7) Oral swabs and smears.
  - (8) Body swabs.
  - (9) Known blood, saliva sample, or buccal swab for DNA analysis and comparison.
  - (10) There are additional instructions that are distinct from the materials in the kit that the emergency medical technicians or police may also need to collect toxicology samples according the jurisdictional law/policy.

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(3-29.6F – continued)

- (11) In addition, separate from the kit: materials and forms for collecting toxicology samples must be available to examiners and to responding law enforcement officers and emergency medical technicians, according to jurisdictional policy.
- G. Timing Considerations for Collecting Evidence. Examiners shall obtain the medical forensic history, examine patients, and document findings (with patients' consent). Patients' demeanor and statements related to the assault shall be documented. Although many jurisdictions currently use 72 hours after the assault as the standard cutoff time for collecting evidence, many other jurisdictions have extended the standard cutoff time up to 7 days. Advancing DNA technologies continue to extend time limits for DNA testing and allow analysis of evidence that was previously unusable after a certain time period in previous years. Where the need for evidence collection is in question, discuss the potential benefits or limitations of collection with the patient. Even if the patient is reluctant to report the assault to law enforcement, it is recommended that the SAFE or SANE conduct the sexual assault examination, document the findings, and collect the evidence. Therefore, inform the patient of the option of conducting a sexual assault examination, collecting the forensic evidence, and storing the evidence as an anonymous sexual assault evidence kit so that, if the patient changes her/his mind, and decides to report the sexual assault to law enforcement, the evidence will be available for prosecution.
- H. Responding to a Subpoena and Testifying in Court. An IHS employee must immediately notify his or her supervisor and the hospital CEO that he or she has received a subpoena or request to testify in court or an administrative proceeding. The CEO or his or her designee if the CEO is not immediately available, will then scan and email the subpoena or request to testify to the Regional OGC. The Regional OGC will review the request or subpoena for legal sufficiency and then forward the request via confidential overnight mail or a confidential same day fax to attention of the IHS Director at (301) 443-4794. In the event that an employee receives a verbal request for testimony, IHS staff must provide his or her supervisor and the hospital CEO with the name and contact information of the caller and the CEO or designee will immediately convey that information to the Regional OGC. All IHS employees must obtain prior approval from the IHS Director or his or her designee before providing testimony in any administrative or judicial proceeding.

## The Operation of a SART

1. Operations. After identifying members and defining roles, members can plan how to operate their team to best serve community needs. To emphasize confidentiality, all SART members must sign a confidentiality agreement.
2. Activation. Activation procedures should take into account that victims enter the “system” at different points (e.g., through a call to 911 or a 24-hour advocacy hotline, arrivals at the IHS health care facility or disclosure to a community professional). The SART must determine how to publicize its services to community professionals who may have frequent contact with individuals disclosing sexual assaults. These professionals might include, but are not limited to, private primary care providers, health clinic staff, mental health and social service program staff, personnel serving persons with disabilities, substance abuse treatment program staff, school personnel, and personnel from Tribes, faith-based communities, corrections and probation staff, and staff from residential living programs and emergency shelters. It also should publicize its services more broadly to the public, explain the dynamics of sexual assault, and encourage victims to seek help.
3. Regular SART Meetings. Although it might be difficult to involve all relevant responders in SART meetings (e.g., crime labs may be a considerable distance from the community and lack resources to respond to local inquiries), consider options such as teleconferencing to include their perspectives. Outside of an immediate response, the SART should meet regularly for two distinct purposes, as follows:
  - A. To review immediate response in individual cases in order to improve overall team performance. These reviews allow team members the opportunity to give each other feedback on effectiveness of response during the exam process, problems needing resolution, and areas needing improvement. Cases are typically reviewed anonymously, without using victims’ names or other identifying information. During these discussions, it is important that the team respect the confidentiality of information in patients’ medical records and the information that is shared with community-based advocates.
  - B. To maintain and enhance the quality of the SART. This task involves addressing system issues, such as creating and revising policies and procedures in response to local changes in governmental or community-based agencies, scientific or technological advances, and feedback from victims. It also involves sharing general information related to the SART and facilitating the continuing education of the team. Information on the common characteristics of the sexual assaults they respond to can assist with understanding community dynamics and needs, such as housing, alcohol and special populations. This, in turn can aid in

developing community education materials and can be valuable to the Tribe in addressing some of the contributing factors to sexual assault.

4. Member Education. All SART members will engage in continuing education on coordinated response during the exam process, for example:
  - A. Discipline-specific training that advances responder skills and emphasizes a team approach is crucial.
  - B. Multidisciplinary training sessions can describe the SART process, stress the need for a prompt exam, explain the roles and challenges of each discipline emphasize a victim-centered approach, and make clear where coordination among disciplines is needed and how it should occur. They can describe multidisciplinary policies, interagency agreements, standardized forms, and other related materials.
  - C. Multidisciplinary training can also build members' understanding of needs, values/beliefs, and practices of specific populations in their community. They can raise awareness of how different populations respond to disclosures of sexual assault and work to build the capacity of involved professionals to be sensitive to the needs of victims from those populations.
  - D. Cross-training sessions are useful to allow responders from one discipline to educate those from another discipline about the specifics of how they intervene in these cases and answer questions that may arise. For example, law enforcement investigators can educate examiners and advocates about what is involved in a thorough investigation, stressing that the forensic exam of the victim is but one part of the investigation. In jurisdictions that border Indian Country, Federal prosecutors can educate other responders regarding Federal Indian law and how it applies to sexual assault cases.
  - E. Multidisciplinary trainings and cross-trainings can provide a forum for staff from different agencies to get to know and respect one another, build common goals, and increase their comfort in working together. Collaboration among agencies and individuals can provide responders with a broader network of support as they do this work. These trainings can also stress the difficulty of working on sexual assault cases and the secondary trauma that responders can experience. They can facilitate discussion among responders about self-care and preventing or coping with secondary trauma, so they in turn can provide optimal interventions and assistance to victims.

- F. There are more informal educational opportunities and tools that can foster coordination among SART members. For example, all key responders, especially those newly involved in sexual assault cases, may find it useful to tour sites and offices involved in SART response. Such tours and discussions with site/office staff can help build knowledge of what response by each discipline entails and the logistics of that response. Sharing related educational materials and literature is an easy way to continuously expand the base of common knowledge among SART members. Tools such as flow charts and discipline-specific checklists that help SART members understand the continuum of response and appropriately coordinate their interventions may also be useful.
  
- G. Several IHS Hospitals may collaborate to provide SART education.