An Garda Síochána

Forensic Clinical Examiner SATU

Psychological Support Services

Sexually Transmitted Infections

Forensic Science Laboratory

General Practitioner

Recent Rape/ Sexual Assault:

National Guidelines on Referral and Forensic Clinical Examination in Ireland

2nd edition 2010

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

AN ROINN DLÍ AGUS CIRT AGUS ATHCHÓIRITHE DLÍ
DEPARTMENT OF JUSTICE AND LAW REFORM

Guidelines document available from:

Members of An Garda Síochána
Garda Síochána Portal

Forensic Science Laboratory
Sexual Assault Team

Sexual Assault Treatment Unit (SATU) Personnel
SATUs nationally p.14 or details from www.rotunda.ie/satu/units

Rape Crisis Network Ireland (RCNI)
RCNI, The Halls, Quay St. Galway. www.rcni.ie

General Practitioners
ICGP website www.icgp.ie

Infectious Diseases Depts./Emergency Depts./Gynaecology Depts:
SATUs nationally p. 14 or details from www.rotunda.ie/satu/units

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National SATU Guidelines Development Group 2010

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FOREWORD

I welcome this second edition of this comprehensive set of Guidelines for the referral, forensic examination, and support of victims of alleged rape and sexual assault. I am aware that many significant and positive developments have taken place in Sexual Assault Treatment services in Ireland since the publication of the first edition in 2006 and I am delighted to see these reflected in this updated version of the guidelines.

Seeking support in the aftermath of a rape or sexual assault is a huge challenge and the work that Sexual Assault Treatment services carry out plays a vital role in assisting recent victims from a number of perspectives: the collection of forensic clinical evidence for potential future legal cases; the immediate physical and psychological care for the victim; and the referral of victims to appropriate long-term support. The Guidelines build on the good practice established through the publication of the first edition and highlight the improvements and expansion in terms of depth and breadth of services available, such as the provision of services to clients who choose not to report to An Garda Síochána and increased preventative care, for example in relation to sexually transmitted infections.

These Guidelines will ensure the equality of care for all men and women following rape and sexual assault, and will also support the education and training of all the staff working in this very challenging environment.

I extend my gratitude to all those who contributed to this project through their participation in the interagency National Guidelines Development Group.

Mary Harney, TD

Minister for Health and Children

Recent Rape/Sexual Assault: National Guidelines on Referral and Forensic Clinical Examination in Ireland. 2nd edition. 2010.

INTRODUCTION

The purpose of this document is to facilitate all aspects of a responsive and coordinated service for men and women over the age of 14 years who have been raped or sexually assaulted. This is the second edition of the 'Recent Rape/Sexual Assault: National Guidelines on Referral and Forensic Clinical Examination in Ireland' and the updates to the various sections emphasise the many positive developments in the service over the past 4 years.

The interagency nature of these guidelines will enable consistent provision of high quality care at all stages of the journey, regardless of the circumstances of the assault or the person's involvement with criminal justice agencies.

This document also ensures that clearly defined referral pathways exist, so that men and women can access appropriate individualised care that is responsive to their needs. It is important to highlight that people respond to instances of sexual violence in different ways, and while this document provides guidance for compassionate and effective care it does not represent the only medically or legally acceptable response. There may be circumstances where personal or clinical factors may mandate appropriate deviation from these guidelines.

In formulating the second edition of these guidelines, an evaluation of the first edition (2006) was carried out. This evaluation, combined with current best practice, provided the roadmap for updating this edition. Ongoing review and appropriate updating of these Guidelines will be a continued objective of this group. Please forward any feedback and suggestions for future editions to SATU@rotunda.ie with the subject heading: Guidelines feedback/suggestions.

Many different agencies and individual professionals gave of their time, knowledge and expertise during the formation of the second edition of this document and the National SATU Guidelines Development Group thank them all for their collective contribution.

USING THE GUIDELINES

Operational Definitions/Glossary of Terms/Abbreviation List

In devising this book of guidelines, the diversity of language used by each discipline/agency has been recognised. In order to facilitate the reader, the correct terminology which is used by the different professionals is reflected in the section relevant to that discipline. For further clarity, operational definitions, glossary of terms and an abbreviations list have also been included. (p. 153). When you first encounter an operational definition or term included in the glossary, the text is in *italic* print. The first time an abbreviation appears in the document it follows the full text in brackets e.g. Rape Crisis Centre (RCC).

Quick Reference Pages

Quick reference pages have been devised in order to enable practitioners to access information quickly. The quick reference pages are:

- Pathway Options: Recent History Of Rape/Sexual Assault (p. 13)
- Referral Pathway: To a Sexual Assault Treatment Unit (p. 14)
- Contact Details for SATUs (p. 14)
- Guide to Help Preserve Forensic Evidence Which May Be Available. (p. 15)

Discipline/Agency Guidelines Colour Coding

To provide a user-friendly format for the reader of the document, the guidelines section for each discipline/agency is located under a specific colour code.

An Garda Síochána	Forensic Clinical Examiner SATU	Psychological Support Services	Sexually Transmitted Infections	The Forensic Science Laboratory	General Practitioner

Boxes with Key Points

Key points relevant to each guideline are emphasised, not only because of their importance, but also for ease of reference when skimming through a particular guideline. The key points are portrayed in a colour coded box applicable to the discipline/agency within which the guideline appears.

References

To facilitate the reader the references quoted in each particular guideline are recorded directly after that guideline.

PATHWAY OPTIONS: RECENT HISTORY OF RAPE/SEXUAL ASSAULT

Option 1: Reporting an Incident or Seeking Advice from An Garda Síochána

Person seeking advice from An Garda Síochána

RCC available to support person in their decision making.

Seeking Advice - Not Reporting
- Information given re: RCC
- Informed re: health check: **Option 2**
- Informed person can contact Garda **at any time** in the future.

Reporting Incident

Contact SATU if:
- 14+ years of age
- Incident within 7 days
- Consenting to Forensic Clinical Examination
- Use Early Evidence Kit if indicated
- Use unmarked car for transport (where possible)
- Accompanying Gardai – plain clothes (where possible)
- Complainant brings change of clothes to SATU if possible.

Contact SATU for Forensic Clinical Examination and Health Check

Immediate medical assistance should be sought, if necessary.

Under 18 years, Children First reporting procedure should be followed[1]

Option 2: Not Reporting Incident: Health Check

Health Check – Can be performed by SATU or GP

A. Psychological Support

RCC

B. Examine, document and treat injuries

C. Emergency Contraception

D. STI prophylaxis and review

E. Encourage use of Primary Health Care Team

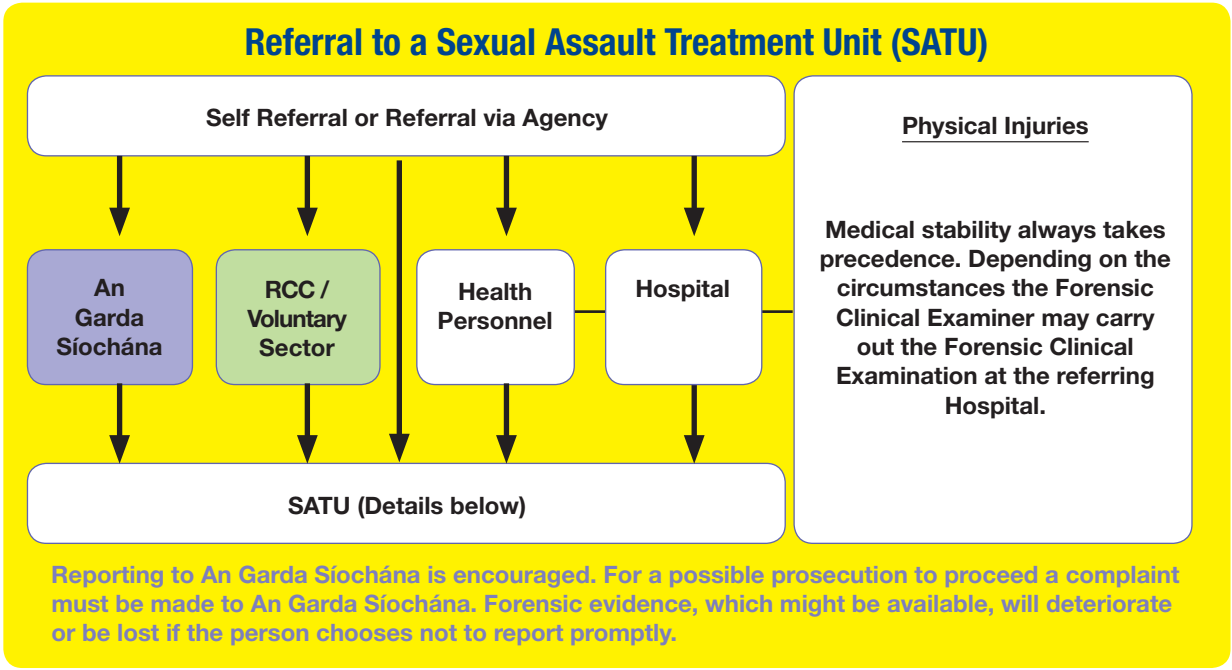
F. Check re:
Friends/family
Ensure Support
Transport
Home is safe

Forensic samples may be taken using the Sexual Offences Examination Kit and stored, providing that protocols, safeguards and appropriate storage facilities are in place. The continuity of evidence must be maintained at all times (p25).

Under 18 years, Children First reporting procedure should be followed[1]

1. Office of the Minister for Children and Youth Affairs (OMC) Children First: National Guidelines for the Protection and Welfare of Children. Dublin: Stationery Office; www.omc.gov.ie or www.lenus.ie

REFERRAL PATHWAY:
TO A SEXUAL ASSAULT TREATMENT UNIT



Sexual Assault Treatment Units (SATUs) in Ireland

LOCATION	ADDRESS	EMAIL ADDRESS	TEL. NO.	OUT OF HOURS
DUBLIN Rotunda Hospital	Parnell Square Dublin 1.	SATU@rotunda.ie	01 817 1736	Phone Hospital 01 8171700 ask for SATU
WATERFORD Waterford Regional Hospital	Dunmore Road Waterford.	wrh.satu@hse.ie	051 842157	Phone Hospital 051 848000 Nurse Manager on duty for Hospital
CORK South Infirmary Victoria University Hospital (SIVUH)	Old Blackrock Rd Cork.	satu@sivuh.ie	021 4926297	Phone Hospital 0214926100 Nurse Manager on duty for Hospital
MULLINGAR Midland Regional Hospital	Mullingar Co. Westmeath.	satu.mrhm@hse.ie	044 9394239 086 0409952	Phone Hospital 044 9340221 Nurse Manager on duty for Hospital
GALWAY Hazelwood House	Parkmore Rd. Galway.	satugalway.hsewest@hse.ie	091 765751 087 6338118	Phone 091757631 Nurse Manager on duty for Merlin Park Hospital
DONEGAL Letterkenny General Hospital	NoWDOC Premises, Oldtown, Letterkenny Co. Donegal.	satu.letterkenny@hse.ie	074 9104436 Bleep 777 087 0664593 087 0681964	Phone Hospital 074 9125888 Nurse Manager on duty in the Emergency Dept.

Preservation of Forensic Evidence

NB. Medical Stability Always Takes Priority

Depending on individual circumstances, this guide should be followed as closely as possible if a person is **reporting the incident and awaiting a forensic clinical examination and collection of forensic evidence**, providing there is no interference with the person's safety and they feel they can comply.

For All Types Of Rape/Sexual Assault

- The type of seat the person sits on should have a clean plastic, leather or leatherette type covering.
- The person should not bathe/shower/douche.[1,3]
- If a condom was used, it should be retained.[1,2]
- The person should not consume alcohol after the assault.

Vaginal & Anal Rape/Sexual Assault

The person should not if possible:

- Pass urine and/or open their bowel.[1]
- Wipe the genital/anal area if they have to go to the toilet.[1]

If possible:

- Save any sanitary protection worn at the time of the assault or afterwards.

Oral Rape/Sexual Assault

The person should not if possible:

- Brush their teeth or use mouthwash.
- Take fluid or food.
- Smoke.

Clothing

The person should if possible:

- Change out of the clothes worn at the time of the rape/sexual assault as soon as possible.
- Place the items of clothing in separate paper bags (not plastic) and label immediately.[1]
- Underwear, worn after the incident, should also be collected and placed in a separate paper bag.[2]

Personnel if possible:

- Do not handle clothing - if clothing is handled then it should be with gloved hands.

If clothing has to be cut:

- It should be cut along the seams of the item.
- Do not cut through any damaged areas or breaks in a garment: which may be the result of the assault or bullet/knife damage.[1]
- Do not cut through blood, semen or fluid marks.[1]

Wounds and Blood/Saliva/Semen Stains

- Blood, saliva or semen stains should have forensic swabs taken prior to cleansing.
- If possible forensic swabs should be taken from any wound area prior to wound cleansing.

Forensic Samples e.g. Weapons, Restraints, Tape, Bullets, Paint, Glass, Soil.

- Do not talk, cough or sneeze over any samples.[1-3]
- Do not handle samples but if specimen must be handled then do so with gloved hands.
- If bullets are handled then use gloved hands – metal forceps should NOT be used.
- Package samples individually in a sealed paper bag and label immediately. (p. 73)

  NB. The continuity of evidence should be maintained. (p. 25)

References

1. Giardino AP, Datner EM, Asher JB. Sexual Assault. Victimisation across the Life Span: A Clinical Guide. St. Louis: GW Medical Publishing Inc; 2003: p.85-6.
2. Crowley S. Sexual Assault: The Medical-Legal Examination. Stamford, Connecticut: Appleton & Lange; 1999.
3. World Health Organisation (WHO). Guidelines for Medico-Legal Care for Victims of Sexual Violence. Geneva: WHO; 2003.

SECTION 1

An Garda Síochána Guidelines

1:1 Role of An Garda Síochána

An Garda Síochána is the **national police service** of the Republic of Ireland. It was established in 1922. An Garda Síochána is a **community based** service organisation with over 14,000 Gardaí and civilian employees. Garda Headquarters is situated at the Phoenix Park, Dublin and there are 703 Garda Stations dispersed throughout the State.

The mission of An Garda Síochána is working with communities to **protect** and **serve**. The functions of An Garda Síochána are laid out by section 7 of the Garda Síochána Act, 2005. The services provided by An Garda Síochána are determined and delivered in consultation and partnership with the community. They are constantly evolving to satisfy the requirements of the community. The key service concerns include **preventing** criminal offences, **investigating** and **detecting** criminal offences, **supporting** victims of crime, safeguarding **human rights** and dignity, guarding the **security** of the State, **preserving** the public peace, **responding** to emergencies, **contributing** to safety on the roads, **improving** the quality of community life and enforcing anti-drug legislation.

When a complaint of a criminal nature is made, the Gardaí have to address two main issues:

- whether an offence was in fact committed, and
- by whom the offence was committed.

The Garda investigation is conducted not with the single-minded objective of creating a case against a particular suspect while ignoring all other evidence, but with a view to establishing the entire truth in relation to the incident(s) concerned.

Once the formal Garda investigation is complete, a file is sent to the Director of Public Prosecutions, whose function it is to decide whether there is sufficient evidence to prosecute any suspects, the charges, if any, to be preferred and the court in which those charges will be tried.

In cases of breaches of the Criminal Law, Gardaí have a right of audience before the District Courts. The Gardaí generally prosecute on behalf of the Director of Public Prosecutions (DPP) at District Court level. Cases heard in the higher courts are prosecuted through the Chief Prosecution Solicitor's Office. The adjudicative stage of the system is totally independent of An Garda Síochána. The Gardaí present the facts to the Court and the Court decides on the innocence or guilt of the accused person.

If the Court does decide that an individual is guilty beyond reasonable doubt, then the Judge, when deciding the appropriate sentence for the convicted person, will request background information on the culprit from the Gardaí. To assist the Judge in making an informed decision regarding the sentence the Gardaí supply all known background information, both favourable and unfavourable, to the Court. The Judge will look for a Victim Impact Report regarding the effect that the criminal offence has had on the injured party.

The penal stage of the system is also independent of An Garda Síochána and Gardaí do not have an input as to where a prisoner is located or the category assigned to the prisoner. An Garda Síochána do provide information to Prison Governors on a particular prisoner's background, especially where the prisoner is unknown to the prison authorities. An Garda Síochána is separate and autonomous from the other elements of the Criminal Justice System, but there is a high degree of goodwill and co-operation between the different agencies.

See also

App. 1: The Law in Relation to Sexual Offences in Ireland.

App. 2: Sexual violence prevalence information.

1:2 Initial Actions on Receipt of a Complaint

These guidelines outline the procedures that Gardaí should adhere to during investigations regarding sexual crime. Gardaí must consider these guidelines in conjunction with the following documents:

- The Garda Síochána Policy on the Investigation of Sexual Crime, Crimes Against Children and Child Welfare.
- Chapter 23 of the Garda Síochána Code.
- The Garda Síochána Crime Investigation Techniques Manual.
- Children First: National Guidelines for the Protection and Welfare of Children.
- Other relevant Garda H.Q. Directives.

Disclosing a sexual offence is often difficult for a *complainant*. Gardaí should adopt a caring, sensitive and non-judgemental approach throughout the entire investigative process. Investigating Gardaí should bear in mind the emotional and physical pain the victim may be suffering, while ensuring that all available evidence regarding the reported offence is obtained. On receipt of a complaint to a member of An Garda Síochána, where a Forensic Clinical Examination is required, the following steps should be followed:

- **Immediate medical assistance should be sought, if necessary.**
- The investigation process **must** be explained to the complainant.
- It should be established if the **complainant** consents to a Forensic Clinical Examination.
- Where the complainant is under 18 years of age, the consent of the parents/guardians is also required.

- Contact is made with a Sexual Assault Treatment Unit/*Forensic Clinical Examiner* to arrange an early Forensic Clinical Examination. (Referral pathway options p. 14).
- Use an Early Evidence Kit where necessary and appropriate, particularly where the forensic examination is expected to be delayed. (p. 23)
- To prevent the cross-contamination of evidence (p.105), ensure any suspect(s) are not brought to any place that the complainant has been.
- Use an unmarked patrol car, where possible, in taking the complainant to the Sexual Assault Treatment Unit/Forensic Clinical Examiner.

KEY POINTS

KEY POINTS: Sensitivity to Complainant

- **Be aware and sensitive to the needs of the complainant.**
- **Explain procedures.**
- **Consent sought for Forensic Medical Examination.**
- **Use unmarked patrol car where possible.**
- **Gardaí should dress in plain clothes if possible.**
- **Avoid areas where complainant may be identified if possible.**
- **Use Early Evidence Kit if indicated. (p. 23).**
- **Change of clothing brought with complainant to SATU.**

- Different vehicles should be used to transport the complainant and the suspect to prevent cross-contamination.
- The Gardaí should dress in plain clothes (where possible) to avoid identification of the complainant.
- To prevent cross-contamination the member dealing with the victim should not have physical contact with any suspect(s) (and vice versa) prior to the taking of forensic samples, clothing, etc from the victim and/or suspect(s).
- If possible avoid using areas of the Hospital where the complainant could be identified.
- Be aware of the needs of the complainant at all times.
- A clothes change for the complainant should also be taken to the SATU if possible.
- Where the forensic examination is cancelled for any reason, the investigating Garda must ensure that all relevant persons are immediately informed, such as the centre providing the Forensic Clinical Examination, Scenes of Crime Unit, etc.

KEY POINTS

KEY POINTS: Preventing Contamination of Evidence (See also p. 106)

- **Do not allow the suspect to be any place that the complainant has been.**
- **Different vehicles should be used to transport the complainant and the suspect.**
- **Different Gardaí should deal with the complainant and suspect(s), before forensic samples, clothing, etc are taken from the complainant and/or suspect(s).**

1:3 Interviewing the Complainant

Following a complaint of Rape or Sexual Assault, a member of An Garda Síochána should interview and take a statement in writing from the complainant. Members should first ensure that the investigation process is explained to the complainant. The interview should be conducted as soon as is practicable in a suitable location for the complainant and the Garda, balancing the needs of the investigation with the needs of the complainant. The statement will contain a detailed account of the events leading up to the incident, the incident itself and the events following the incident. It will be the complainant's account of what took place and any other salient information that may assist the investigation. The statement will provide a written record that will allow a decision to be made on the appropriate action to be taken.

As far as practicable, the complainant will be facilitated with a male or female Garda, depending on the wishes of the complainant. While Garda Specialist Victim Interviewers (see 1:4 below) have been trained specifically to deal with children under the age of 14 years and persons with intellectual disability, they may also be employed to take statements from other adult complainants. On completion of the statement, it will be read over to the complainant and they will be invited to sign the statement if they are satisfied as to its accuracy. The complainant will be given a copy of her/his statement.

1:4 Specialist Victim Interviewers and Dedicated Interview Suites

Section 16(1)(b) of the Criminal Evidence Act, 1992 provides that the video recording of an interview with a child under 14 years of age, or a person with an intellectual disability, may be admissable as direct evidence in court proceedings where that child/person has been a victim of:

- A sexual offence.

- An offence involving violence or threats of violence to a person.
- An offence under section 3, 4, 5 or 6 of the Child Trafficking and Pornography Act 1998.
- An offence under section 2, 4 or 7 of the Criminal Law (Human Trafficking) Act 2008.
- Attempting, conspiring to commit, or aiding, abetting, counselling, procuring or inciting the commission of such an offence.

While the majority of complainants interviewed by Specialist Victim Interviewers may be under 14 years of age and the guidelines herein refer to complainants over the age of 14 years, the provisions of section 16(1)(b) of the Criminal Evidence Act 1992 also apply to persons over the age of 14 years with an intellectual disability. Furthermore, the employment of Specialist Victim Interviewers should be considered for the taking of written statements from all other complainants of sexual crime, where Specialist Victim Interviewers are available.

When video-recorded interviews are deemed appropriate, they are conducted with the complainant's consent, following a discussion with the complainant and her/his family as to the possible outcomes. Where a complainant declines to be video-recorded, a statement will be taken in writing by Specialist Victim Interviewers. (See Key Points)

Garda and HSE personnel throughout the State have received extensive training as Specialist Victim Interviewers and must be employed where appropriate in the circumstances outlined above.

A number of dedicated interview suites have been developed throughout the country to be used for the video-recorded interviewing of such complainants. Depending on the availability of these suites they may also be employed for the taking of written statements from other victims of sexual crime, as the setting may be more appropriate than most areas in Garda stations.

KEY POINTS

KEY POINTS: Taking a Statement

- **Take as early as practicable.**
- **Arrange a suitable location.**
- **Complainant facilitated with male or female Garda.**
- **The investigation process is explained to the complainant.**

Specialist Victim Interviewers and Dedicated Interview Suites:

- **For all complainants under the age of 14 years.**
- **For all persons with an intellectual disability.**
- **For other complainants of sexual crime over the age of 14 years, where appropriate.**

Detailed Account Taken of:

- **Events leading up to incident.**
- **Incident itself.**
- **The events following the incident.**

On Completion of the Statement:

- **It is read over to the complainant.**
- **The complainant signs the statement.**
- **The complainant is given a copy of the written statement.**

1:5 Early Evidence Kits Oral or Drugs/Alcohol Facilitated Rape/Sexual Assault

Occasionally it may not be possible for the complainant to see a Forensic Clinical Examiner immediately after reporting the crime. With every hour that passes, physical evidence may deteriorate or be lost. Because of this, an Early Evidence Kit is available to be used by members of An Garda Síochána in cases of rape/sexual assault.

The early evidence kit contains:

Instructions, disposable gloves, 4 swabs, small universal container, large container for urine sample, sterile water, disposable panties, sanitary towel and a tamper evident bag.

Availability and Use of the Early Evidence Kit

- The Early Evidence Kit should be available in all Garda stations so that it can be accessed quickly.
- The Early Evidence Kit is **not** a replacement for the existing Sexual Offences Examination Kit, or for the Forensic Clinical Examination.
- It is designed to be used in cases where there is going to be a delay between the complaint of rape/sexual assault and the Forensic Clinical Examination.
- **It is to be used primarily in cases where:**

  A. Non-consensual oral sex is reported/suspected to have been an element of the sexual offence, (See Box: A over) and/or

  B. Toxicological examination may be required as it is reported/ suspected that the rape or sexual assault was drug/alcohol facilitated (e.g. where the complainant's drink may have been 'spiked'). (See Box: B over)

Early Evidence Kits

Box A: Oral Sex

If oral sex is disclosed, the swabs should be taken at the earliest opportunity. If the complainant wishes to have a drink, the mouth should be swabbed before the drink is taken. At least three swabs should be taken; an internal mouth swab, a gums/teeth swab and a swab from the lips. It would be preferable if the Garda took these swabs rather than the complainant.

- Gloves must be worn and swabs should be pre-labelled by the Garda with the victim's name and the site that the sample was taken from.
- If the reported sexual assault occurred more than 24 hours prior to presentation, there is no need to take oral swabs, as semen does not persist in the mouth beyond this time. (p. 108)

Box B: Drug/Alcohol Facilitated Rape/Sexual Assault

- If the complainant wishes to urinate and there is a delay getting a Forensic Clinical Examiner, a urine sample should be collected at this point.
- A large container is available in the Early Evidence Kit for the collection of urine. This can then be decanted into the smaller screw cap container provided.
- A Garda should witness the urine sample being taken and fill in the accompanying information form. Standing outside the cubicle is deemed adequate for witnessing.
- Urine samples collected from complainants of drug facilitated rape/ sexual assault are analysed in the Forensic Science Laboratory. A urine sample should be collected as soon as possible after the incident and up to 120 hours after the reported assault (See section 5.8 on toxicology, p. 110).

Procedure when using the Early Evidence Kit

- The Garda who is present for the collection of these samples should have no prior contact with the suspect.
- Check the expiry date on the Early Evidence Kit.
- Gloves must be worn.
- Explain the purpose of the Early Evidence Kit to the complainant.
- Obtain from the complainant her/his written consent (on a separate sheet of paper) for the collection of the samples before using the Early Evidence Kit.

- To enable the Forensic Scientist to interpret any results obtained, the Garda must fill out the information form accompanying the Early Evidence Kit.
- If/when a Forensic Clinical Examination is carried out on the complainant, the Forensic Clinical Examiner should be informed that the Early Evidence Kit was used and whether urine and/or oral swabs have been taken.

KEY POINTS

KEY POINTS: Using Early Evidence Kit

- **Check the expiry date on the Early Evidence Kit.**
- **Take swabs as soon as possible within 24 hours.**
- **Take 3 swabs.**

Swab sites

- **Inside the mouth.**
- **Gums/teeth.**
- **Lips.**

- **Inform the Forensic Examiner when an Early Evidence Kit has been used.**

1:6 Continuity of Evidence

Items of evidence i.e. clothing, swabs, weapons etc., are referred to as exhibits.

Each item of physical evidence to be produced in court as an exhibit, must be identified by whom, where and when it was taken. This is achieved by hearing the evidence of the person who took possession of the item at the particular place and the date and place it was found.

Each witness may be required to give evidence as to what was done with the item.

A Garda assumes the role of Exhibits Officer and all items should be handed over to the Exhibits Officer, who will prepare a chart showing all movements of the exhibits.

It is desirable that physical evidence passes through the custody of as few persons as possible.

A careful record of all exhibits should be maintained as follows:

- Description of the item.
- Source or location of item.
- Date and time of transfer of the item.
- From whom.
- To whom.

1:7 Collection of Clothing from the Complainant

- To avoid contamination, use gloves and other personal protection equipment (such as disposable coats) as required.
- The Garda who takes possession of the complainant's clothing should have no prior contact with the suspect.
- The Garda should establish whether these clothes have been washed since the reported rape/sexual assault.
- Possession should be taken of the clothing the complainant was wearing **during** the reported rape/sexual assault, preferably before attending for a forensic clinical examination to preserve evidence.
- Where the change of clothes has taken place prior to the forensic clinical examination, the need to take possession of the new clothing, particularly underwear, may also be considered. Exhibit bags should be available for such an occurrence.
- Each garment/item should be placed in a separate exhibit bag.
- The exhibit bags should be sealed and clearly labelled by the Garda. Seal the bags by folding over the top of the bag and securing with staples or sellotape.
- If envelopes are used for smaller exhibits, these **should not** be sealed by licking.
- If the clothing is **dry**, pack items into separate sealed paper bags (Wet clothes - see Box 1).
- Sanitary protection should be packed in paper bags supplied in the kit and then placed in the appropriate re-sealable plastic bag labelled "Panties/Sanitary Module".
- Continuity of evidence (p. 25) should be maintained at all times.

KEY POINTS

KEY POINTS: Colds/Allergy/Hay Fever

- **Masks should be worn.**
- **Avoid sneezing directly onto the clothing.**

Box 1: Wet or Heavily Blood Stained Clothing

- If the clothing is wet or heavily stained with wet blood pack items into separate paper bags, seal and submit to the Forensic Science Laboratory immediately for drying.
- Inform the Forensic Science Laboratory when submitting exhibits that are wet or heavily bloodstained and that they require drying.

1:8 Transfer and Storage of the Completed Kits (Sexual Offences Examination Kit and Toxicology Kit)

This guideline covers the transfer and storage of the completed Sexual Offences Examination Kit and if present, the Toxicology Kit from the Examination Centre to the Forensic Science Laboratory.

- **Keep the medical form and toxicology form separate from the kits, do not put them in the tamper evident bags with the samples. The forms must be submitted by the Gardaí when submitting the Kit/s to the Forensic Science Laboratory.**
- On completion of the Forensic Clinical Examination, the samples taken should be packed and sealed in the new tamper evident bag provided for this purpose in all Sexual Offences Examination Kits.
- Toxicology Samples (i.e. alcohol/drug module): if taken, samples should be packaged in the new tamper evident bag provided for this purpose in all alcohol/drug modules.
- The person who packs and seals the used Sexual Offences Examination Kit and Toxicology Kit should fill in the label on the bags.
- The Garda should keep a record of the Serial Number on the Sexual Offences Examination Kit bag and on the Toxicology Kit bag.
- The Sexual Offences and Toxicological Kits should be transported to the Forensic Science Laboratory, as soon as possible, by a member of An Garda Síochána, but in the interim the Kits should be kept in a fridge in a secure location.
- Continuity of evidence should be maintained at all times. (p. 25).

KEY POINTS

KEY POINTS: Transfer and Storage of the Kits

- **Do not pack the medical form or toxicology form in with the samples. The forms must be submitted by the Gardaí when submitting the Kit/s to the Forensic Science Laboratory (p.25).**
- **Samples must be packed and sealed in the tamper evident bag from the Kits.**
- **Person who packs and seals also labels the bag (p. 25).**
- **Garda keeps a record of the serial numbers on the tamper evident bags.**
- **Transported to the Forensic Science Laboratory – ASAP.**
- **If delays in transporting, store in a secure fridge.**
- **Maintain continuity of evidence at all times. (p. 25).**

Recent Rape/Sexual Assault: National Guidelines on Referral and Forensic Clinical Examination in Ireland. 2nd edition. 2010.

SECTION 2

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Forensic Clinical Examination Guidelines

2:1 Forensic Clinical Examiner Role

The Forensic Clinical Examiner has many roles. **A caring, non-judgemental** approach is of the utmost importance when providing services for a victim of sexual crime. The Examiner should clearly convey that no one deserves to be raped and the *patient* is not responsible for the assault. The person should be reassured that he/she made the best choices possible, under the circumstances. It is important to remember, that the person may not recollect the entire incident, or may be unable to talk about some aspects of the incident.

All victims should be encouraged to **report** the assault to An Garda Síochána. The person, however, should be made aware that they can themselves decide whether or not to progress the complaint. Although forensic samples will usually be taken up to 7 days after an alleged incident, physical evidence (if present initially) may not exist more than 72 hours after the assault. **Prompt reporting** should therefore be encouraged.

Healthcare providers are responsible for **documenting** the pertinent aspects of the **history** (p. 52) performing a careful physical **examination**, collecting the required forensic material, treating physical injuries that have resulted from the assault, providing care in terms of prophylaxis against pregnancy and sexually transmitted infections and ensuring that there is appropriate psychological support. **Consent** for all of the procedures undertaken should be obtained after a thorough explanation.*

The history taken should be sufficiently **precise and accurate** to ensure an appropriate examination and collection of relevant forensic evidence. The Examiner must be able to detect and document all physical injuries and for this reason, must be familiar with the normal appearance of the genito-anal region. The Examiner must pay close attention to detail and must **record** all samples taken.

An objective report of the history and examination findings is best prepared immediately, while the details remain fresh in the Forensic Clinical Examiner's mind.

*App. 3: Excerpt re: Consent from National Patient Documentation Template

KEY POINTS

KEY POINTS: Forensic Clinical Examiner Role

- Adopt a caring non-judgmental attitude.
- Consent should be obtained for all the procedures undertaken.
- Pertinent aspects of the history must be documented. (p. 52)
- Collect all forensic evidence and record all samples taken. (p. 57)
- Detect, treat and record any physical injuries.
  - o Provide care and prophylaxis against:
  - o Pregnancy. (p. 79)
- Sexually Transmitted Infections. Section 4 (p. 94)
- Ensure that appropriate psychological support is given. Section 3 (p. 86)
- A report of the history and examination should be prepared as soon as possible.
- The report should include objective interpretation of the findings.**
- Appropriate follow up should be organised and patients given the details in writing.

* App. 3: Excerpt re: Consent from National Patient Documentation Template.

** App. 4: Legal Report Template.

2:1.1 Evaluation of Patients with Serious Injury

The Forensic Clinical Examiner is sometimes asked to evaluate a patient who has significant physical injury. Significant physical injury is rare, but may be more common in *stranger* attacks, rapes by an *intimate partner* and in male rape.[2] In this circumstance, life threatening conditions must be dealt with as a priority, and the Forensic Clinical Examination can then be performed after stabilisation of the patient. Depending on the circumstances the Forensic Clinical Examiner may carry out the Forensic Clinical Examination at the referring Hospital (See Box 2). In these situations it is important to document the extent and reason for any delay. (See consent re: unconscious patient p. 43)

KEY POINTS

KEY POINTS: Patients with Serious Injury

- Life threatening conditions must be dealt with as a priority.
- Forensic Clinical Examination performed after stabilisation of patient.
- The Forensic Clinical Examiner may carry out the examination at the referring Hospital.
- Document any delay and reason for the delay in performing Forensic Clinical Examination.

Box 2: Forensic Clinical Examination in locations other than a SATU

In certain circumstances (e.g. comorbidities, security concerns) it may be necessary to conduct an examination outside the confines of a dedicated SATU (e.g. Emergency Department, Prison).

The following points should be noted

1. A liaison person should be identified by the Hospital or other facility where the Forensic Clinical Examination is to be carried out.
2. Both the Forensic Clinical Examiner and Support Nurse should attend such cases.
3. Each SATU should have a defined list of items to be brought to a case. This list should include the clinical chart, Sexual Offences Examination Kit, equipment and disposable linen (if available).
4. Medications that may be required should also be brought – e.g. Emergency Contraception, Chlamydia prophylaxis, Hepatitis B immunisation and PEP (HIV).
5. Consideration needs to be given to potential sources of DNA contamination in the location of the Forensic Clinical Examination (e.g. Emergency Department).
6. Appropriate cleaning of the location prior to the examination and minimisation of staff throughput during the examination are important factors.
7. Forensic samples must only be taken with a Garda present, to ensure the continuity of evidence from the moment of collection. (Section 1.6, p. 25).
8. Patient information and appointment cards should be provided to facilitate ongoing patient care.
9. Appropriate follow up including RCC is organised.
10. Consent and the unconscious patient (See section 2:3.3, p. 43).

2:2 Support Nurse/Midwife Role

Nurses/Midwives must be registered in the General Nursing and/or Midwifery Section of An Bord Altranais Register and, in addition, must have undertaken special training in providing services for victims of sexual violence in order to work in SATUs. The Nurse/Midwife must also have a clear understanding of unit protocols, guidelines, rules and laws pertaining to this area. On completion of training and achieving competency, the unit management will secure a commitment to the on-call rota for the unit.

The Support Nurse/Midwife is part of a team of professionals responsible for providing a co-ordinated response to victims. The SATU's priority must always be the health and welfare of the patient. The patient's health care needs should take priority over medico legal services. Coping as a victim depends greatly on experiences immediately following the crime of rape/

sexual assault. The care received by the victim from all members of the multidisciplinary team will frame his/her recovery.

The role of the Support Nurse/Midwife in SATU is to co-ordinate the specialist service available for patients who attend the unit as a result of sexual assault and to support the patient during his/her attendance in SATU. Most patients attending SATU out of hours do so in an acute capacity. They are accompanied by An Garda Síochána at a pre-arranged appointed time. The other team members are the Forensic Examiner and a *Psychological Support Worker* from the Rape Crisis Centre.

Duties of Support Nurse/Midwife:

- Arrive 15 minutes in advance of case.
- Inform nursing administration office of arrival.
- Inform Security as per local protocol.
- Ensure that the unit is ready for the patient's reception.
- Clean any hard surfaces in the examination room as per protocol and dress the examination couch.
- Meet the patient, Garda and Rape Crisis Centre (RCC) Psychological Support Worker on arrival.
- Greet the patient by name.
- Introduce yourself by name and title and very briefly outline your role.
- Assess the patient's medical needs. Medical stability must always receive priority over forensics.
- Document any reason why a delay may occur and the extent of that delay.
- Give a brief explanation of the procedures and their purpose, using clear language and in a gentle and sensitive manner.
- Emphasise that their permission will be sought for the process and it will only proceed with their consent. Each step of the process will be clearly explained to the patient before it is undertaken. This helps to restore their self-esteem and sense of control.
- Be relaxed, centred and aware of your body language.
- Sit beside the patient rather than stand over them.
- Provide unhurried and confident actions with direct eye contact.
- Do not judge dress or 'behaviour.'
- Do not try to minimise the individual's trauma by using words such as "well at least……"
- Do not question the patient's actions or decisions, it may cause distress.
- Affirm: "Whatever you did worked, because you survived, you are here now"

- Reassure the patient regarding his/her safety and confidentiality.
- If the patient is alone, offer to contact a family member or friend if needed for support.
- Encourage the patient to vent his/her feelings, concerns and needs.
- Validate the patient's feelings, concerns with empathetic listening, compassion and appropriate information.
- Patients respond to stress in different ways and their behaviour and mood may not be what you expect. Give reassurance that his/her response was normal - be aware that there is no typical victim, so there is no typical response.
- If the patient was not orally assaulted, offer him/her a cup of tea or a cold drink.

Oral Assault

- If the patient was orally assaulted, mouth swabs and external lip swabs could be taken at this time with the patient's consent, and in the presence of the Gardaí (for continuity of evidence: p. 25).
    - Accompany patient to the examination room with the Garda. Open the Sexual Offences Examination Kit under Garda supervision checking that it is in date. Label the swabs appropriately and as per protocol. Take 2 swabs from teeth and gums and 2 swabs from external lips i.e. one moist and one dry. Ensure Garda signs the swabs for continuity of evidence. (p. 25).
    - The patient can now brush his/her teeth and attend to oral hygiene.
- If the patient needs to pass urine urgently, open the Sexual Offences Examination Kit in the presence of the Garda and the labelled urine bottle can be given to obtain a sample – maintaining continuity of evidence.
- Leave the patient in the company of the RCC Psychological Support Worker/family member/friend while you are preparing for the Forensic Clinical Examination.
- Witness the opening of the Sexual Offences Examination Kit in the presence of the Garda and sign documentation.
- Organise the labelled swabs, containers and receptacles for forensic samples on the trolley in the examination room.
- Have the light source, speculum, measuring tape, scissors, and proctoscope available in an organised fashion. Where possible have all this work completed before the patient is taken into the unit as this will provide a sense of calm and tranquillity.
- Sign the chart as a witness to the informed consent being obtained from the patient.*

*App. 3: Excerpt re: Consent from National Patient Documentation Template

- Sit beside the patient during the history taking and offer support if necessary.
- When the Forensic Clinical Examiner has completed taking the history, bring the patient into the examination room.
- Show the patient “a swab” and explain that this is used to obtain the DNA (Deoxyribonucleic Acid) from the part of the body touched by the perpetrator.
- Obtain vital signs, height and weight.
- Leave him/her to undress, put on a hospital gown and provide the urine sample.
- Do a pregnancy test on urine where indicated. Document result.
- The clothing may be collected in brown paper Garda bags by the Garda, itemised, labelled and signed by Garda. Provide gloves for Garda if handling clothing. (Section 1:7 p. 26).
- Provide encouragement and support to the patient throughout the forensic examination.
- Assist and support the Forensic Examiner during the examination and taking of the samples.
- Avoid contamination of swabs – talking over swabs while containers open, sneezing, coughing or touching swabs. (p. 107).
- Collect all samples taken and give to Forensic Examiner and Garda to initial and package appropriately.

Post examination Care

- Offer a shower and change of clothing after the examination.
- Clean and dress wounds where indicated. Section 2:10.1 (p. 76).
- Check the medications with the Forensic Examiner before being administered to the patient:
- Medications that may be prescribed include:
    - Levonorgestrel 1.5mgs Section 2:12 (p. 79)
    - Azithromycin 1gram; Section 4:2.1 (p. 95)
    - Hep B vaccine; Section 4:2.2 (p. 95)
    - PEP (HIV) where indicated after risk assessment. Section 4:2.3 (p. 96)
    - Sign the chart when medications are administered.
- Discuss the medication given including effects and possible side effects, give medication information leaflet and advise actions necessary if medications not tolerated.
- Give the patient a SATU information leaflet which will include contact numbers for the Unit, Garda’s name, station and phone number and information regarding examination and processing of samples.

- Arrange follow-up appointments for Sexually Transmitted Infection (STI) screening as per local protocol. Section 4 (p. 94)
- If patient is less than 18 years inform parent/guardian that notification of attendance will be sent to HSE Social Services. Section 2:13.1 (p. 81)
- Explain to the patient the process of analysing the swabs in the Forensic Science Laboratory and the approximate length of time it takes.
- Ask the patient if he/she has any queries about any part of the process and, if so, provide the appropriate information.
- Consider if a letter for work/school is required and arrange as appropriate.
- Discuss contact details and letter for GP - document in chart. Section 6:2 (p. 119)
- When the Forensic Clinical Examiner has completed all the documentation, allow the patient return to the waiting area and spend some time with family/friend/Psychological Support Worker. Give a cup of tea/coffee if desired.
- When the patient and Garda are ready, see all parties in attendance off the premises in a courteous manner.

Documentation

- Write the case notes in the SATU register and sign accordingly.
- Write up nursing notes pertaining to the case in the patient's chart.
- Document any relevant notes in the communication book e.g. items for ordering or repair.
- Fill in the on-call book.

Cleaning the Unit

- Place used laundry in appropriate bags.
- Treat used instruments as per protocol.
- Clean unit as per protocol. Section 5:5 (p. 106)
- Clean blood spillages if indicated.
- Leave the Unit in an appropriate fashion to receive the next patient.
- Clean and tidy the reception area.
- Ensure doors to the Unit are secure after you exit.
- Inform Security that the case has finished as per local protocol.

Nurses need to be aware of their importance of maintaining their own personal health. Each unit must have a system where psychological support is available to staff to help deal with trauma.

Some Do and Don'ts When Receiving the Patient

Do	Don'ts
Reassure the patient regarding his/her safety and confidentiality.	Proceed if the patient is not medically stable.
Listen, reassure and affirm: "Whatever you did worked, because you survived, you are here now."	Proceed with an examination if the patient is not consenting.
Encourage the patient to vent his/her feelings, concerns and needs.	Judge the patient's dress or behaviour.
Give reassurance that his/her response was normal - be aware that there is no typical victim, so there is no typical response.	Try to minimise patient's trauma by using words such as "well at least……"
If the patient is alone, offer to contact a family member or friend if needed for support.	Question the patient's actions or decisions. This creates disbelief and may re-victimise.
Contact the on-call Psychological Support Worker from the RCC if not already present.	Make assumptions about what the patient needs.

References

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2:3 Consent to Forensic Clinical Examination

The purpose of a forensic clinical examination is explained to the patient in a way that they can understand.[1] The patient should be fully informed throughout the process, allowing them make informed choices about their care.[1-3] A person's consent should be given freely, voluntarily and without coercion providing she/he is of the legal age and with the mental capacity.[2] (See box 3) The patient is entitled to be accompanied during any such discussion by an advocate of their choice.[29]

Box 3 Consent

Consent is obtained when:

- The person is fully informed, is of legal age and has the mental capacity.

Remember

- Consent is fluid and is an ongoing process and the patient can withdraw consent at any stage.
- Every patient and every situation is unique.

Consent is witnessed and signed by:

- Patient or
- Parent/guardian. Where a parent/guardian signs, best practice is to also have the patient sign where possible.
- Forensic Clinical Examiner.
- Attending member of An Garda Síochána.
- Support Nurse/Midwife.

An outline of what should be explained to the patient prior to obtaining consent for forensic clinical examination can be found in the National Patient Documentation Template.* It is vital to ensure that the patient understands that findings of the examination as well as forensic samples will be recorded and disclosed to criminal justice agencies.

Read the consent form to the patient. At each section, a tick box is completed, to indicate if the patient is in agreement with each of the elements of the consent. The Forensic Clinical Examiner then obtains written informed consent for the forensic clinical examination from the patient/parent or guardian. The consent is witnessed and signed by the attending Garda and the assisting Nurse/Midwife. Although a consent form has been signed, gaining consent is seen as a continuing process throughout the patient's attendance at SATU.[20]

* App. 3: Excerpt re: Consent from National Patient Documentation Template.

Consent is also appropriately sought for:

- Any care/treatment given.
- Provision of a report to the GP regarding their attendance at the SATU.
- Future contact with the patient and methods of contact that they would prefer.
- The anonymous use of records for audit and research purposes by the SATU.

2:3.1 Special considerations re: Consent

Age

The age in relation to consent for a forensic clinical examination is governed by different elements of the law (See table 1), all of which should be considered when obtaining consent for someone less than 18 years of age. The Childcare Act 1991[11] provides that due consideration must be taken of the wishes of the child as the child increases in age and understanding. If a parent or guardian is the legal consent signer, the young person, if appropriate, should also be encouraged to co-sign the consent form.

Table 1: Consent and Age Considerations

Age	Legal consideration	Legal reference
16 yrs	A minor who has attained 16yrs can consent to surgical, medical and dental treatment.	Section 23: Non-Fatal Offences Against the Person Act (1997)[7]
<18yrs	A 'child' means a person under the age of 18 years other than a person who is or has been married. The act states that: in so far as is practicable, give due consideration, having regard to their age and understanding, to the wishes of the child.	Childcare Act (1991)[11] Children First: National Guidelines (DOHC, 1999, OMC)[5, 6]

Guidance on Consent and the Young Person

Guidance in obtaining consent for children under 18 years can be obtained from the consent policy within the relevant Hospital, the HSE regional policy or from the following publication: HSE Children and Family Services: Staff Guidelines for Obtaining Consent for Non Emergency Treatment/Services from Parents of Children under the Age of 18 years.[12]
http://www.hse.ie/eng/Publications/services/Children/medconsentpub.html

For a person under the age of 18 years the Children First: National Guidelines [5, 6] reporting mechanisms should be followed.

2:3.2. Capacity

Capacity means the ability to understand the nature and consequences of a decision in the context of available choices, at the time the decision is to be made.[13] Some adults have a decision making ability which is permanently or temporarily limited so they may not have the capacity to make certain decisions.[14]

Assessment of Capacity

There is a presumption of capacity for every person who has reached the age of majority, which is 18 years of age.[10] Capacity should focus on the specific decision that needs to be made, at the specific time the decision is required. It does not matter if the capacity is temporary, or the person retains the capacity to make other decisions, or if the capacity fluctuates. The assessment of capacity is task-specific.[15] (See Box 4)

Box 4: To Demonstrate Capacity Individuals Should Be Able To:

a. Understand in simple language what the forensic clinical examination is, its purpose and nature and why it is being proposed.

b. Understand the principal benefits, risks and alternatives.

c. Understand in broad terms the consequences of not having a forensic clinical examination and appropriate treatment.

d. Retain the information for a sufficient period of time, in order to consider it and arrive at a decision. [3: Adapted]

Best Interests of the Patient

The Forensic Clinical Examiner must always work from a position of best interests or best course of action[17, 18] in any decisions that are made regarding patient care. English law suggests 'best interests' encompasses not only medical but also 'emotional and all other welfare best interests.'[17, 18] Best interest decisions weigh up a range of factors (including the wishes or preferences, if known, of the person and the views of their families and carers) and decide what is on balance, the best for the person both now and in the future.[17, 18]

2:3.3 Patient with Serious Injury/Unconscious

Attendance in an acute care setting to carry out a forensic clinical examination on a seriously ill/unconscious patient should be with the prior knowledge of the consultant in charge of that patient's care. Each patient and their condition should be evaluated on an individual basis. Consideration is always given to the constitutional rights [16, 17] of the patient namely:

- The right to life.
- The right to bodily integrity.
- The right to privacy.
- The right to self-determination.

Acting on the basis of good professional practice,[17,18] the forensic clinical examination should be undertaken[1] if it is considered to be in the best interests of the patient. The rationale behind any decisions, the factors considered and the judgements made about best interests need to stand up to any future scrutiny.[18] All steps taken are clearly documented and why the decision to proceed/not proceed was in the patient's best interests.[1] (See Box 5)

Patient Regains Capacity

If the patient regains capacity to understand, they are informed as soon as possible, that a forensic clinical examination was/was not carried out and why.

Box 5: Patient with Serious Injury/Unconscious

- The Forensic Clinical Examiner independently assesses the patient's capacity/lack of capacity to consent and if they believe any incapacity will persist for a considerable time.
- Prior to undertaking the forensic clinical examination the Forensic Clinical Examiner speaks with and informs the patient's family/ significant others.*
- Elicits any beliefs and values the patient may hold prior to this so these can be taken into account.[1]

* NB: A family member has no legal right to give or refuse consent on behalf of the adult patient.[16,18]

2:3.4 Intoxicated Patients

There may be a temporary loss of capacity in patients who are intoxicated due to alcohol or drugs.[1] Forensic clinical examination should normally be deferred until the patient's capacity has returned. Always record the clear and precise reasons for deferring a forensic clinical examination. Time is crucial as regards the collection of forensic evidence and therefore the forensic clinical examination should take place as soon as capacity returns.

The Gardaí may wish to use an Early Evidence Kit in the interim period. (See section 1:5, p. 23)

2:3.5 Communication Difficulties and Informed Consent

Principles of equity, accessibility and person-centredness are central to effective and efficient services.[22] Patients attending for a forensic clinical examination may have ethnic, cultural, linguistic and/or literacy challenges.[23, 24] Health literacy has been defined as the degree to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate informed decisions.[24, 25] Services should be flexible to meet individual's specific abilities and needs. Several recent studies found that repeating information to patients, in various formats, and modes, at different times, can strengthen comprehension and recall.[24-26]

2:3.6 Use of Interpreters

Using interpreters enables staff to provide high quality care and services through effective communication. It is important to use professional interpreters who are neutral, independent and who accept the responsibility of keeping all information confidential.[22, 31] If the patient has reported the incident then the Gardai should adhere to current Garda Síochána policy regarding the use of interpreters. For the patient who is not-reporting the incident, act according to the Hospital/local policy on the use of interpreters. Obtaining informed consent and maintaining confidentiality are critical elements of medico-legal responsibility.[22] The use of an interpreter, and the interpreter's name and contact details should be recorded in the documentation.

Using family members or friends as interpreters, **is not recommended**.[22, 31] The use of family members or friends may cause the forensic clinical examination and any evidence to be called into question in any subsequent court proceedings.

Good practice guidelines state that friends or relatives do not interpret where there are:

- Child protection issues.
- *Vulnerable adult* issues.
- Reasons to suspect *Domestic Violence*.[22]

Guidance on good practice in the use of interpreters[21] can be accessed from: http://www.hse.ie/eng/Publications/services/Socialinclusion/emaspeaking.pdf

Emergency Multilingual Aids[27] can be accessed from http://www.hse.ie/eng/Publications/services/Socialinclusion/EMA

2:3.7 Deaf/Hard of Hearing

People who are deaf or hard of hearing choose to communicate in different ways depending on their level of deafness. Hard of hearing and deaf people should be allowed to communicate in their preferred mode of communication. They should be asked how they would like to communicate. For example ask if the patient would like an interpreter

or if they would prefer to lip-read you? Clinicians should be prepared to take additional time and be patient during the interview process, as communication is slower when a patient is using lip-reading as a mode to communicate or if a sign language interpreter is being used.

It is important that you write down your name and explain that you are here to help her/him. In order for the patient to give consent it may be necessary to use non traditional methods, for example, the use of anatomical pictures/sketches may help the patient identify the nature, details and circumstances of the sexual assault. (See box 6)

Sign Language Interpreting Services

To reinforce **it is not appropriate** to ask family member/friends to interpret for patients. Using a sign language interpreter is the only effective communication method with someone whose first language is sign language. (See section 2:3.6)

Box 6: Communicating With Deaf/Hard of Hearing Patients

- Find a suitable place to talk, with good lighting, away from noise and distractions.
- Make sure you have the patient's attention before you start speaking.
- Maintain direct eye contact with the person. This helps convey the feeling of direct communication.
- If an interpreter is present continue to talk directly to the deaf person. Do not use phrases such as "Tell her/him that."
- Speak clearly but not too slowly and don't exaggerate your lip movements.
- Avoid distractions such as pencil chewing and putting your hand in front of your face.
- Have the light on your face, not hers/his.
- Do not talk to the patient if your back is turned or when you are writing.
- Don't shout. It is uncomfortable for the patient and looks aggressive.
- If the patient does not understand what you have said, don't keep repeating it. Try to say it a different way.
- Use plain language and avoid jargon and technical medical terms.

For further information contact DeafHear[27]

www.deafhear.ie Tel: 018175700

2:3.8 Blind or Vision Impaired Patients

Over 13,000 people use the services of the National Council for the Blind of Ireland (NCBI) and of this figure 82% have some useful vision. If a person is vision impaired, their vision may be blurred, colours can become dulled and they may not see small details.[28] The NCBI give information on a range of ways in which services for the blind or vision impaired patients can be more accessible. (See box 7)

Box 7: NCBI Services: Care for Blind or Vision Impaired

- Clear print guidelines to make written documents accessible e.g. consent forms.
- A Media Centre which converts information documents into accessible formats.
- Making websites and other technologies accessible.

These and other services can be accessed at:

http://www.ncbi.ie/services/services-for-organisations

Blind or vision impaired patients should be supported through effective communication to understand the process and give their informed consent. (See box 8)

Box 8: Supporting the Process of Informed Consent for Blind or Vision Impaired Patient:

- Providing documents in accessible formats and reading them out loud to the person.
- Facilitating the patient make use of their other senses e.g. when referring to swabs the patient should be encouraged to feel a swab (which is then discarded).

2:3.9 Patients with Disabilities

The Irish Medical Council's Guide to Professional Conduct and Ethics states:

Patients with disabilities are entitled to the same treatment options and respect for their autonomy as any other patient. Disability does not necessarily mean lack of capacity. Any decision you make on intervention or non-intervention in the case of a person with a disability requires their consent. Where necessary you should consider getting a second opinion before making decisions on complex issues.[29]

2:3.10 Patients with Intellectual Disabilities

Each patient should be assessed as an individual regarding their capacity to understand and give their consent to a forensic clinical examination or health check (Section 2:3.2, p. 42). If a person with an intellectual disability lacks the capacity to give consent, you should consult their parents, guardians and/or carers. Many Intellectual Disability Services now have a Designated Person structure, with nominated Organisation Designated Persons and onsite Designated Contact Persons to manage abuse incidents/allegations. The SATU should set up service level agreements with the Intellectual Disability Services locally with regard to referral processes and activating the Organisation Designated Persons system. The benefits of using Garda Specialist Interviewer's skills should also be considered. (Section 1.4 p. 21)

2:3.11 Patients with Mental Health Conditions/Disorders

Consent in relation to a patient with a mental health condition should be obtained in the same manner as all other patients that is - they give their consent freely, following adequate information which is given in the appropriate manner.[29] Where an adult patient is deemed to lack capacity to make the decision then steps should be made to find out whether any other person has legal authority to make decisions on the patient's behalf.[29]

In the case of a patient who is an inpatient through an Involuntary Admission Order to a Psychiatric Hospital, then the Consultant Psychiatrist responsible for the care and treatment of that patient assesses that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment.[20,21] Local guidance on consent with regard to the Mental Health Act[20] and the Mental Health Commission (MHC) reference guide[21] should be available in the SATU.

2:3.12 Ward of Court

A Ward of Court falls into two categories of "Wards":

- The first comprises adults who have been brought into Wardship because of mental incapacity.
- The second is persons under 18 years of age who are taken into Wardship as minors.[30]

Ward of Court and Forensic Clinical Examination

The following approach has been recommended by the Wards of Court Office (December 2009):

In circumstances where the Wards of Court Office cannot be contacted, and the Forensic Examiner deems it to be in the best interests of the Ward, then a Forensic Clinical Examination should be carried out. The Wards of Court Office have recommended that if it is in the best interests of the Ward to have the examination carried out as a matter of urgency it should proceed and be reported to the Wards of Court Office as soon as practicable afterwards.

Any treatment or procedure that might be considered controversial should not be carried out without the consent of the Court. In that regard, it is always possible to arrange an urgent sitting of the High Court, if the Court's intervention is necessary. The Judge on duty is authorised to exercise the Wardship jurisdiction, and the solicitor dealing with any such application can make arrangements by contacting the Four Courts, even after normal business hours and at weekends.

Office of Ward of Court Contact Details

Phone: 01 888 6189/6140

Fax: 01 8724063

E-mail: Wards@courts.ie

NB. Any type of care order or legal guardianship documentation with regard to a patient should be photocopied and attached to the patient's record.

2:3.13 Refusal of a Forensic Clinical Examination

Every adult with capacity is entitled to refuse medical treatment, and their refusal must be respected.[29] If a patient chooses not to have a forensic clinical examination, then they should do so with a clear understanding of the implications of the choice they are making.[29] If the person does not report the incident to An Garda Síochána and have a forensic clinical examination performed they must understand that the case will not progress through the criminal justice system. The person can report the incident to An Garda Síochána at a future date if they change their mind; but they must be aware that any delay in reporting the incident may cause forensic evidence to be lost. The Rape Crisis Centre personnel and SATU Staff are available to support the person with her/his decision making. (Other possible scenarios: see Box 9)

Box 9: Possible Scenarios

Patient Wishes to Seek Advice from An Garda Síochána:

- Without making a formal complaint.
- Without having a forensic clinical examination.

Action:

- Inform An Garda Síochána.
- RCC available for additional support.
- The patient can have an informal discussion with An Garda Síochána.
- Proceed, following informed consent with a **physical/health** examination, appropriate care, treatment and follow up, but no forensic evidence is collected (See section 2:15 p.84).

Patient Does Not wish An Garda Síochána Involvement:

Action:

- Proceed, following informed consent with a **physical/health** examination, appropriate care, treatment and follow up, but no forensic evidence is collected (See section 2:15 p.84).
- The patient is made aware that they can change their mind at any time and involve An Garda Síochána; but that forensic evidence may be lost.

  NB: The documentation needs to reflect the patient's decision making and the Forensic Clinical Examiners facilitation of the patient's choice.

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2:4 Forensic Clinical Examination

2:4.1 History Taking

When taking the history, it is important to bear in mind that each patient will respond differently; having their own unique backgrounds and personalities; also the circumstances of each assault is distinctly different.[6]

The purpose of taking the history in a Forensic Clinical Examination is to:

- Obtain a medical history that may assist in the management of the patient or explain subsequent findings e.g. easy bruising.[1]
- Precisely and accurately record the events that occurred, as relayed by the patient.[2]
- Guide the clinical examination and forensic evidence collection.[1,2,4]
- Assess the risk of possible pregnancy and STIs.

By obtaining a medical and social history early on in the proceedings, the examiner aims to put the patient at ease, rather than escalating their distress by obtaining an account of the events that precipitated their referral.[2] The patient should be informed that it will be necessary to ask some personal questions. Questions should be limited to relevant medical history and the recording by use of pro forma assessment sheets with clear checklists for the historical facts.[2] It is important to remember that the medical history is **not** an exhaustive account of the details of the crime. The history should accurately reflect what the patient has told the Forensic Clinical Examiner in relation to the incident. To ensure accuracy, the history as recorded may be read back to the patient.

KEY POINTS

KEY POINTS: Purpose of History

- **Obtain a medical history that may assist in patient management.**[1]
- **Record the events that occurred as relayed by the patient.**[2]
- **Guide forensic evidence collection.**
- **Assess the risk of possible pregnancy and STIs.**
- **To ensure accuracy, the history may be read back to the patient.**

2:4.2 General History

The general history should include the following information:

- Past relevant medical/surgical/psychiatric/family history.
- Medications.
- Allergies.
- Social history: alcohol intake/cigarettes/illicit drug use.[1,3,4]

Gynaecological/Obstetric history including:[2]

- Menarche and menses.
- Tampon/sanitary pad use.
- Date of last menstrual period.
- Obstetric history.
- The patient is asked if they had sexual intercourse within the last 7 days? If yes:[2]
    - Type of sexual experience.
    - With whom.
    - Use of a condom, spermicide or lubricant.
- Contraceptive use.
- Possibility of current pregnancy.

Noted is the patient's:

- Present demeanour (factual information e.g. crying, shaking etc).
- Skin colour.
- Hair colour.

2:4.3 Forensic History

The forensic history addresses the details of the assault and the patient must be informed that they may stop the questioning for a time if they wish and then continue, if and when ready.[4] The patient is given the time throughout to find the words to articulate details of the event.

Forensic History Taking should Cover:[1-5]

- Brief description of the incident.
- Number and identity of the attacker(s), if known.
- Date and time of the attack and the time lapse from the incident.
- Location where assault took place.
- Type of sexual acts that occurred e.g. kissing/fondling.
    - For a female: contact with the vagina/anus/mouth/breasts and other locations on the body.
    - For a male: contact with the mouth/anus/genitalia or other parts of the body.

Also noted is the following:

- Consideration as to whether and where ejaculation took place.
- Use of a condom by the perpetrator.
- Use of weapons or restraints by the perpetrator.
- Use of objects to achieve penetration.
- Actual or threatened violent behaviour used in the course of the attack.
- Any bites by the perpetrator.

After the assault, document whether the patient has:

- Changed clothes.
- Showered/bathed/douched.
- Passed urine or faeces.
- Douched since the time of the assault.

If the oral cavity was involved, document if the patient:

- Has smoked.
- Eaten or had anything to drink.
- Has carried out any oral hygiene since the assault.

2:4.4 Prior to Commencing a Forensic Clinical Examination

Box 10: Prior to Commencing a Forensic Clinical Examination

Record:

- Date and time (24 hour clock) of the examination.
- Date and time (24 hour clock) of incident.
- Time interval from incident until examination.
- Location of the examination.
- Name of the Support Nurse/Midwife.
- Name of any person observing.
- Garda Name, Garda Station and Badge number.

The Sexual Offences Examination Kit

The Sexual Offences Examination Kit is opened in the presence of the Garda.

Check:

- The expiry date on the outside of the Sexual Offences Examination Kit.

Record:

- The Sexual Offences Examination Kit number.
- The tamper evident bag number.
- Toxicology bag number.

2:4.5 Collection of Clothing

The patient should be asked to remove all clothing, including underwear (if relevant), over a clean paper sheet that will collect any debris that might be used as evidence.[4] The clothing may need to be retained for forensic evidence. (See section 1:7, p. 26 and Section 2:2; p. 37)

2:4.6 General Physical Examination

General Physical Examination:

- Appropriate measures are taken to prevent contamination of evidence by the Forensic Clinical Examiner. (p. 107)
- A thorough physical examination is performed.
- It is best to begin the examination with a non-threatening approach, such as examining the head and neck first.[3]
- A top-to-toe survey[1] is carried out.
- The forensic samples may be collected as the examination progresses.
- Where body fluids may have been deposited, or if there are marks or injuries on the skin that the complainant attributes to direct contact by the offender use the double swab technique.

Double Swab Technique

- Moisten a swab with the sterile water provided.
- Swab the area with the moistened swab.
- Use a second dry swab to mop up any remaining body fluid.[3, 5]

Assessment of Non-Genital Physical Trauma

- The assessment for evidence of non-genital physical trauma is very important, as this occurs in 25% to 45% of cases.[3]
- Non-genital trauma may include: mouth trauma in oral contact, lacerations, bruises, abrasions, evidence of bite marks, kicks, hand tie marks, tape marks etc. or attempted strangulation.[4] (Section 2:10 Classification and documentation of wounds; page 74)

Documentation

- The Forensic Clinical Examiner should document all findings in detail as the physical examination proceeds.[1]
- Relevant negative findings should also be documented.
- Body maps are included in the National Patient Documentation Template and should be used to document injuries.

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2:4.7 Forensic Sample Taking

The following table (2) provides guidance regarding forensic sample collection, it is important to remember that:

If there is an allegation of oral sex

- The patient should not be given a drink until oral swabs have been taken either via an Early Evidence Kit (Section 1:5 p. 23) or during the forensic clinical examination (See table 2 below).

If toxicology is required:

- Blood samples for toxicology should be taken as soon as possible. (See table 2, p. 60, p. 73).
- If the patient needs to urinate, collect a urine sample in case it is required for toxicology (See table 2, p. 60, p. 73).
- **Packaging of the toxicology samples (See p. 110).**

Table 2: Collecting Forensic Samples from Different Locations of the Body.	
Unused Swab (Control Swab)	• Control sample. • Submit one **unopened** swab in every case where swabs have been taken.
External Lips	• Detection of semen on outside of mouth. • Dampen swab with sterile water and rub lips and skin around mouth. • Return swab immediately to tube. • Repeat as above with a second dry swab.
Mouth Swabs	• Detection of semen if oral penetration within 1 day. • Take 2 sequential samples by rubbing swabs around inside of mouth, under tongue and gum margins or over dentures and dental fixtures. • Return swabs immediately to tubes.
Skin Swabs	• Detection of body fluids on skin e.g. semen, saliva on kissed, licked, bitten area; blood stain that may not be from the complainant. • If stain is moist, recover on a dry swab. • If stain is dry use the double swab technique (p. 56). • Return swab/s immediately to tube/s. • **Clearly label the site the swabs were taken from.** **Control Skin Swab** • If skin swabs are being taken a control skin swab should be taken close to but outside the stained or targeted area.
Head Hair	**A.** Detection of semen. Cut or swab relevant area, as applicable, place hair in plastic bag/swab in tube. **B.** Detection of fibres, foreign particles, foreign hairs - draw comb with cotton wool through all the hair, place in plastic bag. **C.** Control sample for microscopic hair comparison. Cut a representative sample of 10-20 hairs close to the root and place in the plastic bag.
Panties and Sanitary Protection	• Semen may be detected on sanitary protection and panties worn after the incident. • Take panties worn at the time of examination and place in a paper bag. • Leave pad attached to panties if present. • Take tampon if worn and place in a paper bag and then place into the self-seal plastic bag.
Vulval Swabs	• Detection of body fluids, if vaginal intercourse within 7 days or if anal intercourse within 3 days, or • Ejaculation on to perineum. • Rub 2 sequential swabs over whole of vulval area. Number the swabs in the order taken. (Moisten swabs with distilled water if required). • Return swabs immediately to their tubes.

When using a speculum or proctoscope take the sample beyond the instrument and avoid contact with its sides to prevent contamination.	
Vaginal Swab – Low	• Detection of body fluids, if vaginal intercourse within 7 days or if anal intercourse within 3 days. • Take 2 sequential swabs, approx. 1 cm above hymen, using a speculum. • Return swab immediately to tube. • Number the swabs in the order taken.
Vaginal Swab - High	• Detection of body fluids, if vaginal intercourse within 7 days or if anal intercourse within 3 days. • Take 2 sequential swabs from the posterior fornix via the speculum. • Return swab immediately to tube. • Number the swabs in the order taken.
Endocervical Swab	• Take if vaginal intercourse more than 48 hours previously but within 7 days. • Take 2 swabs via the speculum. • Return swab immediately to tube.
Pubic Hair	**A.** Detection of semen: Cut or swab relevant area as applicable. Place hair in plastic bag/swab in tube. **B.** Detection of fibres, foreign particles, foreign hairs: draw comb with cotton wool through the hair, place in plastic bag. **C.** Control sample for microscopic hair comparison: Cut a representative sample close to the base (10 - 20 hairs) and place in plastic bag.
Penile Swab– Coronal Sulcus/ Glans/Shaft	• Detection of body fluids, if intercourse within 7 days. • Use swabs moistened with sterile water. • Take 2 sequential swabs from coronal sulcus. • 2 sequential swabs from shaft and glans and • 2 sequential swabs from base of penis including pubic hair and scrotal sac. • Number the swabs in the order taken. • Return swabs immediately to tubes.
Perianal Swab	• Detection of body fluids, if vaginal or anal intercourse within 3 days. • Take 2 sequential swabs from the perianal area using swabs moistened with sterile distilled water. • Return swab immediately to tube. • Number the swabs in the order taken. • Pack as above.
Rectal Swab	• Detection of body fluids if anal intercourse within 3 days. • Take swab from lower rectum after passing proctoscope 2-3 cm into the anal canal. The proctoscope may be lubricated using a recognised lubricant from a single sachet. • Return swab immediately to tube. • Pack as above.

Fingernails	• Recovery of trace evidence (e.g. body fluid, possible fibres) or connection with fingernail broken at scene (if the circumstances suggest this as a possibility). • Preferably cut nails. • If the nails are too short or cutting is unacceptable, moisten swab with sterile water and thoroughly swab the area underneath each fingernail of one hand. • Use a second swab for the fingernails of other hand. • Place in evidence bag.
For DNA Analysis:	
Blood	• Take 5ml of venous blood. • Place venous blood into container (EDTA).
Buccal Swab (x2)	• DNA reference sample. • Take only when blood sample is **NOT** available. • Firmly rub a swab 10 times against the inside of one cheek. • Repeat procedure with second swab on other cheek. • Return swab immediately to tube. **NB. If oral sex within the last 24 hours buccal swabs are not suitable as DNA reference samples.**
Toxicology Samples	
Blood	Detection of alcohol and drugs of abuse: - Only taken if within 24 hours of incident for alcohol analysis or - 48 hours for drugs of abuse • Use non-alcohol skin wipes for cleansing skin. • Take three samples of venous blood in fluoride oxalate bottles. • Packaging toxicology samples see Section 5:8 p. 111.
Urine	• Detection drugs of abuse. • Only taken if within 120 hours of incident. • Ask subject to urinate into the wide universal container. • Packaging toxicology samples see Section 5:8 p. 111.
Testing hair for drugs of abuse is done 1 month after the incident see p. 113.	

2:5 Female External Genitalia

See Table 3 below and figure 1, p. 62

Table 3

NAME	DESCRIPTION
Vulva	The collective term used to describe the external female genitalia. It incorporates the mons pubis, labia majora, labia minora, clitoris, clitoral hood and vestibule.[1]
Labia Majora	The two large folds which form the outer boundary of the vulva,
Labia Minora	Two smaller folds of skin between the labia majora. Anteriorly the labia minora meet at the clitoris and posteriorly they fuse to form the fourchette.[2]
Clitoris	Erectile tissue situated beneath the mons pubis and above the urethra; the clitoris is covered by the clitoral hood or prepuce.[3]
Urethral Orifice	Opening into the urethra.
Hymen	A membranous collar or semi collar inside the vaginal introitus.[3] (See table 4)
Hymenal Remnants	After vaginal delivery.
Fourchette	The posterior margin of the vulva: the site where the labia minora unite posteriorly.[1]
Introitus	An opening or entrance into a canal or cavity as in the vaginal introitus.[3]
Fossa Navicularis	Concavity anterior to the posterior fourchette and posterior to the hymen.[3]
Vestibule	An almond shaped space between the lines of attachment of the labia minora; four structures open into the vestibule-urethral orifice, vaginal orifice, and the two ducts of the glands of Bartholin.[3]

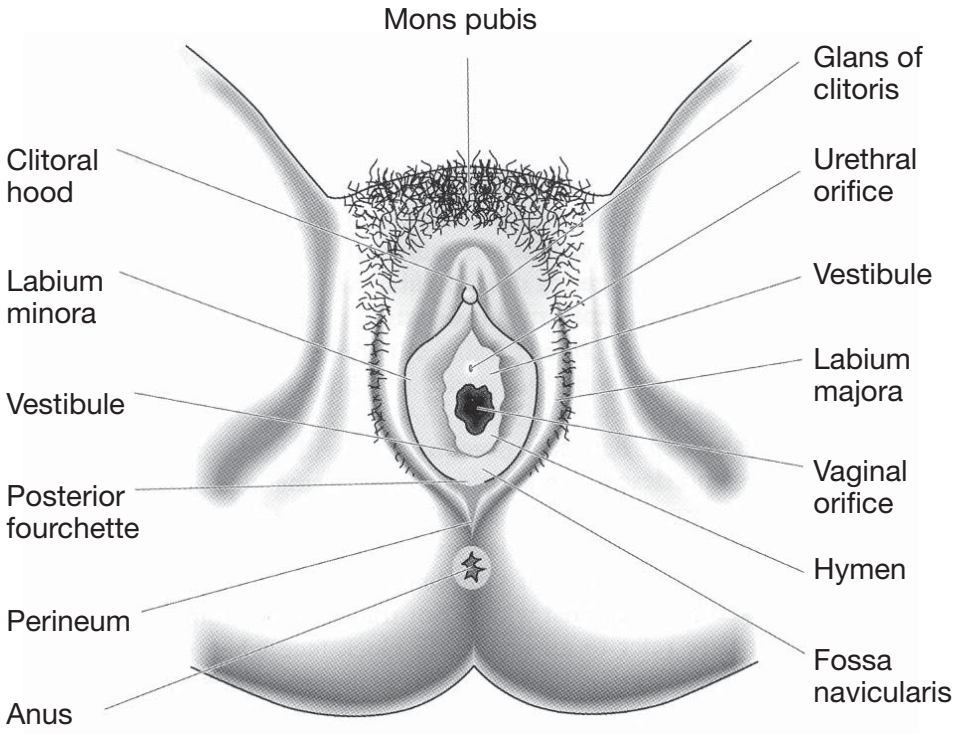

Figure 1: Female: Genital Landmarks
Reproduced with the kind permission from The Royal College of Obstetrics and Gynaecology (RCOG), UK.

2:5.1 Hymen: Definition, Anatomical Variations and Terms (See table 4)

Table 4: Definition of the Hymen: A membranous collar or semi collar inside the vaginal introitus. All females have this structure but there is wide anatomical variation.[3]

Hymen: Anatomical variations

- Annular: (circumferential) the hymenal tissue forms a ring like collar around the vaginal opening.
- Crescentic: the hymen has anterior attachments at approximately the 11 o'clock and 1 o'clock positions, in a crescent shaped pattern. There is no hymenal tissue at the 12 o'clock position.
- Cribiform: the hymen which stretches across the vaginal opening, but is perforated with several holes.
- Imperforate: the hymen with tissue completely occluding the vaginal opening.
- Microperforate: there is a very small hymenal opening.
- Septate: the hymen has bands of tissue attached to either edge, creating two or more openings.

Terms relating to the hymen

- Oestrogenized: effect of influence by the female sex hormone oestrogen, resulting in changes to the genitalia: the hymen takes on a thickened, redundant, pale appearance.
- Fimbriated/denticular: hymen with multiple projections along the edge creating a 'ruffled' or 'scrunchie-like' appearance.
- Redundant: abundant hymenal tissue that tends to fold back on itself or protrude.[3]

2:5.2 The Vagina: Definition and Descriptive Terms (See table 5)

Table 5: Definition of the Vagina and Descriptive Terms for the Vagina

Definition of the vagina: A fibromuscular sheath extending upwards and backwards from the vestibule.[5]

Descriptive terms for the vagina

- Anterior/Posterior.
- Left/Right.
- Lower third/Middle third/Upper third.

The Fornix: Divisions of the upper vagina, formed by the protrusion of the cervix into the vagina.[3] The spaces are referred to as:

- Anterior/posterior.
- Right/left.

2:5.3 Anal Canal: Definition and Descriptive Terms (See table 6)

Table 6: Definition of the Anal Canal and Descriptive Terms for Anal Anatomy

Definition of the anal canal: The terminal part of the large intestine extending from the rectum to the anal orifice.[6]

Descriptive terms for the anal anatomy

- **Anal skin folds:** Folding or puckering of the perianal skin radiating from the anal verge.[6]
- **Anorectal line:** the line where the rectal columns interconnect with the anal papilla: also called the dentate line.[3]
- **Anus:** The anal orifice; the outlet of the large bowel, opening of the rectum.[3]
- **Dentate line:** see anorectal line.[3]

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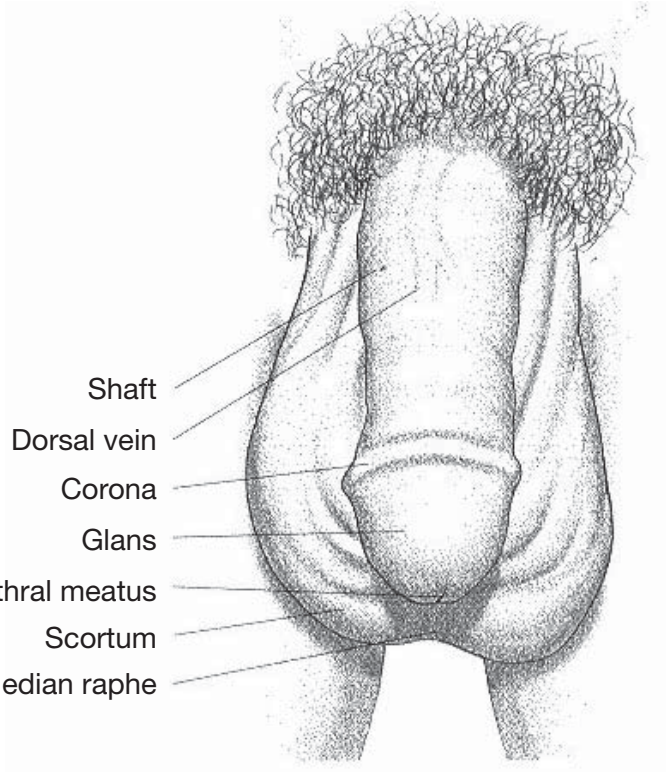
2:6 Male External Genitalia

Table 7: Male External Genitalia (See figure 2, p. 66)	
NAME	**DESCRIPTION**
Penis	Male organ of reproduction and urination,[1] composed of erectile tissue, through which the urethra passes. It has a shaft and glans (head); the glans may be covered by the foreskin.[2,3]
Shaft of the penis	The shaft of the penis is the area from the body of the male to the glans penis and is composed of three cylindrical masses of erectile tissue.[3] The dorsal surface of the penis is located anteriorly on the non-erect penis, and its ventral surface is in contact with the scrotum.[6]
Glans of the penis	The cone shaped head of the penis,[1] distal to the coronal sulcus.
Foreskin	The movable hood of skin covering the glans of the penis.[1]
Frenulum	The thin fold of tissue that attaches the foreskin to the ventral surface of the glans penis.[6] It attaches immediately behind the external urethral meatus.[4]
Corona	The widest portion around the glans,[4] the ridge that delineates the glans from the shaft of the penis.[3]
Coronal sulcus	The groove at the base of the glans.[4]
Urethral meatus	Situated at the end of the penis the external opening of the urethra which serves as the duct for both urine and ejaculate flow.[1]
Scrotum	The scrotum is a pouch of deeply pigmented skin, fibrous and connective tissue and smooth muscle. It is divided into two compartments each containing one testis, one epididymis and the testicular end of a spermatic cord.[5]
Median Raphe	A ridge or furrow that marks the line of union of the two halves.[4]
Perineum (Male)	The area between the base of the scrotum and the anus.[5]
Anus	See Section 2:5.3 p. 64



Frontal view of the external male genitalia

Figure 2: Male Patients: Genital Landmarks
Reproduced with permission from Gafney, D. Genital Injury and Sexual Assault. In: Giardino AP, Datner EM, Asher JB, eds. *Sexual Assault Victimization Across the Life Span: A Clinical Guide.* St. Louis, Massouri: STM Learning: 203: 225. Copyright © 2003 STM Learning, Inc. (www.stmlearning.com).

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2:7 Genito-Anal and Pelvic Examination

When relevant, following the general physical examination, patients should be offered a comprehensive assessment of the genito-anal area; during which injuries, scars and medical conditions are noted. This part of the examination may be particularly difficult for the patient because it may remind them of the assault.[1] Prior to commencing, inform the patient of any expected discomfort and that they can stop the examination at any time.[7] Swabs are taken as suggested in the Sexual Offences Examination Kit (Table 2: p. 58) for forensic evaluation from the external genitalia. A gentle stretch at the posterior fourchette may help reveal abrasions that are otherwise difficult to see.[1]

Vaginal Examination

The speculum examination should be performed after the complete examination of the external genitalia. A transparent plastic speculum, should if possible, be used for the vaginal examination to inspect the vaginal walls and cervix.[1] Assessment is made for vaginal and/or cervical bleeding, lacerations and/or foreign bodies. Any foreign body e.g. a tampon or hair should be removed and retained for forensic analysis.[3] Swabs are taken as suggested in the Sexual Offences Examination Kit for forensic evaluation. (Table 2: p. 58)

Anal Examination

Patients find it particularly difficult to mention anal penetration and concerns they may have with regard to anal penetration. Penetration of the anus may be by an object, digit or penis.[4] Inspection of the anus for tears, bleeding or abrasions should be performed. If there is reason to suspect that a foreign object has been inserted in the anal canal then a digital rectal examination is performed prior to a proctoscopy or anoscopy.[1]

Proctoscopy is usually only performed when anal assault is alleged or in cases of anal bleeding or severe anal pain post-assault. The recommended swabs should be taken from the ano-rectal area. (Table 2: p. 58)

Pelvic Examination

It is important to consider a pelvic bimanual examination, in order to exclude internal trauma e.g. torn broad ligament,[8] which can occur without vaginal bleeding or vaginal discomfort being present, in the early hours after the incident. This is more commonly seen in accompanying physical trauma.

2.7.1 Genito-anal injuries

The majority of genito-anal injuries are minor, but in some cases the trauma may be so extensive as to require hospital admission for surgical repair. Studies on genito - anal injuries following consensual and non-consensual sexual activity show vast variation in results depending on the assessment technique that is used by the examiner,[5] the aim of study, age groups, race and population being studied.[3]

The posterior fourchette, fossa navicularis the labia minora, labia majora, the hymen and the perianal region (See figure 1) are the most common sites for injury, with abrasions, bruises and lacerations being the most common forms of injury.[1,2,7] Using direct or gross visualisation the Forensic Clinical Examiner should record the presence or absence of any injury. If an injury is present it is clearly documented using standard accepted descriptive terminology for classifying wounds.[1,2] (Section 2:10, p. 74) The presence of areas of tenderness should also be documented. Using the genital diagram included in the National Documentation the location of the injury and areas of tenderness is also recorded. If no injury is observed this is also clearly recorded. Genito-anal injury is not an inevitable consequence of sexual assault and the lack of genital injury does not imply consent by the victim, or lack of penetration by the assailant.[6] On the basis of the available literature, it is not possible to determine from the genital and anal injuries whether the sexual acts were consensual or non-consensual.[4]

KEY POINTS

KEY POINTS: Genito-anal and Pelvic Examination

Areas particularly susceptible to injury:

- Posterior fourchette.
- Fossa navicularis.
- Labia minora.
- Labia majora.
- Hymen.

Vaginal Examination using a transparent plastic speculum if possible to assess:

- Vaginal or cervical bleeding.
- Haematoma.
- Lacerations.
- Foreign bodies e.g. Tampon.

Anal Examination for:

- Lacerations.
- Abrasions.
- Bleeding.

Pelvic Bimanual Examination to exclude:

- Exclude internal trauma e.g. torn broad ligament.[8]

KEY POINTS Re: Ano-genital injury

- Ano-genital injury is not an inevitable consequence of sexual assault.[6]
- Lack of genital injury does not imply consent by the victim, or lack of penetration by the assailant.[6]

On the basis of the available literature:

- It is not possible to determine from the genital and anal injuries whether the sexual acts were consensual or non-consensual.[4]

2:7.2 Female Genital Mutilation (FGM)

Definition: The partial, or total removal, of the external female genitalia, or any practice that purposely alters or injures the female genital organs for non-medical reasons. The practice is internationally recognised as a human rights violation of women and girls.[9,10]

With increasing migration to Ireland from FGM practising countries, it is likely that the number of women with FGM in this country has increased. Although women may not be able to correctly self-identify the specific type of FGM that they have experienced, the following WHO classification[9] is useful in terms of documentation.

Type I	Partial or total removal of the clitoris and/or the prepuce **(clitorectomy)**.
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora **(excision).**
Type III	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris **(infibulation).**
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterisation.

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2:8 Male Rape

Prevalence and Incidence

Any man, regardless of size, strength, appearance, age, race, culture, socioeconomic status, or sexual orientation, can be a victim of sexual violence.[1] The literature highlights the need that exists for research to account adequately for both male and female victims alike[2] remarking that male sexual assault is largely a silent phenomenon in men's health.[1]

2:8.1 Obtaining a History from a Male Patient

It is helpful to let the patient know that male sexual assault is not uncommon and that the assault was not their fault.[3] If the person does report the assault they may have difficulties when giving a history due to some of the following:

- Societal beliefs that a man is expected to protect and defend himself against sexual assault.[4, 5]
- When the abuse was perpetrated by a woman.[4]
- The person may fear that his sexual orientation may be suspect.[5]
- Lack of understanding of the normal physiological response of the male body to high levels of physiological arousal associated with fear and anxiety e.g. some men may experience an erection and/or ejaculation during the assault.[6]

2:8.2 Examination of the Male Patient

The Sexual Offences Examination Kit is used for both male and female patients. The examination of the male patient takes the same format as for a female patient. (Section 2:4, p. 52) Any injury may be minor or hidden e.g. tear of the frenulum or foreskin, or major e.g. a laceration requiring surgical repair.[7]

- The external genitalia, perineum and peri-anal, anus and rectum if indicated, are carefully inspected.
- It is **important** to note if the foreskin is present or if circumcision has been performed.

- The foreskin, if present, should be gently retracted where possible to view the urethral meatus and frenulum for any signs of abnormality or any injury.[7]
- Collect any retained foreign materials or secretions under the foreskin.[8]
- Swabs should be collected from the coronal sulcus, the shaft and glans of the penis and from the base of penis including pubic hair and scrotal sac. (p. 65 and figure 2)
- Rectal examination and swabs should be considered and performed if there was anal penetration.[9]

Follow up information for the male patient (See section: 3, p. 85).

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2:9 On Completion of the Forensic Evidence Collection

On Completion of the Forensic Evidence Collection:

The Sexual Offences Examination Kit and Form

- Gloves are worn until the tamper evident bag is sealed.
- Check each sample is correctly labelled.
    - o Patient's name.
    - o Patient's Date of Birth (DOB).
    - o Date sample was taken.
    - o Sample description e.g. endocervical.
- Each sample is signed by the Forensic Clinical Examiner.
- Each sample is also signed by the Garda.
- All samples are packed in the tamper evident bag provided in the kit (except toxicology samples).
- The Garda seals, dates and signs the tamper evident bag in the presence of the Forensic Clinical Examiner.
- All relevant information should be completed on the form by the Forensic Clinical Examiner and the form is signed and dated.
- The form is attached to the outside in a sealed bag, with the patient's name, DOB and the date of examination on the outside.

Samples for Toxicology (Page 110) and Toxicology Form

- As well as the above being recorded on the samples, the time the samples was taken is recorded on blood and urine samples.
- Fill in the separate toxicology form.
- The toxicology form should **not** be packaged inside the tamper evident bag with the toxicology samples.
- Keep the toxicology form and samples separated from the Sexual Offences Examination Kit i.e. they are not packaged together.
- The Garda seals, completes and signs the tamper evident toxicology bag.

Both tamper evident bags and both forms are submitted via the Gardaí to the Forensic Science Laboratory.

2:10 Classification and Documentation of Wounds and Injuries

Any wound or injury should be clearly documented using standard accepted descriptive terms.[1,2] The presence of areas of tenderness should also be documented. (See table 8)

Table 8: Standard Descriptive Terms for Classifying Wounds[1,2] (adapted)

Abrasion	**Defined as: *superficial injuries to the skin caused by the application of blunt force.*** **Produced by a combination of contact pressure and movement applied simultaneously to the skin.** Different types of abrasions subdivided as: o Scratches. o Imprint e.g. pattern of the weapon leaving imprint abrasion on the skin. o Friction e.g. grazes from contact with carpet or concrete.
Bruise	**Defined as: *an area of haemorrhage beneath the skin*** Bruising follows blunt trauma; the discolouration is caused by blood leaking from ruptured vessels. The site of the bruise is not necessarily the site of the trauma and may not necessarily reflect the shape of the weapons. Some bruises may bear features that may well assist in their interpretation. o Bite marks: Oval or circular bruises with a pale central area (p. 76). o Fingertip bruises: Caused by the forceful application of fingertips. Usually appear as 1 – 2 cm. round shaped clusters of three to four bruises. There may also be a linear or curved abrasion from contact with fingernails. o Patterned (imprint) bruises: Occurs when a bruise takes on the specific characteristics of the weapon used (e.g. the sole of a shoe). Clothing imprints may also occur. o Petechial bruises: Pinpoint areas of haemorrhage and are caused by the rupture of very small blood vessels. Usually seen on the face, scalp or eyes after neck compression. o Trainline bruises: These are parallel linear bruises with a pale central area produced by forceful contact with a linear object (e.g. stick or a baton)
Laceration	**Defined as: *ragged or irregular tears or splits in the skin, subcutaneous tissues or organs resulting from blunt trauma. (e.g. trauma by impact)*** Characteristics of a lacerated wound: o Ragged, irregular or bruised margins, which may be inverted. o Intact nerves, tendons and bands of tissue within the wound. o The presence of foreign material or hair in the wound. The shape of the laceration may reflect the shape of the causative implement.

Incised wounds	**Defined as: *injuries produced by sharp edged objects whose length is greater than their depth.*** May be produced by a knife, razorblade, scalpel, sword or glass fragment. Characteristics of an incised wound: o Borders: sharply defined edges. o Surrounds: minimal damage. o Blood loss: variable, often profuse o Contents: rarely contaminated.
Stab wounds	**Defined as: *incised wounds whose depth is greater than their length on the skin surface.*** Important points to note: o The degree of penetration and depth of resulting stab wounds are affected by a number of factors, including: - the amount of force delivered; - the robustness of protective clothing; - the sharpness of the tip of the blade; - tissue resistance and any movement of the victim.

Each wound or injury should be accurately and completely recorded in the documentation. (See table 9) Outline body maps are a useful aid in documenting any injury noted. It is impossible to age most injuries accurately. The best that can be stated is that the colour or state of healing of the injury is consistent with it having occurred at the time of the alleged incident.[4]

Table 9: Documenting and Describing Features of Physical Injuries and Wounds[1,2] (adapted)

Site	Record the anatomical position of the wound (reference to the nearest bony point can be helpful).[3,4]
Size	The dimensions of the wound(s) should be measured.
Shape	Describe the shape of the wound(s) (e.g. linear, curved, irregular).
Surrounds	Note the condition of the surrounding or the nearby tissues (e.g. bruised, swollen).
Colour	Observation of colour is particularly relevant when describing bruises.
Course	Comment on the apparent direction of the force applied (e.g. in abrasions).
Contents	Note the presence of any foreign material in the wound (e.g. dirt, glass).
Age	Comment on any evidence of healing. **Note: Accurate ageing** is impossible and great caution is required when commenting on this aspect.[1, 2,4] **Note: Scars** which predate the incident should be described and noted in the documentation and on the legal report.

Borders	The characteristics of the edges of the wound(s) may provide a clue as to the weapon used.
Classification	Use standard descriptive terminology wherever possible (See table 8).
Depth	Give an indication of the depth of the wound(s); this may have to be estimated.

Injuries Caused by Teeth: Bite Marks

- Swab the affected area[2,7,10] where saliva may be deposited using the double swab technique.[11] (p. 56).
- Measure and record a full description and record also on body maps.
- Liaise with Garda Photographer.[11] (p. 78).
- An odontologist's opinion may be considered if appropriate.

Management

A wide range of pathogens may infect bites; the risk of infection increases with puncture wounds, hand injuries, full thickness wounds and those involving bones, tendons and ligaments.[7] Therefore referral to the relevant emergency services may be required. Wound irrigation is recommended and antibiotics may need to be considered. Tetanus (See below) and Hepatitis B immunisation status of the patient should be established. (see section 4.2.2 p.95)

2:10.1 Wound Management

If the wound is considered minor it should be treated according to best practice for wound care.[8,9] For more significant wounds appropriate referral to the relevant ED should be made after taking forensic samples.

2:10.2 Tetanus Immunisation

Following assessment, consider if the wound is tetanus prone e.g.

- Contaminated with soil, faeces, saliva or foreign bodies.
- Puncture wounds, avulsions, burns or crush injuries.
- Wounds or burns requiring surgical treatment which is delayed for more than 6 hours.

NB. Occasionally, apparently trivial injuries can result in tetanus.[10]

Check the patient's tetanus immunisation status; if appropriate follow the Immunisation Guidelines for Ireland.[10]

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2:11 Photographic Evidence

Written documentation does not always describe or convey adequately the visual depiction. The use of photographs may be felt to be a more appropriate way of conveying the extent and impact of injuries and as a way of supporting the documented findings. If the Forensic Clinical Examiner, in consultation with the patient and the Garda, feels that the use of photographs will be of benefit to the case, then following informed consent, photographs may be taken.

Consent to Photographic Evidence

Before photographic evidence is taken, the patient must have given written consent* and must be fully aware that the photographs may be shown in any subsequent court proceedings, this means the defence team would have access to any photographs. This is of particular relevance for photographs taken of the genital area.

Who Takes the Photographs?

The person with the most appropriate skill and expertise to take the required photographs is a Garda Photographer. This also supports safe practice with regard to continuity and storage of evidence. The details of the Garda Photographer local to the SATU should be available in that SATU. Where a Garda Photographer is not available or not appropriate, some SATUs may choose to have local arrangements for photographic evidence. In this situation it is vital that the chain of evidence is maintained.

The Future

Internationally, the area of photographic evidence is advancing on many fronts. The area of photographic evidence from the Forensic Clinical Examiner perspective will continue to be reviewed.

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KEY POINTS

KEY POINTS: Photographic Evidence

Take photographs if:

- **They would support and better convey the extent and impact of any injuries.**

Taken following:

- **Consultation with patient and Gardaí.**
- **The patient's consent.***

Who Takes the Photographs?

- **If possible a Garda Photographer, if available and appropriate.**
- **The details of the local Garda Photographer should be available in the SATU.**

* App. 3: Excerpt re: Consent from National Patient Documentation Template

2:12 Emergency Contraception (EC)

EC measures should be discussed with all women who attend for evaluation following an allegation of sexual crime. In the USA, the rape related pregnancy rate has been estimated at 5% per rapes among those of reproductive age,[1] if EC is not used.

The most suitable method of EC will depend on the patient characteristics, the time that has elapsed since the assault and the timing of any unprotected consented intercourse.[2] The sooner that EC is started within 72 hours, the greater the efficacy. A pregnancy test is carried out prior to the administration of EC.[2]

2:12.1 Emergency Contraceptive Pill (ECP)

There is some evidence to suggest that the ECP is of value up to 5 days (120 hours) [2-4] after unprotected intercourse, but the efficacy is uncertain and it is not licensed for use after 72 hours.[4] Local medication protocols for the supply and administration of the ECP should be followed and patients should be provided with the appropriate information. A single dose of one Levonorgestrel 1.5 mg. tablet is given orally. This is an effective and well-tolerated regimen, although the woman should be advised that no contraceptive method is 100% reliable.[2]

2:12.2 Insertion of Copper Intrauterine Device

Insertion of a copper containing intrauterine contraceptive device is a highly effective method of preventing pregnancy, and could be considered for women presenting after 72 hours but within 5 days (120 hours) of unprotected intercourse or expected date of ovulation.[2,3] Each SATU should develop local arrangements. (Table: 10).

Table 10: Time Frames for Emergency Contraception

METHOD	TIME FRAME
Single dose of Levonorgestrel 1.5 mg (one tablet) orally.	• As soon as possible within 72 hours. • Some evidence it is of value up to 5 days (120hrs) [2-4] but the efficacy is uncertain and it is not licensed for use after 72 hours. [4]
A copper containing intra-uterine device.	• After 72 hours but within 5 days (120 hours) of unprotected intercourse or expected date of ovulation.[2,4]

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STIs: STI section 4: p. 98

2:13 Follow-Up Referral

SATUs need to have a system in place whereby patients have access to a broad range of services/expertise which is immediately available, if the need arises e.g. Emergency Departments, Gynaecology Services. (See Box: 12)

Some of these needs are identified at the time of the Forensic Clinical Examination, whereas others may become apparent during the follow-up examinations. The examiner will use professional judgement and in consultation with the patient or guardian, make the decision regarding appropriate referrals for support and care.

Box 12: Possible Follow-up Referrals

- Services/expertise from other services e.g. Emergency Department, Gynaecology.
- Follow up appointment or referral for STI review. (p. 98)
- Psychological support services if patient has not seen a Psychological Support Worker. (Section 3:4, p. 90)
- For a patient under the age of 18 years, Children First[1] referral procedures should be followed.
- Social worker referral if appropriate (Section 2:13.1, below)
- GP and/or other Primary *Health Care Professionals* (Section 6:2, p. 119)

  For:

  - Additional support.
  - Wound care/completion of Tetanus and/or Hepatitis B immunisation course etc.
  - Prevention/treatment of short and long term health problems.

2:13.1 Social Services Referral

Social Services referral is made for any person who may benefit from Social Services support and intervention. Each SATU should have local referral arrangements in place. For a person under the age of 18 years, Children First referral procedures[1] should be followed. Particular patients e.g. vulnerable adults,[2] or patients in a vulnerable situation, or belonging to a marginalised group,[3] e.g. the homeless (See App. 2 and also Key Points below), should be referred to the appropriate Social Services Department, where indicated. If the patient has previously been attending Social Services, then with the patient's permission the referral is made through their allocated Social Worker, to facilitate continuity of care.

Where there are concerns of *elder abuse* the HSE Elder Abuse Policy[4] is consulted and followed. If the alleged perpetrator of the abuse is a member of the Health Services Staff the document 'Trust in Care'[5] gives policy guidance for the procedures to be followed.

If concerns exist regarding *domestic violence*[7,8] it is vital that as well as being provided with a place of safety,[9] if required, the patient should also be given information on their local support services. A full list of national and local services available in Ireland can be accessed from the Cosc website www.cosc.ie. In the situation where children may be at risk Children First[1] guidelines must be adhered to. It is also recommended that the contact telephone number of the Garda Station proximate to the SATU, as well as the telephone number of the their local Garda Station be made available.

KEY POINTS

KEY POINTS: Possible Social Work Referral (See also appendix 2: Sexual violence prevalence information)

Possible Vulnerable Adults

- Person with physical/sensory disability.[3,6]
- Person with intellectual disabilities.[3,6]
- Person with mental illness. [3,6]
- *The elderly person. [4,5,6]
- *Domestic violence victim. [7,8,9,10]
- *Trafficked victim.
- Person in a vulnerable situation.

Any person who may benefit from Social Services support and intervention.

Marginalised Groups

- Homeless people [3]
- *Travellers [3]
- Prison population [3]
- *Women in prostitution [3]
- Intellectual disability population.[3,6]
- Psychiatric settings.[3,6]
- *Asylum seeker or migrant worker.

*** Information on national and local support services for these populations is available at www.cosc.ie**

KEY IRISH DOCUMENTS

- Children First: National Guidelines for the Protection and Welfare of Children 1999,[1,11]
- Implementing 'Protecting Our Future' Responding to Allegations of Elder Abuse 2008[4]
- Trust in Care: Procedure for Managing Allegations of Abuse against Staff Members. 2005[5]
- Domestic Violence A Guide for General Practice. 2008[7]

2:14 Discharge

On the completion of care in the SATU, the patient should be discharged to a safe environment, ideally accompanied by a family member, guardian, friend or support person. Consent to contact the patient to remind them of future appointments etc. should be confirmed and documented prior to discharge.

Discharge information given to the patient:

1. Instruction on the care of any injuries.
2. Medication instructions, if applicable.
3. Information leaflet issued by the SATU which will include:
    - o Contact numbers for the SATU.
    - o Garda's name, Garda Station and telephone number.
    - o Information regarding examination and processing of the forensic samples.
4. Follow-up appointments with place, dates and times.
5. Referral letter, if applicable.
6. Letter for G.P., if desired. (Section 6:2, page 119)
7. Letter for work, college, school, if required.
8. Phone number and printed information leaflet (if Psychological Support Worker has not spoken with the patient) from the RCC, which offers psychological support for the patient and her/his family. (Section 3.4: page 90)
9. Name with contact number of accompanying Garda.
10. Relevant information leaflets from The Health Promotion Unit and independent agencies which deal with issues such as:
    - Domestic Violence.
    - Interpersonal Violence.
    - Drug and Alcohol programmes.

2:14.1 Legal Report Writing

The Forensic Clinical Examination report should be dictated and typed as soon as possible after the Forensic Clinical Examination. A legal report template, covering all the salient points may be useful.*

* App. 4: Legal Report Template.

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2:15 Care of the Non – Reporting Patient

Option 2: Not Reporting Incident: Health Check

Health Check – Can be performed by SATU or GP

A. Psychological Support RCC	**B.** Examine, document and treat injuries	**C.** Emergency Contraception	**Forensic samples may be taken using the Sexual Offences Examination Kit and stored, provided protocols, safeguards and appropriate storage facilities are in place. The continuity of evidence must be maintained at all times (Section 1:6, p. 25).**
D. STI prophylaxis and review	**E.** Encourage use of Primary Health Care Team	**F.** Check re: Friends /family Ensure Support Transport Home is safe	

Under 18 years, Children First reporting procedure should be followed[11] Ref. p. 83.

Care should be individualised according to the patient's presentation and history. Post-coital contraception, STI screening and infectious disease immunisation and prophylaxis should be provided as appropriate. Links to relevant support services and appropriate aftercare should also be offered. A summary letter can be provided for the patient's GP with their permission (Section 6:2, p.119). Under 18 years, Children First reporting procedures should be followed.[11,p.83]

Although facilities for storage of forensic evidence, while a patient decides whether or not to engage with An Garda Síochána, do not exist at present, it is a goal of SATUs in Ireland to move towards this when defined structures are in place. This will increase the range of options available to patients following rape and sexual assault and is in line with international recommendations.

SECTION 3

RAPE CRISIS NETWORK IRELAND

Psychological Support Guidelines

3:1 Role of the Psychological Support Services

"The essential element of rape is the physical, psychological, and moral violation of the person. . . . Thus rape, by its nature, is intentionally designed to produce psychological trauma."[1]

When traumatised by sexual violence a *victim/survivor* has a variety of needs – varying from immediate physical and emotional **safety** to overcoming shame, arriving at a fair assessment of her/his conduct, rebuilding **trust**, and recreating a positive sense of self.[1] Psychological **support** encompasses a variety of activities that go some way towards meeting emotional safety and longer term **healing** needs. This support can potentially come from a number of different sources including friends, family, rape crisis personnel, health care staff, members of An Garda Síochána, work colleagues and religious personnel.

Someone subjected to sexual violence must make many, often overwhelming, **decisions**. Official personnel with whom victims/survivors come in contact are focused on objective tasks. The job of the Gardaí is to gather information and collect evidence to facilitate their investigation; that job is best accomplished by treating the victim/survivor respectfully and providing information about the on-going legal process.[2] While health care staff can provide crucial **psychological support** in terms of treating a victim/survivor respectfully, providing **information** in a way that they can understand, and allowing her or him to make their own **choices**, in order for a Forensic Clinical Examiner's report and testimony to be credible, the Forensic Clinical Examination needs to be conducted in an objective manner.

The focus of Rape Crisis Psychological Support Workers is on immediate **crisis intervention** and **advocacy**, as well as providing a tangible and personal connection to longer-term sources of advocacy, support and **counselling**. When Psychological Support Workers support victims/survivors, Forensic Clinical Examiners can more easily maintain an objective stance. The provision of psychological support from rape crisis personnel is vital in terms of victim/survivors ability to access needed services, and if they choose to report the crime, their willingness to continue with a prosecution. Research indicates that sexual violence survivors receive more and better legal and medical services when accompanied by rape crisis support.[3]

The International Association of Forensic Nurses (IAFN) Position Statement is that: ". . . . IAFN recognizes the benefits to victims of violence when there is timely interaction with Victim Advocates. Furthermore, IAFN recognizes and supports the role of the Victim Advocate as part of a patient centered team approach to providing services to victims. IAFN encourages the creation of strong collaborative relationships between forensic nurses, advocates and other team members in order to provide rapid, compassionate, comprehensive, patient centered and evidence-based care to victims."[4] In the United States Rape Crisis Psychological Support Workers are commonly referred to as Victim Advocates.

3:2 Ensuring the Availability of Psychological Support Services

Five steps need to be taken in order for a SATU to be in a position to subsequently provide a victim/survivor with appropriate psychological support. These steps are:

1. RCC membership of and active participation in the SATU multi-agency steering group.
2. One RCC staff person designated to liaise with the SATU.
3. The establishment of a protocol to ensure that the RCC Psychological Support Worker is contacted when the SATU is aware that a victim/survivor is on the way to the SATU.
4. The establishment of a protocol to ensure that the RCC has mechanism to quickly contact the SATU if a victim/survivor contacts the RCC and then chooses to attend the SATU.
5. Information leaflets provided by the RCC/RCNI should be available in the SATU for anyone to take away with them.

1. RCC membership of and active participation in the SATU multi-agency steering group.

- One of the recommendations contained in *Sexual Assault Treatment Services: A National Review*[5] is a multi-agency steering group for each SATU. The steering group is responsible for the on-going operation and governance of the SATU. This group provides for and fosters the integrated inter-agency response and dialogue necessary for appropriate service provision.[5]

2. One RCC staff person designated to liaise with the SATU.

- The liaison person is responsible for regular and on-going communication between the RCC and the SATU. It is helpful if the nominated liaison person is one who is generally available during day-time hours, as this will facilitate contact. This ongoing communication is useful so that both the RCC and SATU personnel are aware of current available services and can sort out any potential difficulties.
- It is the responsibility of the RCC liaison person to inform SATU personnel of any service delivery changes or developments. The nominated liaison person, as well as SATU personnel, needs to be aware of the availability of any other community services that are potentially useful for victims/survivors, such as refugee information services and women's support services and refuges. Some of this information will be available in the information leaflets.
- The liaison person can also be the same person who is a member of the multi-agency steering group.

3. **The establishment of a protocol to ensure that the RCC Psychological Support Worker is contacted whenever the SATU is aware that a victim/survivor is on the way, or, if the SATU does not have any advance notice, when the victim/survivor has arrived at the SATU.**

    - This enables the victim/survivor to make a real choice about whether she or he wants to speak with a Psychological Support Worker. Best practice is that a Psychological Support Worker from the RCC is immediately available to speak with a victim/survivor if she/he so chooses. In rural areas, the required driving time for a Psychological Support Worker to reach the SATU may be problematic. Telephone options while the Psychological Support Worker is en route should be explored and this should be included in the protocol.

4. **The establishment of a protocol to ensure that the RCC has mechanism to quickly contact the SATU if a victim/survivor contacts the RCC and then chooses to attend the SATU, regardless of whether the victim/survivor is reporting to the Gardaí, or not.**

5. **Information leaflets provided by the RCC/RCNI should be available in the SATU for anyone to take away with them.**

    - It is the responsibility of the RCC SATU liaison person to ensure that the leaflets are available.

3:3 Role of the Psychological Support Worker

An individual victim/survivor may need and want to have someone else with them while deciding whether to undergo a Forensic Clinical Examination, whether to make a formal statement to the Gardaí, and which friends and families members, if any, she or he wants to tell about the sexual violence now. She or he may wish to have an additional person with them while undergoing a Forensic Clinical Examination but the potential forensic and legal implications need to be considered. A Psychological Support Worker from a RCC is able to provide advocacy, psychological support and crisis intervention throughout this process and support the victim/survivor in making choices about who is to be told about the violence and any other sources of psychological support that she or he may access in the long-term. Sometimes, victims/survivors decide to use rape crisis personnel for support because they are not sure what their friends or family will think or how they will react.

A Psychological Support Worker is available to come to the SATU at any time, 24 hours a day, when a victim/survivor arrives at the unit or is on the way to the unit. It is fine if the Psychological Support Worker has been contacted, the Psychological Support Worker arrives at the SATU and, at that point, the victim/survivor chooses not to speak with the Psychological Support Worker. The Psychological Support Worker is also available to provide support and information to anyone else who comes to the Unit with the victim/survivor.

Whether a victim/survivor chooses to speak with a Psychological Support Worker at the time or not, information about rape and other forms of sexual violence and the various supports available should be given to all victim/survivors.

Services Offered by the Psychological Support Worker include:[6]

- Accompaniment through each step of the process that the victim/survivor chooses.
- Crisis intervention and psychological support.
- Advocating for victim/survivor's self-articulated needs to be identified and their choices respected.
- Advocating for the elimination of any communication barriers the victim/survivor may face.
- Providing information about sexual violence and its after effects.
- Aiding victims/survivors in identifying individuals who could support them in their healing process.
- Assisting victims/survivors in planning for their own safety and well-being.
- Linking victims/survivors to more long-term counselling, support and advocacy service options.
    - o This means making contact with a victim/survivor, using a method agreed by the victim/survivor, at a time chosen by the victim/survivor, to offer information, support, advocacy crisis intervention and links to counselling.
- Supporting victims/survivors in voicing any concerns and complaints to legal and medical personnel.
- Helping families and friends to cope with their own reactions to the rape/sexual assault, providing information and increasing their understanding of the type of support victims/survivors may need.

3:4 When a Victim/Survivor Leaves the SATU

Psychological Support Workers, Support Nurses/Midwives and Gardaí (if involved) should co-ordinate activities as much as possible to reduce repetition and avoid further overwhelming victims/survivors.[6]

All Victims/Survivors are Entitled to Leave the SATU with:

1. Factual information about sexual violence and potential after-effects.
2. Information about any appointments that the victim/survivor has with the local RCC or any other agency.
3. Any proactive contact arrangements that have been made with the Psychological Support Worker.
4. Name, telephone number and times available of a contact person within the SATU.
5. Referrals to or contact information for other local agencies that could be useful.
    a. This information needs to be specifically tailored to the victim/survivor – e.g. gender, age, ethnicity, ability/disability, etc.

All of this is to be provided in a language in which the victim/survivor is comfortable and can understand.

If a victim/survivor has chosen to speak with a Psychological Support Worker, the Psychological Support Worker is responsible for ensuring that all of this is provided to the victim/survivor. If the victim/survivor has chosen not to speak with a Psychological Support Worker, other SATU personnel are responsible for ensuring that all of this is provided to the victim/survivor.

A Victim/Survivor Chooses Not to Have a Health Check Examination

Any victim/survivors who has chosen not to have a health check examination is entitled to leave with:

1. Availability and benefits of using GP and other primary health care professionals for additional support.
2. Relevance of sexually transmitted infection review at least 2 weeks after the violence.
3. If female, possible pregnancy/post coital contraception information.

Any Victim/Survivor who has Chosen not to have a Forensic Clinical Examination is Additionally Entitled to Leave with:

1. Contact information for the Gardai station closest to the crime if she or he chooses to speak with the Gardaí in the future.

The victim/survivor needs to have a safe place to go and a safe way to get there when leaving the SATU. If the victim/survivor has chosen to speak with a Psychological Support Worker, the Psychological Support Worker needs to ensure that these arrangements are in place. If the victim/survivor has been taken to the SATU by a member of An Garda Síochána, then An Garda Síochána normally provides transportation. If the victim/survivor has chosen not to speak with a Psychological Support Worker, other SATU personnel need to ensure that these arrangements are in place.

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SECTION 4

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Sexually Transmitted Infection (STI) Guidelines

4:1 Epidemiology and Demography

Rates of STIs following sexual assault vary depending on the population studied, known risk factors for STIs and the sensitivity of the test used for identifying the STI.

It is difficult to determine the incidence of STIs following sexual assault, as infection may pre-date the sexual assault. Prior history of sexual activity is an important factor in determining risk for an STI.[3] The most frequently identified infections are Gonorrhoea, Chlamydia, Trichomoniasis. Chlamydial and Gonococcal infections in women are of particular concern because of the possibility of ascending infection and potential tubal infertility.[1]

Of 149 STI screens performed at the SATU Rotunda Hospital in 2008, 27 (18%) were positive, with Chlamydia Trachomatis being the organism identified in 10 of the 27 (37%) positive results. In the same year, 49% of patients who were seen at the Rotunda SATU following an alleged assault defaulted on the follow up STI screening appointment.[4]

It is important to acknowledge that the identification of an STI in the immediate period after sexual assault is seldom useful in court, as it can be used by the defence to denigrate the patient's character.[5] In view of this, and also considering the low patient return rates for screening, the service is aiming to offer appropriate STI prophylaxis for all men and women presenting after alleged sexual assault. Appropriate follow-up screens and defined protocols for management of any STIs identified are also integral to the provision of a comprehensive sexual assault service.

4:2 Screening and Treatment at Forensic Clinical Examination

The identification of a sexually transmitted infection immediately after an assault is usually more important for the psychological and medical management of the patient than for legal purposes, as the infection is likely to pre-date the assault. Even if a patient has acquired an infection at the time of an assault it will take some time for screening tests to become positive. For these reasons, as well as the significant default rates for STI follow-up appointments, empiric prophylactic treatment should be considered.[1,13] Screening for STIs prior to prophylactic treatment is appropriate if the patient presents for the first time >2 weeks after the alleged assault.

Recommended treatment depends on factors specific to the assault and assailant as well as local disease prevalence but prophylaxis for C. trachomatis and N. gonorrhoeae should be considered. A Hepatitis B Immunisation schedule can also be commenced and need for post-exposure prophylaxis (PEP) for Human Immunodeficiency Virus (HIV) should also be evaluated.

KEY POINTS

KEY POINTS: Recommended treatment depends on:

- **The assault**
- **The assailant**
- **Local disease prevalence**

Prophylaxis should be considered for:

- **C. trachomatis (Section 4:2.1)**
- **N. gonorrhoeae (Section 4:2.1)**
- **Hepatitis B immunisation (Section 4:2.2)**

4:2.1 Antibiotic Prophylaxis

The efficacy of antibiotics in preventing bacterial STIs following sexual assault has not been proven. Antibiotic choices should be based on local disease prevalence, but cover against C. trachomatis and N. gonorrhoeae should be considered. At present most Irish SATUs are only offering prophylactic treatment for C. trachomatis as prevalence of N. gonorrhoeae is low.

Sensitivities of these organisms to antibiotics, particularly N. gonorrhoeae, may change and recommendations must reflect the likely sensitivities in the population. At present, appropriate prophylaxis against C. trachomatis and N. gonorrhoeae is Azithromycin 1g stat PO + Cefixime 400mg stat PO.

4:2.2 Hepatitis B Post-Exposure Prophylaxis (PEP)

British and US guidelines[1,6] recommend that all patients be offered vaccination against Hepatitis B following sexual assault. There is evidence that where there is a risk of Hepatitis B acquisition, that the administering of Hepatitis B vaccine may prevent Hepatitis B infection.[1] This is a 3-vaccine course and is administered in the SATU when the patient initially presents, and then 1 month and 6 months following the incident.

The role of Hepatitis B immunoglobulin is uncertain in these circumstances, but may be considered, where the perceived risk for Hepatitis B acquisition is high. In those who have previously been vaccinated, or in whom natural immunity is likely, urgent Anti-Hepatitis B full markers (specimen sent to the Virus Reference Laboratory) can be checked to assess the need for vaccination.

Adequate hepatitis B immunity following completion of the vaccine course should be confirmed by checking Hepatitis B antibodies 2 months after the final vaccine dose. (See table 11)

Table 11: Actions Required Following Post-HB Vaccination Testing (Except for Patients with Renal Failure)[12]	
Anti-HBs level	**Action Required**
0 or <10 mIU/ml	Non responder. It is advisable to test for anti-HBc. If anti-HBc negative, repeat full course of hepatitis B vaccine (a different brand of vaccine is advised). Recheck anti-HBs at 2 months post completion. If anti-HBs remain <10mIU/ml, person is susceptible to HBV.
10-99 mIU/ml	Low response. If low level anti-HBs confirmed by 2 different assays, administer booster dose of vaccine but there is no need to retest for anti-HBs.
100mIU/ml or greater	Good response. No need for further vaccination or anti-HBs investigations.

4:2.3 HIV PEP

Although pathogenesis studies indicate that there may be a window of opportunity to abort HIV infection by inhibiting viral replication following an exposure, PEP against HIV following sexual exposure is controversial. While animal studies showed benefit if medication was administered within two hours and continued for 28 days,[7] prospective studies in humans are difficult due to ethical problems of withholding potentially efficacious treatment. Retrospective studies in the context of occupational exposure suggest benefit,[8] although there are instances where PEP has failed to protect.[9] With regard to sexual exposure, prospective observational studies suggest benefit.[10]

The British Association for Sexual Health and HIV (BASHH) guideline for PEP following Sexual Exposure (PEPSE) should be consulted.[11] The decision to proceed with HIV PEP must be made on a case-by-case basis, depending on factors specific to the nature of the assault and the assailant (Table 12). The risks and benefits must be discussed with the patient in the knowledge that the drugs can be difficult to tolerate (headache, nausea, diarrhoea) and their effectiveness remains unproven. Each unit should have close links with Infectious Disease specialists for additional advice and follow-up.

4.3 High Risk Indicators

Table12: Decision to Proceed with PEP: Consider the Type of Sexual Assault and the Assailant [11] adapted

Type of Assault	The Assailant i.e. The Source		
	Source known HIV positive	**Source high risk***	**Source not high risk**
Receptive anal sex	Recommended	Recommended	Considered
Insertive anal sex	Recommended	Considered	Not Recommended
Receptive vaginal sex	Recommended	Considered	Not Recommended
Insertive vaginal sex	Recommended	Considered	Not Recommended
Fellatio with ejaculation	Considered	Considered	Not Recommended
Splash of semen into eye	Considered	Not Recommended	Not Recommended
Fellatio without ejaculation	Not Recommended	Not Recommended	Not Recommended
Cunnilingus	Not Recommended	Not Recommended	Not Recommended

* High prevalence groups include Men who have Sex with Men (MSM) and those from Countries of High Prevalence (CHP) (+/- Intravenous Drug Addicts (IVDA) within the Irish context)

Units with infrequent use of HIV PEP do not need to keep supplies on site as patients can be referred to appropriate services should PEP be indicated. It is, however, important to note that when deemed appropriate, HIV PEP should be administered as soon as possible after the assault within 72 hours. Individual units should develop a referral pathway with local Infectious Disease or Genitourinary Medicine services to ensure availability within 72 hours.

For those attending the SATU at the Rotunda Hospital, the decision to administer HIV PEP is made locally with discussion with the Department of Infectious Diseases at the Mater Hospital if needed. Patients are given a 5-day starter pack of Truvada® (Tenofovir, Emtricitabine) and Kaletra® (Lopinavir, Ritonivir) and an appointment to attend the Mater Misericordiae University Hospital within 72 hours of commencing treatment to discuss completion of a 28 day treatment course.

NB. CONFIDENTIALITY

Samples and information relating to sexually transmitted infections may be dealt with by health care professionals and personnel outside of the forensic arena. It is important that any person who comes in contact with information regarding an attendance at a SATU is aware of the confidentiality of that information and if there is a need to respond in terms of treatment and follow-up, that this will be through the SATU examining Forensic Clinical Examiner. If, for any reason, this is not possible, contact with the patient will be in a sensitive and appropriate manner.

4:4 Sexually Transmitted Infection (STI) Follow Up (See tables 13, 14, 15)

Table 13: Appropriate STI Screening Tests at Time of Initial Examination or 4 weeks after Prophylactic Treatment.

Organism	Specific To Organism	Swabs/Urine/Blood
Neisseria gonorrhoeae	N. gonorrhoeae is a fastidious organism and specific culture media are required	Swab from sites of penetration or attempted penetration e.g. • Endocervical. • Anal. • Urethral in males. • Mouth. Some units may have a facility for Nucleic Acid Amplification Tests (NAATS). from 1st void urine (FVU).
Chlamydia trachomatis	Culture or NAAT for C. trachomatis if available.	• FVU (bladder not emptied x 2 hrs prior) **and/or** • Urethral and/or endocervical swab. **Also:** Sites of penetration or attempted penetration, but **not** from the mouth.
Trichomoniasis vaginalis	Wet prep can be used to identify organism at the time of examination using an on-site microscope or can be prepared from a charcoal swab, according to local protocols.	Swab x 1: • Vaginal.

Treponema pallidum: Syphilis		Serology.

NB. Each SATU should liaise with their laboratory to discuss the best means of collecting and processing samples according to local facilities.

Table 14: Screening for HIV and Hepatitis B and C

- Serology for HIV, and Hepatitis B (hBsAg and anti hBcoreAb) and Hepatitis C (hCAb), Syphilis serology.
- Repeat screening at least 3 months after the incident (to reflect the window period for sero-conversion for these viruses).

Table 15: Recommended Timeline for STI Prophylaxis and Follow-Up

Time	Treatment/Procedure	Rationale
0	1g Azithromycin PO.	Prophylaxis/treatment of C. trachomatis.
	400mg Cefixime PO.*	Prophylaxis/treatment of N. gonorrhoeae.
	1st Hepatitis B Vaccine.	Immunisation against hepatitis B.
1 month	FVU (if NAAT available).	Screening for C. trachomatis and N. gonorrhoeae. **
	Endocervical culture.	Screening for C. trachomatis.**
	Urethral and Endocervical culture.	Screening for N. gonorrhoeae.**
	Serology	HIV/Hepatitis B & C/Syphilis.
	2nd Hepatitis B Vaccine.	Immunisation against hepatitis B.
3 months	Serology.	HIV/Hepatitis B & C/Syphilis.
6 months	3rd Hepatitis B Vaccine.	Immunisation against hepatitis B.
8 months* **	Serology.	AntiHBs - Ensure hepatitis B immunity. (See table 11)

* According to local prevalence
** All tests of cure if prophylaxis previously given
*** Can be checked by GP/local services

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SECTION 5

Forensic Science Laboratory Guidelines

5:1 History and Role of the Forensic Science Laboratory

Mission Statement

The mission Statement of the Forensic Science Laboratory is to **assist** in the **investigation** of crime and to serve the administration of **Justice**, in an effective manner, by a highly trained and **dedicated** staff, providing **scientific** analysis and **objective** expert **evidence** to international **standards**.

History

The Irish Forensic Science Laboratory was established in 1975. The Laboratory offers a full service, from crime scene to courtroom and is part of the criminal justice sector.

The Forensic Science Laboratory is divided into 9 functional teams. One of these teams is the Sexual Assault Team, which consists of a Scientific Team Manager, Scientists and Analysts. The workload of the Forensic Science Laboratory has steadily increased throughout the years as An Garda Síochána and the courts realised the value of forensic scientific evidence. The staff numbers including administrative staff are currently approximately 100.

The bulk of the work carried out in the Forensic Science Laboratory, consists of the examination of samples submitted by An Garda Síochána. In specific instances, staff from the Laboratory are invited to attend scenes of crime, where they assist in interpretation, give advice on the taking of samples and on the potential of evidence.

Each year, the Laboratory receives more than 400 cases of alleged rape/sexual assault.

DNA Service

The initiation of a DNA service in 1994 was a quantum leap in the Forensic Science Laboratory's ability to compare biological samples. DNA profiling is the technique used to identify areas of high variability in the DNA of individuals. DNA (Deoxyribonucleic Acid) is present in all body tissues, except for red blood cells. But those most commonly encountered in criminal cases for forensic analysis are stains, or deposits such as blood, semen, vaginal fluid, saliva and vomit. Also cellular material (epithelial cells) can be profiled where there has been skin to skin contact (e.g. gripping the arm). The DNA from crime stains is compared with the reference DNA from suspects and complainants. This reference DNA is extracted from either blood samples, or from buccal (mouth) swabs. Cases of alleged rape/ sexual assault are usually dealt with by the Sexual Assault Team.

KEY POINTS

KEY POINTS: DNA Service

- **DNA from crime stains is compared with the reference DNA from suspects and complainants.**
- **Reference DNA is extracted from blood or buccal (mouth) swabs.**

5:2 Key Objectives of the Forensic Science Laboratory

The objective of the Forensic Science Laboratory is to have the best possible samples collected from the complainant, in a way that minimises the risk of contamination and to elicit the information that aids in the interpretation of the results obtained. The Forensic Science Laboratory is very dependant on the selection and quality of the samples received. Therefore the laboratory sees education as a very important part of their role. Training is provided by the laboratory to An Garda Síochána on collection of samples at crime scenes. The Forensic Science Laboratory work closely with the SATUs across the country and provide training and speakers for various SATU conferences and for the Higher Diploma in Nursing (Sexual Assault Forensic Examination). This increased communication has been very beneficial and the Forensic Science Laboratory welcomes any vehicle, which allows them to further improve the quality of the samples they receive. The Forensic Science Laboratory views the National Guidelines as a vehicle for the achievement of all of the outlined key objectives.

KEY POINTS

KEY POINTS: Requirements for the Forensic Science Laboratory in Cases of Alleged Rape/ Sexual Assault:

- **To have the correct samples collected in a way that best suits forensic analysis.**
- **To ensure that all the potential evidence is collected.**
- **To ensure that the samples are taken and stored in such a way that there is no risk of contamination from the surrounding area.**
- **To have the samples preserved in such a way that they reach the Laboratory in the best possible condition.**
- **To provide the Laboratory with the information needed to interpret the results obtained.**

5:3 Cases of Alleged Rape/Sexual Assault (See Table 2, p. 58 Re: Taking Forensic Samples)

In most rape/sexual assault cases, the Forensic Science Laboratory receives Sexual Offences Examination Kits, taken from the complainant and also from the suspect. The Laboratory also receives the clothes worn by the person at the time of the assault and where appropriate, the clothes worn by the suspect. In some cases, samples taken from the scene are also analysed.

Sexual Offences Examination Kit

The Sexual Offences Examination Kit is for use in the Forensic Clinical Examination of either the complainant or suspect. It is designed so that it can be used by Forensic Clinical Examiners who are experienced in the collection of evidence from complainants of rape/sexual assault and also by those that have limited experience.

It includes a form to be completed by the Forensic Clinical Examiner, which elicits information necessary for the scientific interpretation of results. The form also has a complete list of possible samples, where the Forensic Clinical Examiner can itemise the samples taken. These may depend on the crime and the subject being examined, but include swabs used to collect samples from the vagina, anus, mouth and also blood samples, hair samples, nail scrapings and other samples considered relevant by the Forensic Clinical Examiner. The medical form should not be put in with the samples taken for the Sexual Offences Examination Kit. It should be kept separate and submitted to the Forensic Science Laboratory at the same time as the Kit.

Supply of Sexual Offences Examination Kits

Sexual Offences Examination Kits are supplied by the Forensic Science Laboratory to the SATUs across the country and designated units for children. The aim is to have a Sexual Offences Examination Kit readily available when a Forensic Clinical Examination is requested. The Sexual Offences Examination Kits have an expiry date and it is therefore more appropriate that they are stored in an area where there is going to be a constant throughput.

KEY POINTS

KEY POINTS:

Clothing:
Taken where appropriate:
- **From complainant.**
- **From suspect.**

Sexual Offences Kit:
- **Designed for use for both complainant and suspect.**

Samples may include:
- **Swabs from the vagina, anus, mouth.**
- **Blood samples.**
- **Hair samples**
- **Nail samples.**
- **Toxicology samples.**
- **Other relevant samples.**

5:4 Risk of Contamination

The objective of the Forensic Clinical Examination from a forensic science point of view is to collect the best possible samples from the complainant, in a way that minimises the risk of contamination and to elicit the information from them that aids in the interpretation of the results obtained.

Contamination is most likely to be from epithelial (skin) cells from hands, saliva and dandruff. Hair is also a potential DNA source. Contamination between different cases is also a concern.

With increased sensitivity in DNA techniques, it has become very important that practitioners take all possible steps to ensure that their own cellular material does not contaminate the samples they obtain. It is desirable that practitioners supply DNA Reference Elimination Samples.

DNA Reference Elimination Swabs from Healthcare Personnel

Due to the sensitivity of current DNA profiling technology, contamination of casework samples is a constant danger. Since June 1st 2009, anyone entering the Forensic Science Laboratory areas are asked to provide a DNA sample (Buccal Swabs) for elimination purposes. This is in line with international practice, in an attempt to ensure that profiles generated in the laboratory are relevant to a particular investigation. This policy has been extended to SATU personnel taking samples from individuals, in particular in relation to sexual offences. Personnel in SATUs and General Practitioners, who take forensic samples, are asked to provide buccal swabs for elimination purposes. The DNA profiles generated from the above personnel will not be used for any purpose other than for elimination.

Elimination swabs only have to be taken once: They do not have to be taken at the same time as the medical examination and can be forwarded to the Forensic Science Laboratory at a later date.

The 'Elimination Swabs' packs can be collected from any SATU. Each pack contains two sterile swabs and a consent form. The consent form should be completed which gives details of your occupation etc. and describes the purpose of the elimination swabs.

Environmental Monitoring of SATUs

Examination rooms in the SATUs are monitored twice a year for contaminants. Swabs, moistened with sterile water, are taken from the examination couch and other surfaces in the room. Each swab should be labelled as follows: SATU; item swabbed; date; operator.

These swabs are submitted to the Forensic Science Laboratory.

5:5 Prevention of Contamination

The following are adaptations of guidelines for the prevention of contamination followed by the Staff of the Forensic Science Laboratory. These should also be considered during the Forensic Clinical Examination of the complainant in cases of alleged rape/sexual assault.

- The examination couch should be cleaned with bleach or a recommended cleaning agent before and after examinations. (See Box 13)
- Fresh paper roll should be used under complainants.
- Chairs on which the complainant may have sat before or after the Forensic Clinical Examination should also be cleaned with bleach or a recommended cleaning agent.
- The practitioner should wear disposable apron and gloves.
- Gloves must be worn when handling samples and clothing.
- Ensure that the gloves reach the cuffs and that the wrists are not exposed.
- If coats have shrunk or the wristbands have become loose, the coats should be replaced.
- A chronological log or record should be kept of cases examined on each examination couch.

Box 13: Recommended Cleaning Agents

- **Microsol**
- **Trionic D wipes**
- **Actichlor**
- **Klor Kleen**

NB. The above cleaning agents were tested for efficiency in the Forensic Science Laboratory in 2010.

Masks must be worn if:

- You have a cold/hay fever/allergy etc.
- Talking while taking the samples.

When not masked:

- Do not talk over open swabs etc.

KEY POINTS

KEY POINTS: Prevention of Contamination

- **Clean with Bleach or recommended cleaning agent (See box 13):**
  - **Examination couch.**
  - **Chairs on which complainant sat before or after exam.**
- **Fresh paper roll should be used under complainants.**
- **A log or record should be kept of cases examined on each examination couch.**

Handling damp items:

- **Use disposable aprons.**

Use gloves when:

- **Handling relevant samples and clothing.**
- **Gloves should reach the cuffs – wrists should not be exposed.**

5:6 Analysing Samples for Semen

The Forensic Science Laboratory analyses the swabs for the presence of semen. The presence of semen confirms that sexual activity has taken place. Obviously, this evidence alone does not indicate whether or not a rape/sexual assault has taken place. **Also the absence of semen on the swabs does not mean that penetration did not occur.**

In the majority of alleged Sexual Offences, the accused agrees that sexual activity occurred and the issue is whether the complainant consented. In most of these cases DNA profiling is not required.

When the suspect denies that intercourse took place, or when the complainant has had a previous sexual partner, DNA profiling will be carried out on seminal staining on the swabs or on the clothes. In cases of "stranger rape", where the victim does not know the assailant, DNA profiling will always be carried out on any seminal staining recovered and this profile is kept on file for future reference. (Figure 3)

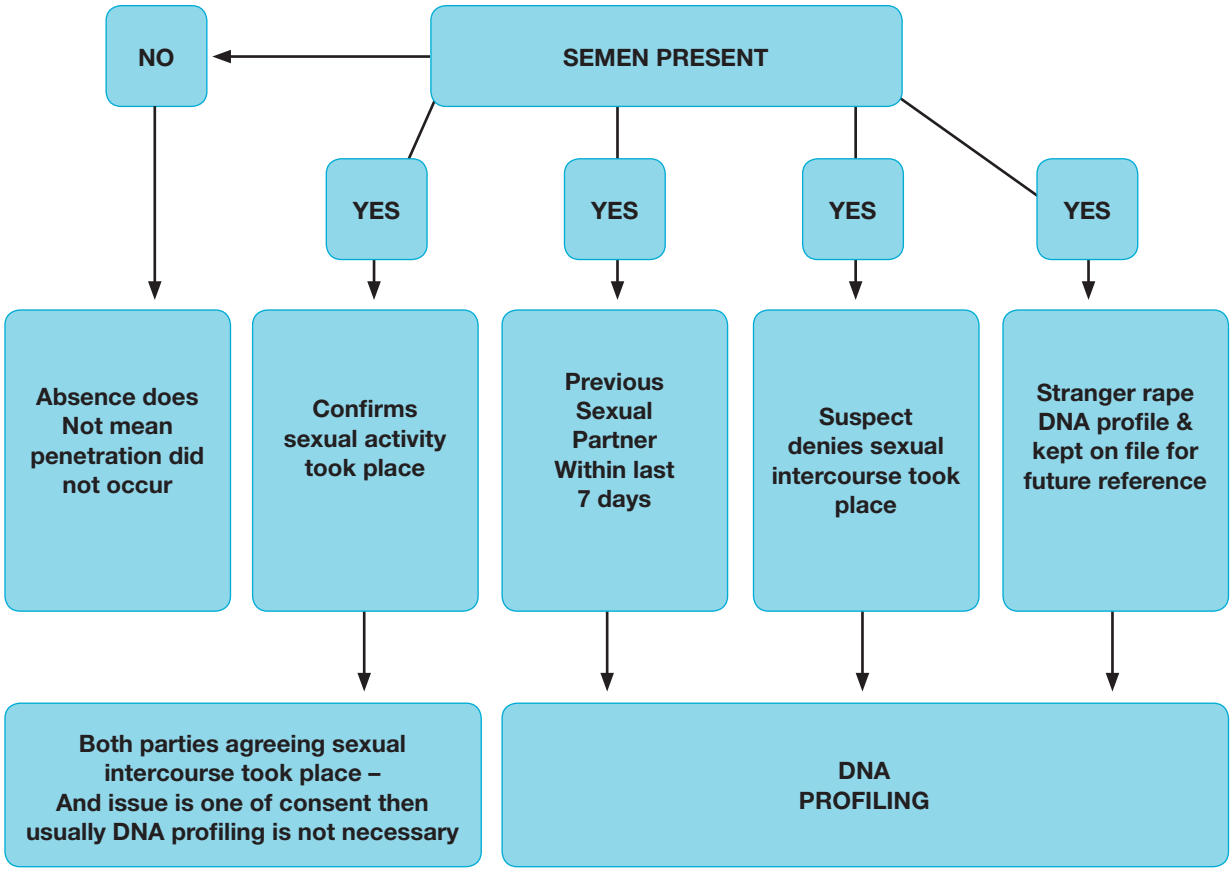


Figure 3: Outline of when DNA profiling may be carried out.

5:7 Time Frames For Detecting Semen

The persistence of semen varies between individuals and is influenced by the activity of the individual after the alleged offence.[1] The experience of the Forensic Science Laboratory is that semen may be detected on vaginal swabs taken up to approximately four days after intercourse. In the majority of cases, however, it will not be detected on swabs taken more than 48 hours after intercourse.[2] There are reports in the literature of traces of seminal staining being recovered up to a week afterwards,[3] so this is the outer limit after which the Forensic Science Laboratory will not analyse kits.

Semen will persist for much shorter periods in the rectum and in the mouth.[4] Generally, in the laboratory, semen is not found on anal swabs taken 24 hours after the alleged incident, but swabs are analysed up to 72 hours afterwards. On oral swabs semen is rarely found if these are taken approximately 6 hours after the alleged incident. However, oral swabs taken up to 24 hours afterwards are examined, if oral sex is alleged.

Semen will persist in dead bodies for a much longer period of time and, in the Forensic Science Laboratory, it has been recovered on vaginal swabs taken 6 weeks after death, however, semen may persist for longer periods (e.g. 6 months). Once the swabs are taken from the person, the semen, if present, will persist indefinitely on dry swabs. Dried seminal staining on clothes will persist until the clothes are washed, this can be useful in cases which are not reported within a few days. (See table 16)

Table 16: Sites and Time Limits for Examination for Presence of Semen	
Site	**Time Limits for Examination for Semen**
Vaginal	**7 days**
Rectum	**3 days**
Mouth	**1 day**
Skin	**Semen can persist until washing**
Dead bodies	**Semen can persist for a much longer period of time**
Dried seminal staining on clothing	**Semen persists until clothes are washed**
Washing, douching, bathing or menstruation may accelerate the loss of semen	

Other Samples

As well as analysing the Sexual Offences Examination Kit for the presence of semen, it may be necessary to carry out other analyses in cases of alleged rape/sexual assault. The clothes of the complainant will be tested for seminal staining depending on the circumstances of the case. The clothing will also be checked for damage and blood staining (See section 5:11, p. 115). In some cases, the Forensic Scientist will look for hairs and fibres (See section 5:10, p. 112), which may have transferred between the two parties. If necessary, samples of urine and blood will be sent for toxicology (Section 5:8, p. 110). Depending on the circumstances of the case, items from the scene may also be analysed for the presence of blood, semen and fibres.

Role of the Forensic Clinical Examiner as an Investigator.

While the samples to be taken are listed and instructions on how they are to be taken are set out clearly in the Sexual Offences Examination Kit, it cannot cover every eventuality. The Laboratory views the Forensic Clinical Examiner as having an investigative role in the procedure of evidence collection, just as the Gardaí do in collecting evidence at the scene of a crime. It is important that they have as complete an account from the complainant as possible, in order to guide them in the direction of potential forensic evidence. Any opportunity that the alleged assailant had to deposit DNA on the victim, or vice versa, should be considered and areas of contact should be swabbed (see p. 56). Stains, which are at odds with the account of what happened, should also be swabbed for further examination in the Forensic Science Laboratory.

References

1. Davies, A. and Wilson, E. The persistence of seminal constituents in the human vagina. Forensic Science: 1972, 3, pp 45-55.
2. The Forensic Science Laboratory. Data 2010. Garda Headquarters, Phoenix Park, Dublin.
3. Allard, J.E. The collection of data from findings in cases of sexual assault and the significance of spermatozoa on vaginal, anal and oral swabs. Science and Justice, 1997, 37 (2) pp 99-108.
4. Keating, S.M. and Allard, J.E. What's in a name? – Medical samples in cases of alleged sexual assault. Med. Sci. Law, 34 (3).

5:8 Samples for Toxicology

To have an effect, a drug has to be present in an individual's blood. A blood sample will, therefore, identify what drug is affecting an individual's behaviour at the time of sampling. Detection times for drugs in blood can be comparatively short. A delay of even 2 to 3 hours between the report of an incident and the collection of a blood sample can be significant.

Blood samples can, however, be particularly useful when examining an individual's recent alcohol intake, as it is possible to 'back calculate' to earlier blood alcohol concentrations. When found in combination with drugs, an accurate determination of a person's blood alcohol concentration, at the time of an incident, can be particularly useful in explaining events. Blood samples, however, have to be collected by medical staff and this can introduce delays to sample collection, potentially losing valuable information.

Drugs and their metabolites are eliminated from the body through a variety of routes, including urine. Urine tends to concentrate drugs to a level that can be relatively easily detected and measured, thus extending the detection times.

Urine samples reflect what has been through the body rather than what is now affecting an individual's behaviour. Urine can, therefore, be particularly useful if the alleged event happened more than a few hours earlier. It is not possible, however, to carry out an alcohol back calculation from a urine sample. In addition, the extended detection time of drugs in urine can include drug use prior to an incident.

Urine samples can be collected by non-medical staff and should be collected, as soon as possible, after the incident is reported (See section1:5, p. 23 and Section 5:9 p. 111). The most important factor in cases of suspected drug facilitated sexual assault is speed of response. The sooner the samples are collected, the more likely that a useful forensic toxicological examination can be carried out. If there is any doubt as to whether or not a particular sample should be taken, it should be collected and submitted to the laboratory for evaluation, to establish what analysis is appropriate.

Screening and confirmation tests are available for a range of drugs of abuse and their metabolites such as Amphetamine, Barbiturate, Benzodiazepines (including Rohypnol), Methadone, Cannabis, Cocaine, Methamphetamine, Opiates (heroin and morphine) etc.

The persistence of different substances or their metabolites in the blood and urine of an individual depends on numerous factors, for example, some individuals have significantly different metabolisms, derived from their genetics. There are differing views in the literature as to the timelines for the detection of alcohol and drugs in blood and urine samples. The detection windows depend on a number of different factors including the amount of substance used and the frequency of use.

The timelines for the detection of drugs of abuse in the Forensic Science Laboratory are as follows:

	BLOOD	URINE
Alcohol	**24 hours**	**N/A**
Drugs of Abuse	**48 hours**	**120 hours**

Sending Samples for Toxicology Screening

- The expiry date on blood bottles should be checked before use.
- Fill in the separate toxicology form.
- The toxicology form should **not** be packaged inside the tamper evident bag with the toxicology samples. Submit the toxicology form and the tamper evident bag with the toxicology samples to the Forensic Science Laboratory.
- Keep the toxicology form and samples separated from the Sexual Offences Examination Kit i.e. not packaged together.

5:9 Early Evidence Kits

In 2004 the Forensic Science Laboratory introduced an Early Evidence Kit. Sometimes, it may not be possible for the victim of an alleged rape/sexual assault to see a Forensic Clinical Examiner immediately after reporting the crime. Some complainants have to travel long distances in order to be examined at the nearest SATU, or a Forensic Clinical Examiner may not be immediately available. With every hour that passes physical evidence may be lost or deteriorate. Because of this, an Early Evidence Kit is available to be used by An Garda Síochána in cases of rape/sexual assault. For details relating to the use of the Early Evidence Kit see under An Garda Síochána guidelines. (Section 1:5, p. 23)

5:10 Trace Evidence

Trace evidence includes any kind of physical evidence, which might help link a suspect to a victim or to a scene. When the Forensic Scientist looks for the transfer of materials such as paint, glass, soil, hair and fibres, they are looking for trace evidence.

If a suspect is denying any contact with a complainant, the Forensic Scientist can look for evidence of fibre transfer, between the suspect and the complainant's clothes.

Transfer of Fabric Traces on Contact

Textile fabrics are composed of mainly woven or knitted yarns and fibres. Tiny fragments of the fibres are broken off the surface of the fabric and may transfer to a second surface on contact. These fibres are generally invisible to the naked eye and have the potential to provide evidence of contact. The size of the fibres and the ability to transfer means that great care must be taken at all times to avoid contamination.

Work in the Forensic Science Laboratory involves searching for transferred foreign fibres and comparing these to suspect sources e.g. fibres from the suspect's jumper, on the clothing of the complainant and visa versa. Although fabrics are generally mass-produced the finding of large numbers of transferred fibres, especially if these involve more than one type, is a strong indicator of recent contact.[2]

Example

It is suspected that John Smith attacked Mary Jones. The finding of 20 fibres matching her jumper and 15 fibres matching her trousers on John Smith's clothes may support the allegation of contact. If, in addition, fibres matching John Smith's jacket were found on Mary Jones clothing, this may also support the suggestion that they were in contact. Given these findings an evaluation could be made regarding the strength of evidence given. This is so, not withstanding the fact that all the garments are mass produced.

Difficult Fabrics

Some fabrics are not suitable as a source of fibres for various reasons. These include a non-shedding surface, pale colours or very common fibres such as blue cotton fibres which is used in denim. The retention of transferred fibres is also affected by the surface of the garment and regardless of the surface type, fibres will be rapidly lost with wearing.

Hair

Hair is continuously shed from the body throughout life. The main types of hair encountered in Forensic Clinical Examinations are head and pubic hair. Samples submitted to the Laboratory on which hair may be found include: balaclavas, clothing and bedclothes. Hairs may be compared in the Laboratory with possible sources.[1] Control samples of hair from the complainant and from the suspect are essential for comparative work. (See Section 2:4.7 Table 2 p. 58. How to collect control hair samples). Because hair is continuously growing, control samples taken more than approximately 12 weeks after the incident will generally not be of use. Microscopic comparison of hairs alone is considered to be weak evidence. Hairs would be selected for DNA profiling using a visual comparison.

If there is an allegation that the hair was pulled out, a microscopic examination of the root can indicate if the hair was removed forcibly or fell out naturally.

Detection of Ingested Drugs from Hair

In instances of once off doses, it takes approximately 4 weeks for the drug to emerge sufficiently above the scalp to be evident in cut hair.

As a rough guide, hair grows approximately 1cm per month, thus the longer the hair the greater the time frame covered. At present drug concentrations in hair cannot be correlated with dose or time of administration. The Forensic Science Laboratory should be contacted in cases where testing hair for drugs of abuse is required.

Contamination of Trace Evidence

In Forensic Science terms, contamination is any transfer or deposition of material, which occurs after a crime, possibly via a third party not involved with the crime. It may also occur because of a common place of contact e.g. complainant and suspect carried sequentially in the same patrol car, or clothing from the complainant and the suspect being exposed in the same room. The danger of contamination exists with all forms of trace evidence, i.e. paint, glass, fibres, hair, soil, and body fluids.

Contamination is probably the greatest problem that exists in the area of trace evidence. (See tables17 & 18). The possibility of accidental contamination exists from the first moment of contact between the Gardai and the scene, suspect or complainant.

Table 17: Contamination of Evidence.
Contamination can be due to: Primary transfer of evidence from direct contact between items.
Secondary transfer of evidence caused, for example, by the same person handling items from different aspects of a case, or by packing items from different persons or scenes in the same room.

Table 18: Precautions to Avoid Contamination of Evidence
Taking clothing etc. as soon as possible at source (e.g. at the home of the complainant) avoids the issues of contamination.
• The same car should not be used to convey the suspect and complainant, for example the complainant to the hospital and the suspect to the Garda station.
• If the suspect denies contact with the complainant or vice versa, any Garda who has had contact with the suspect should not have contact with the complainant.
• Within the Garda Station the suspect and the complainant should not be interviewed in the same room, or sit on the same seat.
• Clothing and other samples from the complainant and suspect should be taken, packed and sealed by different Gardai in different rooms. The bags should be sealed using sellotape or staples.
• Sealed bags should be labelled immediately to eliminate any need for reopening.
• The history of the handling and packing must be available to the Forensic Scientist.
• If the same Forensic Clinical Examiner takes samples from the complainant and the suspect, this should be done at separate locations and the examiner should ideally wear different disposable scene of crime suits and gloves for each.

References

1. Mann MJ. Hair transfers in sexual assault, Journal Forensic Science; 1990: 35, 951-5.
2. Cook R. and Wilson C. The significance of finding extraneous fibres in contact cases. Forensic Science International; 1986: 32, 267-273.

5:11 Damage to Clothing

In cases of alleged rape/sexual assault, damage to clothing is sometimes encountered[1,2]. Its examination may provide valuable information about the possible implement that caused the damage, or the manner in which it was caused. Damage analysis may corroborate or refute a particular crime scenario. This can be especially important in cases of alleged rape/sexual assault where the only issue is whether the complainant consented. In some cases, simulation experiments are used, in an attempt to reproduce the damage to a garment. The use of simulation experiments makes it vital that detailed descriptions of how the damage was allegedly caused are available to the scientist.

Care should be taken when removing garments so that any damage is not altered. If clothing needs to be cut off do not cut through any damaged areas. Washing a garment may change the nature of any damage evidence and make it more difficult for the Forensic Scientist to interpret. Therefore if a garment has been washed since the alleged incident this should be communicated to the Laboratory.

Damage to clothing can be separated into a number of different types:

- **Damage Due to Normal Wear and Tear.** This is to be distinguished from other forms of damage, which may be related to a crime. It may include unravelling of hems and seams, snags (especially in nylon stockings/tights), pilling and the thinning of fabric prior to hole formation).
- **Rip.** A severance caused by breaking or unravelling of the sewing thread usually at a seam.
- **Tear.** A severance caused by the pulling apart of a material, leaving ragged or irregular edges.
- **Cut.** A severance with neat edges caused by a sharp edged instrument. Types of cuts include stab cuts, slash cuts and scissor cuts.
- **Puncture.** Penetration through material by an implement producing an irregular hole.
- **Abrasive damage.** Caused by the material rubbing against another surface.

References

1. Taupin, J, Adolf FP, and Robertson J. Examination of damage to textiles in Forensic Clinical Examination of Fibres, 2nd ed. Eds. Grieve MC. and Robertson J. London: Taylor and Francis; 1999.
2. Boland, C.A., McDermott, S.D and Ryan, J. Clothing damage analysis in alleged sexual assault - The need for a systematic approach. Forensic Science International, 2007, 167, pp 110-115.

Recent Rape/Sexual Assault: National Guidelines on Referral and Forensic Clinical Examination in Ireland. 2nd edition. 2010.

SECTION 6

General Practitioners (GPs) Guidelines

6:1 Care of a Patient Who Discloses Rape/Sexual Assault

Information from these guidelines regarding the care of the patient giving a history of rape /sexual assault, which is relevant to the General Practitioner, is available on the ICGP website via a hyper link: National Guidelines on Rape/Sexual Assault. This includes the referral pathways for Forensic Clinical Examination to a SATU and information if the patient is not reporting the incident to An Garda Síochána and wishes the GP to carry out a health check (See Non-Reporting Incident: Health Check outline below). The website assists the GP in the immediate and follow-up care, if the patient wishes to have care only with the GP.

Not-Reporting Incident: Health Check

Health Check – Can be Performed by SATU or GP

A.
RCC
Available for Psychological Support
Section 3 p. 86

B.
Examine, document and treat injuries
Section 2:10 p. 74

C.
Emergency Contraception
Section 2:12 p. 79

D.
STI prophylaxis & review
Section 4 p. 93

E.
Encourage use of Primary Health Care Team

F.
Ensure appropriate support, follow-up and home is safe

Under 18 years, Children First reporting procedure should be followed.[1]

1. Office of the Minister for Children and Youth Affairs (OMC). Children First: National Guidelines for the Protection and Welfare of Children. Dublin: Stationery Office. Available from www.omc.gov.ie or www.lenus.ie

6:2 Contact with a GP following Patient Evaluation in a SATU

Following an incident, which has required attendance at a SATU, it is best practice to suggest to the patient that the GP is provided with a short report regarding the incident. As the primary care giver for the patient, this would enable the GP to ensure that the appropriate follow up services have been offered to her/him, including evaluation with regard to sexually transmitted infections and counselling with regard to the incident.

There may be long-term consequences of the incident which may present with seemingly unrelated symptoms. The GP's knowledge of the incident may ensure a more holistic approach.

KEY POINTS

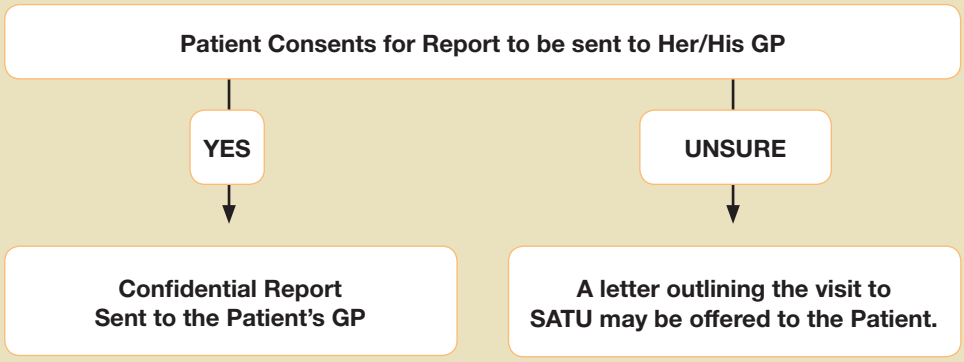
KEY POINTS: Referral to GP

The GP is the primary care giver. There may be long-term effects of the incident, the patient may present to the GP with seemingly unrelated symptomatology. The GP having knowledge of the incident can ensure a more holistic approach.

In this context, it is appropriate to ask the patient for permission to send a report to the GP, even in circumstances where the referral to the SATU has not involved the primary care doctor. In circumstances where the patient feels that it is not appropriate, at least at that time, for this contact to be made, the patient may be offered a letter outlining that a sensitive incident requiring her/his attendance at a SATU has occurred. The patient can choose to give this to the GP at some time in the future.

KEY POINTS

KEY POINTS: Process of Referral from SATU to GP



Some patients may wish to complete the infectious disease screening or Hepatitis B vaccination programme under the care of their GP rather than returning to SATU. In such situations it is important to ensure that the GP is aware of the treatment provided in SATU and has access to required swabs, laboratory facilities and vaccines to ensure that complete follow-up is provided (See Section: 4:4, p. 98).

NB. CONFIDENTIALITY

Samples and information relating to sexually transmitted infections and cervical cytology will be dealt with by health professionals and personnel outside of the forensic area. It is important that any person who comes in contact with information regarding an attendance at a SATU is aware of the confidentiality of that information and if there is a need to respond in terms of treatment and follow-up, that this will be through the SATU examining doctor. If, for any reason, this is not possible, contact with the patient will be in a sensitive and appropriate manner.

Appendix List

APPENDIX LIST 121

Appendix 1

The Law in Relation to Sexual Offences in Ireland

Introduction

The criminal law provides for a wide range of sexual offences, for severe penalties on conviction for these offences and provides anonymity to victims in sexual offence cases. Legislation enacted in 1991 created new offences and updated legislation, which up to that time merely consisted of rape and indecent assault. The Sex Offenders Act 2001 places requirements on certain convicted sex offenders to notify An Garda Síochána of their place of residence.

The most recent legislation enacted in this jurisdiction has made substantial changes in relation to sexual crimes committed against children. On 23rd May 2006 the Supreme Court found that Section 1(1) of the Criminal Law Amendment Act 1935 was inconsistent with the provisions of the constitution. New legislation was enacted in June 2006 to take account of that judgment with further amendments in 2007.

The Criminal Law (Human Trafficking) Act 2008 amended the Child Trafficking and Pornography Act 1998 in relation to the sexual exploitation of children, a single offence which criminalises a wide spectrum of sexual activity with children.

NB. This section briefly outlines the relevant legislation in relation to sexual offences, it is not exhaustive in its coverage of sexual offences and the law is subject to change. For further information check the Irish Statute Book website http://www.irishstatutebook.ie

Rape

Act	Criminal Law (Rape) Act, 1981
S 2.(1).	A man committed rape if: (a) he has sexual intercourse with a woman who at the time of the intercourse does not consent to it, and (b) at that time he knows that she does not consent to the intercourse or he is reckless as to whether she does or does not consent to it.
Maximum Penalty	Imprisonment for life.
Court Venue	Central Criminal Court

Act	Criminal Law (Rape) Amendment Act, 1990
S.5.	Any rule of law by virtue of which a husband cannot be guilty of the rape of his wife is hereby abolished.

Rape under Section 4 of the Criminal Law (Rape) (Amendment) Act 1990

Act	Criminal Law (Rape) (Amendment) Act 1990
S.4.	Rape under section 4 means a sexual assault that includes:– (a) penetration (however slight) of the anus or mouth by the penis or (b) penetration (however slight) of the vagina by any object held or manipulated by another person.
Maximum Penalty	Imprisonment for life
Court Venue	Central Criminal Court.

Aggravated Sexual Assault

Act	Criminal Law (Rape) (Amendment Act) 1990
S.3.	Aggravated sexual assault means a sexual assault that involves serious violence or the threat of serious violence or is such as to cause injury, humiliation or degradation of a grave nature to the person assaulted.
Maximum Penalty	Imprisonment for life
Court Venue	Central Criminal Court.

Sexual Assault

Act	Criminal Law (Rape) Amendment Act 1990
S.2.	The offence of indecent assault upon any male person and the offence of indecent assault upon any female person shall be known as sexual assault.
Maximum Penalty	Where complainant is a child – imprisonment not exceeding 14 years – any other case period not exceeding 10 years.
Court Venue	District/Circuit Criminal Court

Act	Criminal Law (Amendment) Act 1935
S.14.	It shall not be a defence to a charge of indecent assault upon a person under the age of 15 years to prove that such a person consented to the act alleged to constitute such indecent assault. This section also applies to the newer offence of sexual assault. Persons under 15 years cannot consent to a sexual assault. No statutory definition for sexual assault, but it had been defined as an assault accompanied with circumstances of indecency.

Incest

Act	Punishment of Incest Act 1908 as amended by the Criminal Law Amendment Act 1935, The Criminal Justice Act 1993, The Criminal law (Incest Proceedings) Act 1995
S.1. **S.2.**	Any male person who has carnal knowledge of a female person, who is to his knowledge his grand-daughter, daughter, sister or mother. Any female of or above the age of 17 years who with consent permits her grandfather, father, brother or son to have carnal knowledge of her (knowing him to be her grandfather, brother or son as the case may be).
Maximum Penalty	Incest by a male with a female over 15 years of age - Life imprisonment. Incest by a male with a female under 15 years of age - Life imprisonment. Incest by a female over 17 years - 7 years imprisonment.
Court Venue	Central/Circuit Criminal Court.

Defilement of a Child Under 15 Years

Act	Criminal Law (Sexual Offences) Act 2006
S.2(1).	Any person who engages in a sexual act with a child (male or female) who is under the age of 15 years shall be guilty of an offence.
S.2(2).	Any person who attempts to engage in a sexual act with a child (male or female) who is under the age of 15 years shall be guilty of an offence.
S.2(3).	It shall be a defence for the defendant to prove that he or she honestly believed that the child had attained the age of 15 years.
S.2(5).	Consent of the child is immaterial.
Maximum Penalty	Life imprisonment
Court Venue	Central Criminal Court (District Court for attempts in certain cases – section 4).

Definition of "sexual act"

"sexual act" means—

(a) an act consisting of—
  (i) sexual intercourse, or
  (ii) buggery,

between persons not married to each other, or

(b) an act described in
  (i) section 3 (aggravated sexual assault) or
  (ii) section 4 (rape under section 4)

of the Criminal Law (Rape) (Amendment) Act 1990;

Defilement of a Child Under 17 Years

Act	Criminal Law (Sexual Offences) Act 2006 as amended by the Criminal Law (Sexual Offences) (Amendment) Act 2007
S.3(1).	Any person who engages in a sexual act with a child (male or female) who is under the age of 17 years shall be guilty of an offence.
S.3(2).	Any person who attempts to engage in a sexual act with a child (male or female) who is under the age of 17 years shall be guilty of an offence.
S.3(5).	It shall be a defence for the defendant to prove that he or she honestly believed that the child had attained the age of 17 years.
S.3(7).	Consent of the child is immaterial. For definition of "sexual act", see Defilement of Child Under 15 years, above.
Maximum Penalty	1st Conviction - 5 years imprisonment (10 years if by a person in authority). 2nd or Subsequent Conviction – 10 years imprisonment (15 years if by a person in authority).
Court Venue	Central Criminal Court (District Court for attempts in certain cases – section 4).

Sexual Exploitation of a Child Under 18 Years

Act	Child Trafficking & Pornography Act 1998 by the Criminal Law (Sexual Offences) (Amendment) Act 2007 and the Criminal Law (Human Trafficking) Act 2008
S.3(2).	A person who— (a) sexually exploits a child, or (b) takes, detains, or restricts the personal liberty of a child for the purpose of his or her sexual exploitation, shall be guilty of an offence.
Maximum Penalty	Imprisonment for life or for a lesser term, or a fine.
Court Venue	Circuit Criminal Court

Definition of "child" (for section 3 of the 1998 Act only)
"child" means a person under the age of 18 years

Definition of "sexual exploitation"
'sexual exploitation' means, in relation to a child—

(a) inviting, inducing or coercing the child to engage in prostitution or the production of child pornography,
(b) the prostitution of the child or the use of the child for the production of child pornography,
(c) the commission of an offence specified in the Schedule to the Sex Offenders Act 2001 against the child; causing another person to commit such an offence against the child; or inviting, inducing or coercing the child to commit such an offence against another person,
(d) inviting, inducing or coercing the child to engage or participate in any sexual, indecent or obscene act, or
(e) inviting, inducing or coercing the child to observe any sexual, indecent or obscene act, for the purpose of corrupting or depraving the child,

and 'sexually exploits' shall be construed accordingly.

Sexual Activity with Mentally Impaired Persons

Act	Criminal Law (Sexual Offences) Act 1993
S.5.	A person who (a) Has or attempts to have sexual intercourse, or (b) Commits or attempts to commit an act of buggery with a person who is mentally impaired (other than a person to whom he is married or to whom he believes with reasonable cause he is married) shall be guilty of an offence.
Maximum Penalty	Imprisonment not exceeding 10 years. Attempt :– 1st conviction – imprisonment not exceeding 3 years 2nd or subsequent conviction – imprisonment not exceeding 5 years.
Court Venue	Central Criminal Court.
Definition "Mentally impaired" "Mentally impaired" means suffering from a disorder of the mind, whether through mental handicap or mental illness, which is of such a nature and degree as to render a person incapable of having an independent life or of guarding against serious exploitation.	

Anonymity

Act	Section 7: Criminal Law (Rape) Act, 1981 as amended by Section 17 of the 1990 Act
S.7.	After a person is charged with a sexual assault offence, no matter likely to lead members of the public to identify a person as the complainant in relation to that charge shall be published in a written publication available to the public or be broadcast except as authorised by a direction given in pursuance of this section. In certain circumstances, on application to the court, the Judge may direct that section 7 shall not apply. In a case where the complainant wishes to waiver his or her anonymity the direction of the Court is required.
S.8.	After a person is charged with a rape offence no matter likely to lead member of the public to identify him as the person against whom the charge is made shall be published in a written publication available to the public or be broadcast except :- (a) As authorised by a direction of the Court in certain circumstances, or after he has been convicted of the offence.
NB.	Section 8 provides for the anonymity of a person accused of a rape offence but this protection is lifted if the accused is found guilty

Restriction of Public Access – In Camera Rule

Act	Criminal Law (Rape) Act 1981 as substituted by Section 11 of the Criminal Law (Rape) (Amendment) Act 1990
S.6.	In any proceeding for a rape offence or the offence of aggravated sexual assault or attempted aggravated sexual assault or of aiding and abetting counselling or procuring the offence of aggravated sexual assault or attempted aggravated sexual assault or of incitement to the offence of aggravated sexual assault or conspiracy to commit any of the foregoing offences, the Judge, the Justice or the court as the case may be, shall exclude from the court during the hearing all persons except officers of the Court, persons directly concerned in the proceedings, bona fide representatives of the press and such other persons if any as the Judge, the Justice or the Court as the case may be, may in his or its discretion permit to remain. This provides for the exclusion of the public from proceedings in a rape case but allows bone fide representatives of the press and others with the courts permission to remain. This section also provides that the verdict and sentence must be announced in public. There is no specific legislation restricting public access to trials of sexual assault.

Criminal Justice Act 1990 (Forensic Evidence)

Act	Criminal Justice (Forensic Evidence) Act 1990
S.2.(1)	**Power to take bodily samples –** Subject to the provisions of subsections (4) to (8) of this section where a person is in custody under the provisions of section 30 of the Offences against the State Act, 1939, or section 4 of the Criminal Justice Act, 1984, a member of the Garda Síochána may take, or cause to be taken, from that person for the purpose of forensic testing all or any of the following samples, namely:– (a) A sample of – (i) Blood. (ii) Pubic hair. (iii) Urine. (iv) Saliva. (v) Hair other than pubic hair. (vi) Nail. (vii) Any material found under a nail. (b) A swab from any part of the body other than a body orifice or a genital region. (c) A swab from a body orifice or genital region. (d) A dental impression. (e) A footprint or similar impression of any part of the person's body other than a part of his hand or mouth.
NB.	Certain authorisation and consents are required in the taking of samples as outlined in Section 2 of this Act.

Appendix 2:

Sexual Violence Prevalence Information

Overall Rates

- **6% of adult women in Ireland are raped as adults, an additional 13% experience some other form of contact sexual abuse.**
- **1% of adult men in Ireland are raped as adults, an additional 9% experience some other form of contact sexual abuse.**[1]

Rates of Sexual Violence within Vulnerable Groups

There are a number of groups of people who have different vulnerabilities to sexual violence – some of these groups are listed below. The vulnerability may affect not only the risk of being targeted for sexual violence, but also someone's ability to seek and receive support after sexual violence. Some people are members of more than one group. These numbers only give a flavour of the issues for people who are members of differently vulnerable groups.

People with Learning Disabilities

- International research indicates that people with learning disabilities are at a greater risk for sexual violence than non-disabled peers. Published prevalence estimates vary enormously and range from 8 to 58%.[1]

People with Mental Illnesses

- In the US, for individuals with severe mental illness, experience of violent crime, including sexual assault was two times greater than the general population.[2]

People resident in a psychiatric institution

- In a UK study 32% of women resident in a psychiatric hospital reported sexual molestation and 4% reported sexual assault. 7% of men reported sexual molestation.[3]

Travellers

- There is no current research comparing the rates of sexual violence among Travellers and non-Travellers. The percentage of clients of Rape Crisis Centres who are Travellers is similar to the percentage of Travellers in the general population.[4]

Teenagers

- One-third (33%) of the rape and attempted rapes reported in the US National Violence Against Women Survey occurred when the survivor was aged between 12 and 17.[5]
- In Ireland 19% of female teenagers and 0.4% of male teenagers knew of at least one other young person who had been forced to have sex.[6]

Lesbian, Bisexual, Gay and Transgender Persons

- People perceived to be deviating from sexual and gender norms are often sexually targeted.[7]
- Lesbian women experience sexual violence from non-partner males at the same rate as heterosexual women.[8]
- Existing research, although minimal, primarily suggests sexual violence perpetration rates of between 10% and 20% by one same sex partner against the other partner.[9]

Women in prostitution and men in prostitution

- 63% of 854 people in prostitution in nine countries were raped. 62% of women in prostitution in five countries (South Africa, Thailand, Turkey, USA, and Zambia) reported having been raped while in prostitution.[10]
- Staff working with women in prostitution in Ireland estimated that upwards of 70% were raped as a direct result of being in prostitution. Staff further estimated that the women were raped once every two months.[11]
- Many men in prostitution are heterosexual. In an Irish survey of gay men 6.5% had paid for sex in the previous year and 5.8% had been paid for sex in the previous year.[12]

Trafficked Persons

- Ireland is a destination and a transit country for women, children and men subjected to trafficking in persons, specifically forced prostitution and forced labour.[13]
- In 2009 An Garda Síochána identified 66 potential and suspected victims of trafficking. Of the 37 that had been referred by NGOs, 29 were because of sexual exploitation.[14]
- 56% of women trafficked into Ireland were raped in transit or once they had reached this country.[15]

Homeless People

- Being homeless dramatically increases women's risk of being sexually assaulted and women who are dependent on drugs or alcohol; who receive income from survival strategies such as panhandling, selling items on the street, or trading sex for drugs or other items; who lived outdoors; who experienced mania or schizophrenia; or who had physical limitations were especially likely to have endured sexual assault in the past month in North America.[16]
- In the US, homeless youth (aged 12-24) are far more likely to be physically and sexually victimized than their peers who are housed and females are more likely to experience sexual violence than males. Lesbian, bisexual, gay and transgendered youth are more likely to experience sexual violence while homeless than straight youth.[17]

People who are poor

- About half of all rape survivors in the US are in the lowest third of income distribution; half are in the upper two-thirds.[18]

Men and women in prison

- The numbers are higher for men than women and average 20% and 7%, a recent US Department of Justice study found that female prison imates where more than twice as likely as male inmates to have been subjected to sexual violence by other inmates (4.7% versus 1.9%).[19]
- A small Irish study found a prevalence rate of sexual assault (not rape) in a male prison of 7.4%.[20]

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17. National Alliance to End Homelessness. Numerous studies cited in 'Homeless Youth and Sexual Exploitation.' National Alliance to End Homelessness. www.endhomelessness.org

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Appendix 3: Consent

Excerpt from National Patient Documentation Template

Read to Patient in Front of Witness.

History and General Physical Examination:

The primary purpose of this examination is to provide appropriate care and document findings. This involves a doctor or nurse taking a relevant history and undertaking a general physical examination, including an intimate examination if appropriate.

Forensic Examination:

The following has been explained to me and I understand that:

- The examination will involve intimate and non-intimate samples being taken which will be sent to the Forensic Science Laboratory for examination.
- The details of the examination will be recorded and any information obtained will be disclosed to the criminal justice agencies i.e. An Garda Síochána and the courts: prosecution and defence.
- The findings of the examination and/or laboratory tests may also be released to the courts for use in evidence.
- If photography is required to document details of physical findings, this will usually be undertaken by An Garda Síochána. In certain circumstances, however, photographs may be taken in the SATU at the time of this examination and subsequently released to An Garda Siochana.
- Any clothing taken from me during the examination will be given to An Garda Síochána and will be sent for laboratory tests, and may be retained indefinitely.
- Up to the age of 18 years the Children First reporting procedure will be followed and parental/guardian consent will be required for forensic examination.
- I understand that I can stop the examination or any part of the examination at any time.

History and General Physical Examination:

I consent to a general physical examination as outlined above.

Patient signature:	Date:
Parent/guardian signature:	Date:
Doctor/nurse signature (name and grade):	Date:

Forensic Examination:

I consent to the forensic examination as outlined above.

Patient signature:	Date:
Parent/guardian signature:	Date:
Doctor/Forensic Examiner signature (plus grade):	Date:
Garda signature:	Date:
Assisting nurse/midwife signature (plus grade):	Date:

Pre-Discharge Care:

Emergency PCC given: Yes ☐ No ☐ _____

Post Coital Contraception (PCC):	
The nature, possible side effects, success rates and consequences of PCC have been fully explained to me.	
Patient Signature:	Date:
Parent/Guardian Sig:	Date:
Witness Sig. & Grade:	Date:

- ☐ Antibiotics _____
- ☐ Immunisation _____
- ☐ Post Exposure Prophylaxis _____
- ☐ Other Medications _____
- ☐ Referral to other support services _____
- ☐ SATU information leaflet given _____
- ☐ Other advice given _____

Sexually Transmitted Infection (STI) Screening

Date and location of STI Screening follow-up appointment:

I consent to the following forms of contact:

Letter No ☐ Yes ☐ Address _____

Telephone/Text No ☐ Yes ☐ Number _____

Voicemail No ☐ Yes ☐

I consent to provision of a short report for my GP regarding my attendance at SATU: No ☐ Yes ☐

I consent to the anonymous use of these records for audit and research by SATU: No ☐ Yes ☐

Patient signature:	Date:
Parent/Guardian signature:	Date:
Witness Signature:	Date:

Appendix 4

Legal Report Template

LOGO

CONFIDENTIAL
FORENSIC CLINICAL EXAMINATION REPORT

Sexual Assault Treatment Unit,
Address

Hospital No:
SATU Number: ????
email@.ie

Report by:	
Date of examination:	
Requesting Garda:	
Registration Badge No:	
Garda Station Address:	

Contents Page

NB. When a word is included in the glossary, the text on the page is in *italic* print when you first encounter it.

1. Introduction

Subject matter: This is a confidential *Forensic Clinical Examination* report

2. The Report Author

Name: **Professional P.I.N.**

Work Address: SATU, The Rotunda Hospital

Work Telephone Number: 01 8730700 Ext:

Email:

Professional qualifications:

Position of Employment at time of writing this report

At the time of this report I am a Medical Forensic Examiner/Clinical Nurse Specialist *(Sexual Assault Forensic Examination)* (delete as appropriate), SATU, Hospital Name, Address

I was on duty on _____ as the Sexual Assault *Forensic Clinical Examiner*, for the SATU, when I carried out the Forensic Clinical Examination outlined in this report.

3. Patient Details

Name: | **SATU Chart Number:**

Address:

Date of Birth: | **Age at time of Examination:** | **Sex:**

4. Arrival in the SATU

Date of arrival in the SATU: | **Time of arrival in the SATU:**

Accompanied by:

5. Previous Health History

Can be nil relevant

The first day of the patient's last menstrual period was:

History of sexual intercourse within the last 7 days:

Record whether it was protected or unprotected sexual intercourse

6. Alleged Assault

Date of alleged assault: | **Time of alleged assault:**

Time interval from alleged assault till the examination:

History of alleged assault as given in the patient's own words:

Must accurately reflect what the patient has told the Forensic Clinical Examiner. To ensure accuracy, the history as recorded may be read back to the patient.

7. Demeanour

Be factual e.g. crying/sobbing/shaking

NOT distressed/calm etc.

8. Consent for the Forensic Clinical Examination

Following full explanation of the forensic clinical examination procedures to the patient, I obtained signed consent prior to commencing the forensic clinical examination

Can be nil relevant. If there were any special considerations regarding consent then amend this section during dictation.

9. Forensic Clinical Examination

Date of Examination: | **Time examination commenced:**

Location where the Forensic Clinical Examination was carried out:

I opened the *Sexual Offences Examination Kit* in the presence of:

Garda:

Registration No:

Garda Station:

The Sexual Offences Examination Kit expiry date was

The Sexual Offences Examination Kit bag that was opened number:

Also present during the Forensic Clinical Examination was:

10. Physical Top-to-Toe examination

I noted and recorded the following:

Height: _____ **Weight:** _____

Put in other observations if appropriate: _____

10.1. Face

Dictate any clinical findings at each point or state: No abnormality found

10.2. Head and neck

10.3. Right arm hand and fingers

10.4. Left arm hand and fingers

10.5. Shoulders

10.6. Upper back

10.7. Lower back and buttocks

10.8. Chest and breasts

10.9. Abdomen

10.10. Right thigh, upper leg, lower leg and foot

10.11. Left thigh, upper leg, lower leg and foot

Wounds: ensure the following is recorded:

- Use terms from the National Guidelines
- State anatomical position
- State distance from a fixed point.
- Shape
- Size in measurement of all dimensions including depth
- If apparent: course or direction
- Contents: if any FB
- If appropriate: Borders
- Colour

Record

- Physical Deformities

11. Female Genital Examination

11.1 Labia majora

11.2 Labia minora

11.3 Clitoris

11.4 Urethral orifice

11.5 Hymenal opening

11.6 Fourchette

11.7 Introitus/vestibule

11.8 Fossa navicularus

11.9 Vagina

NB: Instruct to delete the male or female section 11 depending on gender of patient

Use National Guidelines

If speculum/proctoscope or anoscope was used record same

Record what type of lubricating gel was used

11. Male Genital Examination

11.1 Shaft of the penis

11.2 Foreskin

11.3 Glans of the penis

11.4 Coronal sulcus

11.5 Urethral meatus

11.6 Scrotum

11.7 Median raphe

Use National Guidelines

If proctoscope was used record same

Record what type of lubricating gel was used

11b. Anal Examination

12. *Swabs*/Samples

I took the following swabs/samples

12.1.

Use the patient's notes:
List: what swabs/samples were taken and how many

12.2. Other swabs/samples taken:

Include any other samples taken

12.3 Medications:

Medications record:

- **What you have entered on the toxicology form and**
- **Medications administered in SATU**

13. Continuity of Evidence

Sexual Offences Examination Kit

On completion of the Forensic Clinical Examination, I packed the Sexual Offences Examination Kit into the *tamper evident bag* no: _____

Toxicology Samples

The blood and urine samples I packed in the Toxicology tamper evident bag no: _____

I gave both the Sexual Offences Examination Kit bag and the Toxicology bag to Garda _____ who sealed and signed both the tamper evident bags containing the samples in my presence, and took possession of the bags, maintaining the continuity of evidence.

14. Clothing

State EXACTLY what YOUR part if any was re: the clothing – leave no ambiguity

If clothing was taken and given to the Garda state:

- **Item**
- **Colour**
- **Any obvious damage e.g. button missing from left cuff**
- **Wet, dirty, blood stained etc**
  NB: If wet/heavy blood stained state how packaged according to National Guidelines

15. Summary of Forensic Clinical Examination

- **Include summary of findings any wound/s etc.**
- **One of the following range of phrases could be chosen as appropriate for interpretation of the findings in the medical report:**
  - **o Precludes**
  - **o Does not preclude**
  - **o Consistent with**
  - **o Suggests**
  - **o Strongly suggests**

If no genital trauma found on Examination

- **There was no sign on recent trauma on genital examination, but the absence of genital trauma does not preclude the possibility of unconsented sexual intercourse.**

Date examination finished: _____ **Time examination finished:** _____

I hereby declare that this report is true to the best of my knowledge and belief and that I make it knowing that if it is tendered in evidence I will be liable to prosecution if I state anything in it that I know to be false or do not believe to be true.

Signed: _____ **Date this report was signed** _____
Forensic Clinical Examiner

Printed Name: _____ **Date report was typed** _____
Forensic Clinical Examiner

Appendix 5:

Monitoring and Evaluation

On-going monitoring, evaluation and audit is an integral part of all agencies /disciplines involved in providing an Integrated Inter-Agency SATU service. Possible areas for audit using a structure, process and outcome approach are tabulated below.[1]

Table 19: Structure, Process and Outcome Audit.

Structure	Process	Outcome

Resources:
Appropriate Staff education e.g.
• Education criteria to fulfil practitioner role.
• Specialised induction packages.
• Continuing professional development.
 	
Buildings Appropriate:
• Physical space and equipment for: SATU care, forensic clinical examination and follow-up.
• Patient and security measures.
• Forensic quality check: Environmental monitoring carried out twice yearly.
 	
Documentation Use:
• Standardised best practice documentation, policies, protocols, guidelines etc.
• Standardised prospective data collection, data analysis and production of clinical reports.
• Ensure availability of Recent Rape/ Sexual Assault National Guidelines, 2010.
 	
Service:
• Available 24 hours a day 365 days a year.
• Both reporting and non-reporting patients seen.
• STI follow-up in the SATU.
 	
Finance
Ring fenced local and national budgets.
	Processes:
	Explicit evidence of communication lines e.g.
	• Referral pathways to SATU.
	• Distinct referral processes from SATU to other relevant disciplines.
	• Defined links with relevant Hospital support services e.g. Laboratory, IT, laundry, post etc.
	• Inter-agency/disciplinary meetings with agenda, action plan and minutes.
	• Partnership approach to a coordinated inter-disciplinary response strategy.
	• Cross-sectoral cooperation in line with national strategies e.g. HSE, Cosc etc.
	• Readily available and accessible service information e.g. clear appropriate patient information, specific training packages, use of websites, etc.
	
	Confidentiality
	• Explicit systems are in place to ensure patient confidentiality.
	
	Service Expansion
	• Ensure knowledge of services is available to all sections of the population.
	
	Forensic Quality checks
	• % Staff provided DNA elimination profiles.
	• Quality and appropriateness of forensic evidence submitted.
		Key performance Indicators for each specialist area should be defined. Examples for use within the SATU could include the following:
		• Ensure quality and appropriateness of response from victim/survivor's perspective:
		  • Service received.
		  • Staff response.
		  • Suitability of environment.
		
		Measure against the following standards:
		• % of patients will be seen within 3 hours from reporting to Gardai to attendance at SATU. (See sample telephone referral form overleaf)
		• % of patients will have a Psychological Support Worker available.
		• % of patients <18 years are referred to HSE Social Services, in line with Children First recommendations.
		• % of patients reporting a sexual crime to An Garda Siochána will have a legal report completed.
		• % of female patients eligible for ECP, will have ECP administered in SATU.
		• % of patients who meet the criteria for PEPSE, will be commenced on PEP.
		• % of patients are given an appointment for STI screening follow up.
		• % of patients are asked for their consent regarding:
		  • Sending a report to the GPs.
		  • SATU making future contact.
		  • Use of their records for audit and/or research.

Evaluation should take place both from an individual agency/discipline standpoint and from the collective Integrated Inter-Agency team, using clinical audit methodologies.		

References: 1. Lazenbatt, A. The Evaluation Handbook for Health Professionals. London: Routledge; 2002.

Sample Form:

Telephone referral/advice calls to SATU

A. CALLER DETAILS			
Garda or contact:		**Garda Station**	
Mobile No:		**Landline No:**	
Date of call		**Time of call (24 hr clock)**	
Referral by: Gardai ☐ Self ☐ G.P. ☐ R.C.C. ☐ Other:	**Nature of call:** **Advice:** ☐ **Forensic Clinical Examination** ☐ **Non Reporting/Health Check** ☐ Comments:		

B. FORENSIC CLINICAL EXAMINATION					
Person medically stable? YES ☐ NO ☐ **If NO:** Emergency Dept/GP					
Incident date		**Incident time (24 hr clock)**		**Time interval from incident:**	
County referral from		**Travel time to SATU approx.**		**Early evidence kit use?**	
DETAILS OF COMPLAINANT					
Age		**Gender**	Female ☐ Male ☐		
Person's first language			**Interpreter arranged**	Yes ☐ No ☐ N/A ☐	
CONSENT					
Able to give consent? YES ☐ NO ☐ **If NO:** o <18 years: parent/guardian required ☐ o Temporary loss of capacity (e.g. alcohol) ☐ o Permanent loss of capacity ☐ o Vulnerable adult ☐			Comments:		
Forensic Clinical Examination booked for:			**Date:**	**Time (24 hr clock)**	

C. DELAY OF MORE THAN 3 HOURS FOR FORENSIC CLINICAL EXAMINATION: Reason:	
No Forensic Clinical Examiner available ☐	No Sexual Offences Exam Kit ☐
No Support Nurse/Midwife available ☐	SATU Unavailable for use ☐
No female Garda available ☐	Getting consent ☐
No RCC Psychological Support available ☐	Distance ☐
No Interpreter available ☐	Other (please state) ☐
Length of delay in hours:	

Signed:	**Role:**

Appendix 6:

Critical Readers List

Ms. Noeleen O'Donnell. Information Officer, Health Promotion Department. HSE West, Drumany Church Letterkenny, C. Donegal.

Ms. Rioghnach Corbett. Solicitor.
Contactable at rioghnachcorbett@gmail.com

Ms. Catherine Hallahan, CNM 2, SATU/Women's Health, Midland's Regional Hospital, Mullingar, Co. Westmeath.

Dr. Elizabeth Walsh, Medical Director, Community Child Centre, Waterford Regional Hospital, Waterford.

Ms. Finola Tobin, CNS (Sexual Assault Forensic Examination (SAFE)) and CNM 2, SATU, South Infirmary – Victoria University Hospital, Old Blackrock Road, Cork.

Ms. Georgina Farren, Professional Development Officer, National Council for Professional Development of Nursing and Midwifery, Manor St., Business Park, Manor St., Dublin 7.

Ms. Deirdra Richardson, CMS (SAFE), SATU, Rotunda Hospital, Parnell Sq., Dublin 1.

Ms. Aideen Walsh, CNS (SAFE), SATU, Rotunda Hospital, Parnell Sq., Dublin 1.

Ms. Bernadette Carpenter, Advanced Nurse Practitioner (ANP) Emergency Department, Mater Misericordiae Hospital, Eccles St. Dublin 7.

Ms. Mags Campion, Administrative Assistant, School of Midwifery and Practice Development Unit, Rotunda Hospital, Parnell Sq. Dublin 1.

Ms. Jane Casserley, CNS (SAFE), SATU Donegal, NoWDOC Premises, Oldtown, Letterkenny, Co. Donegal.

Dr. Martina McBride, Murder/Assault Team Manager, the Forensic Science Laboratory, Garda Headquarters, Phoenix Park, Dublin 8.

Dr. Jennifer Ryan, Sexual Assault Team Manager, the Forensic Science Laboratory, Garda Headquarters, Phoenix Park, Dublin 8.

Ms. Eleanor Comer, CNS (SAFE) SATU Galway , Hazelwood House, Parkmore Rd. Galway.

Office of the Director of Public Prosecutions, Prosecution Policy Unit. 14-16 Merrion St. Dublin 2.

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Recent Rape/Sexual Assault: National Guidelines on Referral and Forensic Clinical Examination in Ireland. 2nd edition. 2010.

Operational Definitions and Glossary of Terms

Operational Definitions and Glossary of Terms

Abrasion: Superficial injury to the skin caused by the application of blunt force. Produced by a combination of contact pressure and movement applied simultaneously to the skin Section 2:10 p. 74 for different types of abrasions).[4,19]

Acquaintance: someone who the person knew for 24 hours or more. (See also recent acquaintance).

Adult Forensic Clinical Examination: In law a person is an adult when they reach the age of 18 years.[6] For the purpose of carrying out an adult Forensic Clinical Examination, 14 years of age is taken as the age where physical maturity has been reached in the average young person. **NB.** For a person under the age of 18 years, Children First guidelines[7] reporting mechanisms should be followed.

Anal canal: The terminal part of the large intestine extending from the rectum to the anal orifice.[17]

Anal skin folds: Folding or puckering of the perianal skin radiating from the anal verge.[17]

Anatomical position:
Descriptions in human anatomy are expressed in relation to the anatomical position. These positions describe where different body parts are found or what the direction of a movement, relative to the midline of the body, or to another body part. Anatomical positions are referred according to their orientation:

- **Anterior** - toward the front of the body
- **Superior** - toward the head
- **Inferior** - toward the feet
- **Posterior** - toward the back of the body
- **Medial** - toward the midline of the body
- **Lateral** - away from the midline of the body

Anorectal line: the line where the rectal columns interconnect with the anal papilla: also called the dentate line.[14]

Anus: The anal orifice; the outlet of the large bowel, opening of the rectum.[14]

Bruise: an area of haemorrhage beneath the skin. [4,19] Section 2:10 p. 74 for further details)

Cervical os: Opening in the cervix leading to the uterine cavity.

Cervix: The neck of the uterus, penetrated by the cervical canal, it is about 2.5cms. in length, with a rounded surface that protrudes into the vagina; for descriptive purposes the rounded surface is divided in half at the cervical os, into the anterior and posterior cervix.

Clinical Nurse/Midwife Specialist: A nurse or midwife in clinical practice who has undertaken formal recognised post-registration education relevant to his/her area of specialist practice.[2]

Clitoris: Erectile tissue situated beneath the mons pubis and above the urethra; the clitoris is covered by the clitoral hood or prepuce.[14]

Complainant: The person who alleges that a crime has been committed.[1]

Corona: The widest portion around the glans,[17] the ridge that delineates the glans from the shaft of the penis.[18]

Coronal Sulcus: The groove at the base of the glans.[17]

Cosc: Cosc is the National Office for the Prevention of Domestic, Sexual and Gender-based Violence. It provides a dedicated, resourced office at Government level to deliver a properly co-ordinated, whole-of-Government response to these forms of violence.

Dentate line: see anorectal line.[14]

Domestic violence: …the use of physical or emotional force or the threat of physical force, including sexual violence in close adult relationships….[10] The terms "domestic violence and "intimate partner violence" are both used to describe violence between two adults in an intimate relationship.[11]

Elder abuse: A single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person or violates their human and civil rights.[9]

Evidence: That which tends to prove the existence or non-existence of some fact,[1] the truth of which is submitted to judicial investigation.

1. Testimony.
2. Hearsay Evidence.
3. Documentary Evidence.
4. Real Evidence (e.g. weapon).
5. Circumstantial Evidence.

Ex-intimate Partner: ex-husband/wife, ex-boyfriend/girlfriend or ex-lover.[4]

Female Genital Mutilation: The partial or total removal of the external female genitalia, or any practice that purposely alters or injures the female genital organs for non-medical reasons. The practice is internationally recognised as a human rights violation of women and girls.[24]

Forensic Clinical Examiner: In the context of these guidelines, the term Forensic Clinical Examiner is deemed to be an appropriately trained healthcare professional who undertakes the Forensic Clinical Examination and collects forensic evidence from the patient, following alleged rape or sexual assault. This healthcare professional may be a Medical Doctor, a Registered Nurse or a Registered Midwife.[3]

Foreskin: The movable hood of skin covering the glans of the penis.[21]

Fossa Navicularis: Concavity anterior to the posterior fourchette and posterior to the hymen.[14]

Fourchette: the posterior margin of the vulva: the site where the labia minora unite posteriorly.[12]

Frenulum: The thin fold of tissue that attaches the foreskin to the ventral surface of the glans penis.[21] It attaches immediately behind the external urethral meatus.[17]

Glans of the penis: The cone shaped head of the penis,[21] distal to the coronal sulsus.

Health Care Professionals: Doctors, nurses, midwives and other professionals, who have specific training in the field of health care delivery.[4]

Human Trafficking: The Palermo Protocol states: "Trafficking in persons" shall mean the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation or the prostitution of others or other forms of sexual exploitation, forced labour or devices, slavery or practices similar to slavery, servitude or the removal of organs.[23]

Hymen: A membranous collar or semi collar inside the vaginal introitus.[14] (p. 62; table 4: Anatomical variations and terms relating to the hymen)

Intimate Partner: a husband/wife, boyfriend/girlfriend or lover.[4]

Introitus: An opening or entrance into a canal or cavity as in the vaginal intoitus.[14]

Labia Majora: The two large folds which form the boundary of the vulva.[13]

Labia Minora: Two smaller folds of skin between the labia majora. Anteriorly the labia minora meet at the clitoris and posteriorly they fuse to form the fourchette.[13]

Laceration: ragged or irregular tears or splits in the skin, subcutaneous tissues or organs resulting from blunt trauma. (e.g. trauma by impact).[4,19] (See Section 2:10 p. 74 for further details)

Median Raphe: A ridge or furrow that marks the line of union of the two halves.[17]

Patient: Individuals, who are receiving a service from, or are being cared for by, a health care worker.[4]

Penis: Male organ of reproduction and urination, composed of erectile tissue, through which the urethra passes. It has a shaft and glans (head); the glans may be covered by the foreskin.[14,18] (p. 65: Table 7)

Perineum: The external surface of the perineal body. Lies between the posterior fourchette and the anus in the female and the scrotum and the anus in males.[13]

Proctoscope: An instrument to aid visualisation of the anal canal and lower rectum.

Psychological Support Worker: A Rape Crisis Centre volunteer or staff person trained and available to provide advocacy, crisis intervention and support to a sexual violence victim/survivor in a Sexual Assault Treatment Unit.

Rape: Definitions for rape as legally defined in Irish law (p. 122: Appendix. 1, also http://irishstatutebook.ie).

Recent Acquaintance: someone who the person knew for less than 24 hours[5]

Recent Rape/Sexual Assault: In the context of carrying out a Forensic Clinical Examination, for the purpose of retrieving forensic evidence, recent rape/sexual assault is categorised as up to and within seven days following the rape/sexual assault.

Rectum: The final straight portion of the large intestine, terminating in the anus.

Scrotum: The scrotum is a pouch of deeply pigmented skin, fibrous and connective tissue and smooth muscle. It is divided into two compartments each containing one testis, one epididymis and the testicular end of a spermatic cord.[13]

Sexual Assault: Definitions for sexual assault as legally defined in Irish law (p. 122: Appendix. 1, also http://irishstatutebook.ie).

Sexual Offences Examination Kit: Specifically designed kit for use with either male or female complainants or alleged perpetrators during a Forensic Clinical Examination, for the purpose of taking forensic samples.[3]

Sexual Violence: a term covering a wide range of crimes, including rape, sexual assault, incest and buggery. (p. 122: Appendix. 1, also http://irishstatutebook.ie).

Shaft of the Penis: The shaft of the penis is the area from the body of the male to the glans penis and is composed of three cylindrical masses of erectile tissue.[18] The dorsal surface of the penis is located anteriorly on the non-erect penis, and its ventral surface is in contact with the scrotum.[20]

Speculum: An instrument for exposing a cavity or channel in the body by enlarging the opening to allow viewing.

Speculum Examination: The viewing of a canal of the body, using a speculum. Specifically viewing the vagina and cervix with a vaginal speculum.

Stranger: someone whom the person has never met.

Swab: A swab in the context of a forensic clinical examination is a one ended 'cotton bud.' Each swab comes in its own individual cylindrical container.

Tamper Evident Bag: A bag specially designed for secure containment of forensic samples, the seal of the bag cannot be tampered with, without it being evident.

Tanner Stages: A classification system which is used to categorise secondary sexual development: the degree of sexual maturation defined by physical evidence of breast development and pubic hair in the female, the testicular, scrotal and penile size along with the location of pubic hair are used in the male ranging from Stage 1 (pre-pubertal child) to Stage 5 (fully mature adult).[22]

Time Frames:
For the purpose of these guidelines and in the context of SATUs, the following are the recognised time frames from the reported time of the rape/ sexual assault until Forensic Clinical Examination:

- ***Acute case:*** where the incident happened < 72hours
- ***Recent incident:*** where the incident happened < 7 days
- ***Non-acute case:*** where the incident > 7 days

Trafficking: (See Human Trafficking)

Urethral Orifice: Opening into the urethra.

Vagina: A fibromuscular sheath extending upwards and backwards from the vestibule.[16] Section 2:5.2 p. 63: Table 5: Descriptive terms for the vagina).

Vestibule: An almond shaped space between the lines of attachment of the labia minora; four structures open into the vestibule-urethral orifice, vaginal orifice, and the two ducts of the glands of Bartholin.[14]

Victim/Survivor: A person who has lived through a rape or sexual assault.

Vulnerable Adult: A person who is or may be in need of community care services by reason of mental illness or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself from significant harm or exploitation.[8]

Vulva: The collective term used to describe the external female genitalia. It incorporates the mons pubis, labia majora, labia minora, clitoris, clitoral hood and vestibule.[12]

Wounds: See Section 2:10 p. 74. Table 8: Classification and documentation of wounds.

Abbreviations

BASHH:	British Association for Sexual Health and HIV
CHP:	Countries of High Prevalence
CN/MS (SAFE):	Clinical Nurse /Midwife Specialist (Sexual Assault Forensic Examination)
DNA:	Deoxyribonucleic acid
DOB:	Date of Birth
DOHC:	Department of Health and Children
DOJELR:	Department of Justice, Equality and Law Reform
DPP:	Director of Public Prosecutions
DVSAIU:	Domestic Violence Sexual Assault Investigation Unit
EC:	Emergency contraception
ECP:	Emergency Contraceptive Pill
FFLM:	Faculty of Forensic and Legal Medicine
FGM:	Female Genital Mutilation
FVU:	First Void Urine
GP:	General Practitioner
hCG:	Human Chorionic Gonadotropin
HIV:	Human Immunodeficiency Virus
H.Q.	Head Quarters
HSE:	Health Service Executive.
ICGP:	Irish College of General Practitioners
IVDA:	Intravenous Drug Addict/s
LMP:	Last Menstrual Period
MSM:	Men who have Sex with Men
NAATs:	Nucleic Acid Amplification Tests
NCBI:	National Council for the Blind of Ireland
NHO:	National Hospitals Office
OMC:	Office for the Minister for Children and Youth Affairs
PCC:	Post Coital Contraception
PEP:	Post-Exposure Prophylaxis
PEPSE:	Post Exposure Prophylaxis following Sexual Exposure
RCC:	Rape Crisis Centre.

RCNI:	Rape Crisis Network Ireland.
RCOG:	Royal College of Obstetricians and Gynaecologists
SATU:	Sexual Assault Treatment Unit.
SIVUH:	South Infirmary Victoria University Hospital
SLIS:	Sign Language Interpreting Service
STI:	Sexually Transmitted Infection/s
WHO:	World Health Organisation

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