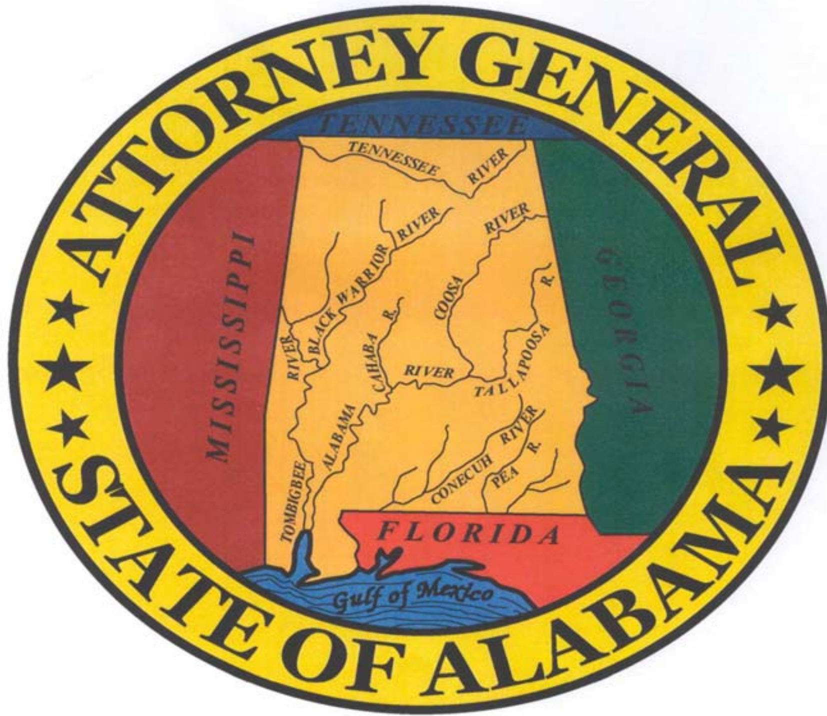

ALABAMA

PROTOCOL

FOR THE

EXAMINATION AND TREATMENT

OF VICTIMS OF

SEXUAL ASSAULT

ATTORNEY GENERAL TROY KING'S

SEXUAL ASSAULT TASK FORCE

To the Citizens of Alabama:

Sexual Assault is one of the most serious, violent, and traumatic crimes that occurs in our society. In the United States, over 67,000 rapes alone are committed each year. In Alabama, we average 1,530 rapes reported each year. This does not include other sexual assaults such as sodomy, sexual abuse, sexual misconduct, and other related crimes under Alabama law.

In an effort to combat these heinous crimes, careful investigation, optimum evidence collection, and evidence preservation are the keys. In 1988 and 1989, the Office of the Attorney General developed the Alabama Protocol for the Examination and Treatment of Victims of Sexual Assault. The Protocol aids in standardizing procedures for a variety of professions which are the contacts encountered by a person victimized in a sexual assault. It also sets a minimum of investigative, medical, victim assistance, forensic science, prosecutorial actions, and sensitivity issues to be addressed when appropriately handling these difficult cases.

I realize this Protocol helps us all to better serve our citizens, patients, and fellow Alabamians who happen to be singled out by a violent criminal. For this reason, a group of dedicated and skilled Alabamians have researched and updated this valuable literature to include new and pertinent information necessary in today's ever-changing technological society.

I endorse the changes made to improve the Alabama Protocol for the Examination and Treatment of Victims of Sexual Assault and strongly encourage its use in responding to and assisting victims of sexual assaults.

Respectfully,

Troy King

Attorney General

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PREFACE

Reports of sexual assaults against adults have **decreased** throughout the past decade, although no one knows for certain how many actual assaults take place each year. Some victims still choose not to report the assault because of embarrassment, fear, and trauma as a result of the assault. Others lack faith in the follow-up treatment, investigative, and prosecutorial systems. Additionally, there is often variance among, and sometimes within, communities as to what constitutes sexual assault. For example, many communities only submit statistics concerning cases of forced penetration of a female by a male – the traditional but very narrow definition of "rape". Others report all types of deviate sexual behavior including the use of foreign objects and anal or oral copulation.

Reports of child sexual abuse have increased dramatically in the past few years, although these reports remain even more difficult to document than adult reports. This is due largely to a deficiency in the collection of child sexual abuse data and submission of that data to one central location. The lack of available data is compounded by the low rate of reporting of the abuse by either the victim or a third party.

The reasons for this are extremely complex. Many children are too young to understand that certain kinds of physical contact by adults or older children are inappropriate. Others may realize that something is wrong but are unable to articulate their feelings or are dependent upon the abuser for care. When children do report the abuse to a third party, their story may be dismissed as fantasy or even a lie. Further complicating the situation is the fact that threats, however subtle, may be made which discourage reporting by children. Children can be led to believe that something terrible will happen to them or to their families if anyone finds out or that in some way they are responsible for the abuse.

Traditionally, the successful prosecution of both adult and child sexual assault cases have been difficult. Since the victim often is the only witness to the crime, the collection of physical evidence as well as documentation of medical trauma may be necessary either to substantiate an allegation or to help strengthen a case for court. Evidence from the offender and the crime scene often may be found on the body and clothing of the victim. When immediate medical attention is received, the chances increase that some type of physical evidence will be found.

Conversely, the chances of finding physical evidence decrease in direct proportion to the length of time which elapses between the assault and the examination.

By necessity, the job of collecting physical evidence in sexual assault cases used to fall to physicians and nurses in hospital emergency rooms and pediatric units. Although evidence collection is the primary focus of the document, by necessity, basic medical, psychological, and support issues also have been included as much as possible throughout the protocol. However, for more detailed information on the medical,

psychological, investigative, and legal aspects surrounding sexual assault treatment, topic-specific literature should be consulted.

For the purpose of this protocol, the term "sexual assault" will be used to refer to all sex crimes perpetrated against adults and the term "sexual abuse" will refer to all sex crimes perpetrated against children. Both terms are defined by the Committee in a broad context as follows:

> **Any act of sexual contact or intimacy performed upon one person by another, and without consent, or with an inability of the victim to give consent due to age, mental or physical incapacity.**

A listing of sexual offenses as well as the rape shield law and counselor confidentiality is contained in Appendix B of this document.

Currently, many jurisdictions in Alabama utilize specially trained SANEs (Sexual Assault Nurse Examiners) to collect this evidence. The role of medical personnel **whether at a hospital ER or at a SANE facility,** in this process often can be the key to successful prosecution and can help promote early victim recovery.

The primary purpose of this document is to assist hospitals and **SANE facilities** in:

- minimizing the physical and psychological trauma to the victim of sexual assault or sexual abuse;

- maximizing the probability of collecting and preserving the physical evidence for potential use in the legal system; and,

- addressing important issues of current controversy surrounding the collection of medical and physical evidence.

The Rape Victims Committee was first formed in 1987 as a part of the Victims Task Force at the request of the Attorney General to examine the issues of Victims' Rights and to suggest solutions to victim problems. Committee members, representing the State of Alabama, had extensive experience and expertise in working with sexually assaulted adults and children. The Rape Victims Committee found that there was no protocol in the State of Alabama for the forensic collection of evidence in sexual assault cases. It was the feeling of the Committee that a statewide protocol was necessary to ensure the proper collection of evidence in sexual assault cases balanced with the physical and emotional needs of the sexual assault victim.

The sexual assault procedures recommended in the first document were taken largely from a protocol funded by the Office for Victims of Crime, the Office of Justice Programs, and U.S. Department of Justice, which was developed by a grant administered by the Office of the Illinois Attorney General. The protocol incorporated certain changes that addressed the needs of victims in the State of Alabama.

This printing is the third edition of the protocol and includes revisions suggested by a protocol review committee, led by the Attorney General, comprised of the following individuals:

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I. ADULT PROTOCOL

A. General Information

Sensitivity to Victim Needs

Some sexual assault victims suffer severe physical injuries, contract a sexually transmitted or other communicable disease, or become pregnant as a result of the attack. **Most** do not. In each situation, victims will experience varying degrees of psychological trauma which may be more difficult to recognize than physical trauma. An individual's perceptions of how sexual assault victims should look, dress or act and the way those perceptions are conveyed can have a major effect upon the victim's recovery process following the crime. Each person has his or her own method of coping with sudden stress. Severely traumatized victims can appear to be calm, indifferent, submissive, jocular, angry, or even uncooperative and hostile toward those who are trying to help. All of these responses are within the normal range of anticipated reactions. An inappropriate response to information concerning the circumstances surrounding the assault or a misinterpretation of a victim's reaction to the assault may lead to further **trauma** and hinder the interview or evidence gathering process.

For some victims, the problems of poverty and discrimination already have resulted in a high incidence of victimization, as well as inadequate access to quality hospital treatment. There may be a mistrust of medical and law enforcement personnel who play a vital role in the aftermath of sexual assault, particularly if there has been a history of unpleasant or disappointing experiences with these professionals.

It is recommended hospitals serving specific populations seek the assistance of reliable community consultants to help develop procedures and counseling resources which reflect the special needs of those populations.

In certain cultures, the loss of virginity is an issue of paramount importance which may render the victim unacceptable for an honorable marriage. In other cultures, the loss of virginity may not be as great an issue as that of the assault itself. Also, religious doctrines may prohibit a female from being disrobed in the presence of a male who is not her husband or forbid a genital examination by a male physician. Such practices are considered a further violation. A female physician should be made available for patients who request them.

Age is an important factor to consider when responding to a victim of a sexual assault and when determining the proper method of administering an interview, conducting a medical examination, and/or providing psychological support.

The Elderly Victim

As with most other victims, the elderly victim experiences extreme humiliation, shock, disbelief, and denial. The full emotional impact of the assault may not be felt until after initial contact with physicians, police, legal, and advocacy groups, or later, when the victim is alone. It is at this time that older victims must deal with having been violated and possibly diseased, and when they become more acutely aware of their physical vulnerability, reduced resilience, and mortality. Fear, anger, or depression can be especially severe in older victims who many times are isolated, have no confidant, and live on meager incomes.

In general, the elderly are physically more fragile than the young and injuries from an assault are more likely to be life-threatening. In addition to possible pelvic injury and sexually transmitted diseases, the older victim may be more at risk for other tissue or skeletal damage and exacerbation of existing illnesses and vulnerabilities. The recovery process for elderly victims also tends to be far lengthier than for younger victims.

Hearing impairment and other physical conditions attendant to advancing age, coupled with the initial reaction to the crime, often render the elderly patient unable to make his or her needs known which may result in prolonged or inappropriate treatment. It is also not unusual for responders to mistake this confusion and stress for senility.

Medical and social follow-up services must be made easily accessible to older victims or they may not be willing or able to seek or receive assistance. Without encouragement and assistance in locating services older victims may be reluctant to proceed with the prosecution of their offenders.

Victims with Disabilities

Criminal and sexual acts committed against **people with disabilities (physically, cognitive, or communicative)** generally are unreported and seldom are successfully prosecuted. Offenders often are family members, caretakers, or friends who repeat their abuse because their victims are not able to report the crimes against them. **It is important to interview victims with disabilities away from family members or caretakers whenever possible.**

The difficulty of providing adequate responses to the sexual assault victim is compounded when the victim **has a disability**. Some have limited mobility, cognitive defects which impair perceptual abilities, impaired and/or reduced mental capacity to comprehend questions or limited language/communications skills to tell what happened. They may be confused or frightened, unsure of what has occurred, or they may not even understand that they have been exploited and are victims of a crime.

Victims with disabilities and their families should be given the *highest priority*. Additional time should be allotted for evaluation, medical examination and the collection of evidence. A victim with a physical disability may be more vulnerable to a brutalizing assault and may need special assistance to assume the positions necessary for a complete examination and collection of evidence. Improvisation from normal protocol may be indicated in some instances.

The use of anatomical dolls has proved to be a successful method of communication in sexual assault cases involving the communicatively disabled victim. Under Section 504 of the Federal Rehabilitation Act of 1973, any agency (including hospitals and police departments) that directly receives federal assistance or indirectly benefits from such assistance must be prepared to offer a full variety of communication options in order to ensure that hearing-impaired persons are provided effective health care services. This variety of options which must be provided at no cost to the patient also includes an arrangement to provide interpreters who can accurately and fluently communicate information in sign language.

Finally, referrals to specialized support services and reports to law enforcement agencies are particularly necessary for the developmentally and physically disabled who may need protection, physical assistance, and transportation for follow-up treatment and counseling.

<u>The Male Victim</u>

It is believed that the number of adult male victims of sexual assault who report the crime or seek medical care or counseling represents only a very small percentage of those actually victimized. Many adult males do not seek medical care unless they also have been seriously injured. Male child victims are now being seen at hospitals in increasing numbers as a direct result of public education and more stringent child abuse reporting laws throughout the nation.

There has been significant progress in educating the public toward understanding the concept of sexual assault of both sexes as being an act of violence. There still

remains a great reluctance on the part of most male victims to report a sexual assault. Present societal and cultural values can make the trauma of the reporting experience by the male victim equal to that of the female victim.

The male victim may have serious problems concerning his inability to resist the assault or confusion about the nature of his role as victim/participant because of a possible involuntary physiological response to the assault such as stimulation to ejaculation. It is important for males to be reassured that they were victims of a violent crime which was not their fault and that other sexually assaulted males survive to function normally in every way.

Referrals to **local rape crisis centers**, available therapists, or advocacy groups with expertise in the area of sexual assault of males are vital to assist in the recovery process.

B. Initial Law Enforcement Response

Many adult victims of sexual assault will have their first contact with a law enforcement office following the assault.

The primary responsibilities of the first responding officer are to ensure the immediate safety and security of the victim, to obtain some basic information about the assault in order to apprehend the assailant, and to transport the victim to a medical facility for examination and treatment.

The responding officer should convey the following information to the sexual assault victim:

1. The importance of seeking an immediate medical examination since injuries can go unnoticed or appear at a later time.
2. The importance of preserving potentially valuable physical evidence prior to the hospital examination. The officer should explain to the victim that evidence can inadvertently be destroyed by activities such as washing/showering, brushing teeth/using mouthwash, and douching.
3. The importance of preserving potentially valuable evidence which may be present on clothing worn during the assault as well as on bedding or other materials involved at the crime scene. The officer should let the victim know the local rape crisis center will bring a change of clothes to the hospital in the event clothing is collected for evidentiary purposes.

Intimate details of the sexual assault are not needed at this point in the investigation. However, a preliminary interview with the victim is necessary so that the responding officer can relay information that may be vital to the

apprehension of the assailant. The preliminary interview should include the following questions:

1. The extent of injuries, if any, to the victim
2. A brief description of what happened
3. Where the assault took place
4. The identity or description of the assailant(s), if known
5. Where the assailant(s) lives and/or works, if known
6. The direction in which the assailant(s) left and by what means
7. Whether a weapon was involved

The responding officer should provide the **medical personnel** at the treatment facility with any available information about the assault which may assist in the examination and evidence collection procedures.

C. Emergency Medical Technicians and Paramedics

Victims of sexual assault will, in some cases, have their first contact following the assault with Emergency Medical Technicians (EMTs) or Paramedics.

The primary responsibility of the EMT is to ensure that the victim is in a medically stable condition. The EMT should then convey the following information to the sexual assault victim:

1. The importance of seeking an immediate medical examination since injuries can go unnoticed or appear at a later time.
2. The importance of preserving potentially valuable physical evidence prior to the hospital examination. The EMT should explain to the victim that evidence can inadvertently be destroyed by activities such as **urinating,** washing/showering, brushing teeth/using mouthwash and douching.
3. The importance of preserving potentially valuable evidence which may be present on clothing worn during the assault, as well as on bedding or other materials involved at the crime scene. The EMT should **let the victim know that the local rape crisis center will bring** a change of clothes to the hospital in the event clothing is collected for evidentiary purposes.

The EMT should be mindful of the extremely sensitive nature of this crime and the emotional effects it can have on the victim. Furthermore, they should consider the importance of preserving potentially valuable physical evidence which may be present on clothing worn during the assault or on the victim's person.

The EMT should provide the hospital staff and law enforcement personnel with any available information about the assault which may assist in the examination and evidence collection procedures. **The responding EMT should notify the local rape crisis center either to provide the exam at the SANE facility or to send an advocate to the hospital to provide information, clothing, and emotional support.**

D. Treatment Plan

Sexual Assault Response Team (SART)/Nurse Examiners (SANE) Program

Many jurisdictions in Alabama have formed Sexual Assault Response Teams (SART). They are comprised of representatives from law enforcement, District Attorney's offices, Alabama Department of Forensic Sciences, juvenile advocacy centers, rape crisis centers, local medical centers, child protection advocates, sexual assault victims/survivors, and media representatives. The team brings a multi-disciplinary approach to the issue of sexual assault. The team produces collaborative efforts to improve the treatment of sexual assault victims and the investigation and prosecution of their cases. SART seeks to improve the prosecution rate of criminals who commit sexual assaults while providing immediate support for the victims.

As an adjunct to the SART program, these groups have also implemented the Sexual Assault Nurse Examiners (SANE) program. SANE is a corps of volunteer nurses who are specifically trained to perform the forensics medical examination on victims of sexual assault. A nurse examiner collects forensic evidence following chain of custody procedures and administers a medical protocol to treat and prevent sexually transmitted disease. This system enables the victim to receive immediate attention which is critical for timely evidence collection. SART/SANE promotes access to a dedicated examination room at the local medical center which is away from the emergency room **or at a designated separate facility.** When a victim presents for an exam, the emergency room is bypassed and the dedicated exam room is used. This prevents long waits for victims as the forensics medical exam does not meet emergent criteria and is not a priority for the emergency room. SANE reduces the amount of time involved in forensics medical exams, provides a better environment for the victim, and insures quality and thorough evidence gathering.

SART's goals include evaluating the strengths and weaknesses of the SART program, improving the quality of the forensic exam, trending judicial outcome and providing data for grant funding and clinical research on sexual assault victims. SART programs may also track the number of evidentiary exams

performed, law enforcement agency involvement, sexual assault victim demographics, examination time sequence, and judicial outcome.

Facility

It is advantageous for all victims of sexual assault to seek both medical treatment and evidence collection at a SANE program, or if one is available, at a hospital facility. Physicians who work primarily in private office-based facilities usually do not have evidence collection kits on hand and may not be as familiar as hospital-based physicians with the specific medical and evidence collection procedures relevant to sexual assault victims. Additionally, many private medical offices are not open on a 24-hour basis and may not have equipment available to make the necessary cultures.

Adults should be treated in an emergency room **for serious injuries. Otherwise, they may be treated in a SART/SANE facility.** Some **SANE rooms treat adult and children victims but some do not treat children. If a SANE room is not available,** children should be treated in a hospital pediatrics unit, if available, because the staff in these units is specially trained to treat them. However, if the abuse occurred over seventy-two (72) hours prior to the time that an initial examination is to be done, children should be referred to appropriately trained physicians instead of the emergency room in order to avoid repeat exams. While some jurisdictions have some type of hospital reimbursement plans, victims receiving treatment in private facilities very often will have to be charged.

Hospitals designated to provide sexual assault treatment should have a 24-hour emergency room facility with staff trained in sexual assault examinations. The ideal situation would also include the on-call availability of a specially trained obstetrician/gynecologist for consultation, the services of a local sexual assault victim advocate, and contingency plans for cases requiring photographs and bite mark impressions. Compilation of a local treatment facility list will provide an excellent opportunity for hospital and law enforcement personnel to meet to discuss transportation issues and other mutual concerns involving treatment and follow-up policy.

C.H.I.P.S.

Children's Hospital Intervention and Prevention Services (C.H.I.P.S.) is located at 1600 7th Avenue South, Birmingham, AL 35233. C.H.I.P.S. is a place where child victims of sexual abuse can come for help and healing. The C.H.I.P.S. staff is a team of specially trained clinical counselors, doctors, social workers, and nurses who work with law enforcement, the Department of Human Resources (DHR), and

child advocacy center (CAC) representatives to provide the best possible care for children and families traumatized by sexual abuse.

What services are available at C.H.I.P.S?

- **Extended Assessments** – An extended assessment is a comprehensive evaluation of child sexual abuse allegations conducted by a specially trained counselor or social worker. Such an assessment, which includes gathering information from multiple sources and carefully conducted non-leading interviews with the suspected victim, is appropriate in cases where, for whatever reason, it is not clear that abuse has occurred. (Please note: This service is available at C.H.I.P.S. for children from counties where there is no child advocacy center that already provides extended assessments.)

- **Counseling** – Children who have been sexually abused require a very specific type of counseling aimed at assessing and alleviating any current problems as well as minimizing the possibility of future difficulties. The C.H.I.P.S. Clinic provides such counseling for child victims of sexual abuse and their non-offending caregivers. This may consist of individual sessions for the child and/or caregiver, family sessions or participation in a support group.

- **Forensic Medical Evaluations** – A medical examination is sometimes necessary to evaluate medical problems related to the abuse and document any legal evidence when a child has been sexually abused. At C.H.I.P.S., these examinations are conducted in a protective and supportive environment designed to promote emotional healing from abuse. An important part of this is their commitment to give the child as much control as possible in decisions relating to the exam. A clinical counselor spends time

with each child explaining the "check-up" and discussing any concerns, and also meets with the child's caregivers to gather information and answer questions. A clinic nurse shows the child and the companion of his/her choice around the check-up room, answering any additional questions they may have with the help of

- "Miss Lilly" (a stuffed frog). When the child is ready, the C.H.I.P.S. doctor performs a complete exam. Afterwards, the doctor and counselor meet with caregivers to discuss any findings and develop a plan for follow-up care. Under no circumstances is any child ever forced to undergo an examination.

- **Support Services** – The effects of child sexual abuse can have a far-reaching impact on families' lives. A C.H.I.P.S. Social Worker is available to meet with all caregivers to assess the family's needs, identify resources, make referrals, and provide on-going support services as necessary.

How does a child come to C.H.I.P.S.? The C.H.I.P.S. Clinic accepts referrals from primary care doctors, DHR caseworkers, CAC representatives, law enforcement officials, mental health professionals, and teachers. These referrals may be done by calling (205) 558-2751 to make the child's initial appointment with the C.H.I.P.S. intake worker

What about the cost? Insurance can be billed if a medical exam is provided. There is no charge for the other services provided at C.H.I.P.S.

The Alabama Sexual Assault Evidence Collection Kits are provided free by the Alabama Department of Forensic Sciences. The victim should not be charged for the kit. Sexual Assault Evidence Collection Kits can be obtained from the **Department of Forensic Sciences, 2026 Valleydale Road, Hoover, Alabama 35244, telephone number (205) 982-9292, facsimile number (205) 402-9589.**

According to Alabama law (Section 15-23-5), victims should **not** be billed for sexual assault examinations. Payment for this service may be paid by the victim's insurance or by the Alabama Crime Victims Compensation Commission. The law states that "the commission shall have the power to ... provide for the cost of medical examinations for the purpose of gathering evidence and treatment for

preventing venereal disease in sexual abuse crimes and offenses." Rape victims may also apply for payment by the Commission of other expenses related to the crime. Contact the Commission directly at **(334) 290-4420** for more information.

Transfer

If a victim of sexual assault arrives at a hospital that is not equipped to provide a sexual assault examination, arrangements should be made to transfer the victim to the nearest designated treatment facility immediately. Acute medical or psychological injuries requiring immediate treatment should be attended to at the initial receiving facility. A copy of all records, including any x-rays taken, should be transported with the victim to the designated treatment hospital or **SART/SANE facility**.

Transfer plans should be developed in conjunction with other treatment facilities in the immediate and surrounding community. The list of designated hospitals should be provided to all local law enforcement agencies and victim advocacy organizations. This action greatly reduces the amount of confusion and additional trauma incurred by victims who are initially taken or referred to a non-treatment facility as well as reduces the loss of valuable evidence.

Intake

The treatment of victims of sexual assault should be considered a medical emergency **when seen in a hospital setting**. Many victims may not have visible signs of physical injury but they will be suffering from emotional trauma. A private location within the hospital should be utilized, if at all possible, for the preliminary consultation with the victim. A room adjacent to the emergency department or a private office located nearby is sufficient. This same type of facility can be provided for the follow-up law enforcement interview at the conclusion of the examination in order to prevent others from hearing the conversation.

Many hospitals have developed code plans, such as "Code R" or "SA," to refer to sexual assault cases. This eliminates the needless embarrassment to victims and/or their families of being identified in the public emergency or examining room setting as the "rape" or "sexual assault" victim. **Names of rape victims should be omitted if the hospital posts patients' names on a board visible to the public.**

Other methods can be devised to avoid inappropriate references to sexual assault cases, and hospitals are encouraged to develop their own sensitive code plans to ensure privacy.

The responding officer should wait in the prescribed waiting area while the victim is being treated at the hospital. Some law enforcement protocols call for the officer who accompanies the victim to the hospital to also conduct the follow-up investigation. Officers in these departments should remain at the hospital until the examination is complete before making arrangements to conduct the more in-depth interview with the victim.

Reporting

Many jurisdictions have mandated reporting laws for violent crimes including sexual assault. In those instances, local law enforcement authorities are routinely notified by hospital personnel upon arrival of the sexual assault victim. **Other jurisdictions leave the decision to report the assault to law enforcement authorities up to the individual victim, District Attorney, or the guardian.** In both instances, victims of sexual assault should be encouraged to report and cooperate in the police investigation. **Law enforcement officers should be educated that delays in reporting are common in rape cases and are not a reason to doubt the veracity of the victim's complaint.**

Support Personnel

The importance of having an **appropriately trained victim's advocate** available to sexual assault victims cannot be over-emphasized. One person should be assigned to stay with the victim throughout the entire emergency department or **SANE room** visit when possible.

Appropriately trained victim's advocates can provide the crisis intervention necessary when victims first enter the hospital for treatment. They can assist hospital emergency room staff in explaining the necessity of medical and evidence collection procedures, and they can counsel the victim's family members or friends who may be at the hospital. An advocate **can also** help provide counseling referrals and other information such as the existence and availability of victim compensation programs or other types of assistance, emphasize the importance of follow-up testing for possible **STDs** or other medical problems, and answer additional questions victims may have following their medical and evidence collection examination.

Increasing numbers of communities throughout the nation now have local rape crisis centers with resources for counseling, and many hospitals have entered into working agreements with victim advocate organizations. These organizations may provide immediate crisis intervention to victims who have arrived at the hospital seeking treatment as well as follow-up counseling and referrals. In most instances,

they also are able to provide support for the victim throughout the entire criminal justice process.

However, at any time throughout the treatment and evidence collection process, the patient should be able to refuse interaction with the designated advocate and/or request the advocate leave.

A list of Rape Crisis Centers in Alabama is located on the Survivor Support Form located within the Sexual Assault Evidence Collection Kit.

Victim/Patient Consent

Obtaining a patient's written consent prior to conducting a medical examination or administering treatment is standard hospital practice. With the advent of evidence collection requirements and crisis intervention services, sexual assault victims are expected to make a decision about consent to these procedures as well. **This applies to exams at SANE facilities as well.**

Informed consent should be a continuing process that involves more than obtaining a signature on a form. When under stress, many victims may not always understand or remember the reason for, or significance of, unfamiliar, embarrassing and sometimes intimidating procedures. Therefore, all procedures should be explained as much as possible so the patient can understand what the attending physician and nurse are doing and why. This function is ultimately the responsibility of hospital personnel although much of the examination and evidence collection process can be explained by the victim's advocate.

Written consent should not be interpreted as a "blank check" for performing tests or pursuing questions. If a patient expresses resistance or non-cooperation, the physician should immediately discontinue that portion of the process and consider going back to it at a later time in the examination if the patient then agrees. The patient should have the right to refuse one or more tests and to refuse to answer any questions. Having a sense of control is an important part of the healing process for victims especially at the early stages of examination and initial interviewing.

Hospitals should follow their usual procedures for obtaining consent in extraordinary cases (e.g., for severely injured or incoherent patients).

E. Evidentiary and Medical Examinations

When to Perform an Exam

A physical examination should be performed in all cases of sexual assault regardless of the length of time which may have elapsed between the time of the assault and the examination.

Some victims may ignore symptoms which would ordinarily indicate serious physical trauma such as internal injuries sustained by blunt trauma or foreign objects inserted into body orifices. There may be areas of tenderness which will later develop into bruises but which are not apparent at the time of initial examination.

An evidence collection kit should be used if the assault occurred within 72 hours prior to the examination.

If it is determined that the assault took place more than 72 hours prior to the examination, the use of an evidence collection kit may not be necessary. It is unlikely that trace evidence would still be present on the victim. Evidence may still be gathered by documenting any findings obtained during the medical examination (such as bruises or lacerations), photographs and bite mark impressions (if appropriate), and statements about the assault made by the victim. Additionally, clothing worn during or immediately after the assault should be collected.

It is vital that the medical and evidence collection procedures be integrated at all times when a forensic examination is performed. This coordination of medical and forensic procedures is crucial to the successful examination of sexual assault patients. For example, when evidence specimens are collected from the oral, vaginal, or rectal orifices, cultures for sexually transmitted disease should be taken immediately following these collection procedures.

Attending Personnel

The only people who should be with the adult victim in the examining room are 1) the examining physician, 2) the attending nurse, and, with the consent of the victim, 3) a trained victim advocate. Although every effort should be made to limit the number of people in attendance during the examination, there may be instances when a victim requests the presence of a close friend or family member. These requests should be honored when possible.

There is no medical or legal reason for any law enforcement representative to observe the medical examination. Maintaining the chain of evidence or custody during the examination should be the responsibility of the attending medical personnel. However, close cooperation and coordination with the local law enforcement agency is encouraged.

Subjecting patients to the observation of law enforcement personnel during this process, as well as having the law enforcement representative privy to the private communications between the victim and the hospital examining/support team or the SANE, is an invasion of the patient's privacy. Therefore, law enforcement personnel should not be present during the examination of a **sexual** assault victim.

F. Evidence Collection Documentation

NOTE: Many of the evidence collection issues apply equally to adult and child victims of sexual assault/abuse, and are discussed in the following section. However, particular issues regarding the interviewing and medical examination needs of children are discussed beginning on page __ of this report.

Packaging

Clothing and other evidence specimens must be sealed in paper or cardboard containers to prevent the loss of hairs, fibers, and other trace evidence. Plastic containers must **not** be used as moisture remaining in the evidence items will be sealed in and bacteria will quickly destroy any unstable biological fluid evidence. Unlike plastic, paper "breathes" and allows moisture to escape. No plastic bags or specimen containers should be used **except for collection of urine specimens.**

Preserving the Integrity of Evidence

The custody of any evidence collection kit and the contained specimens must be accounted for from collection until it is introduced in court as evidence. This is necessary to maintain the legally necessary "chain of evidence," sometimes called "chain of custody" or "chain of possession." Therefore, persons who handle evidence items should label them with their initials, the date, the sources of the specimen, and the name of the victim. **Hospital-generated labels may be used for this purpose.** In addition, the outside labels of the evidence collection kit and clothing bags provide a chain of custody record for transfer of the kit from hospital personnel to the law enforcement agency.

Importance of Spermatozoa and Semen

Spermatozoa and semen are the primary source of the evidentiary DNA used for identification of a perpetrator in a sexual assault case. DNA stands for deoxyribonucleic acid, the chemical substance found in the chromosomes within the nucleus of living cells. DNA contains the genetic code which defines us as individuals and which can be used to distinguish one person from another in a manner similar to the way fingerprints are used. DNA can be extracted from blood, saliva, or other bodily fluids and used for identity testing. Advances in DNA testing allow forensic scientists to examine extremely small, sometimes microscopic, pieces of evidence and generate the DNA profile of the donor of the evidence sample.

Forensic biologists perform DNA analyses upon items of evidence primarily related to violent and sex-related offenses. Examples of DNA analyses include the testing of a bloodstain, semen stain, condom, **and other evidentiary stains that may contain saliva such as a bite mark, sucking, licking and kissing, etc. T**he comparison of the questioned DNA profile to that of the known individuals can determine potential donors of the evidence.

Semen is composed of cells and fluid, known as spermatozoa and seminal plasma, respectively. Historically, medical and law enforcement personnel have placed significant emphasis on the presence of spermatozoa in or on the body or clothing of a sexual assault victim as the most positive indicator of sexual assault. Conversely, when no spermatozoa were found, doubt was sometimes cast upon the victim's allegation of sexual assault, contributing to the misconception that the absence of spermatozoa meant no sexual assault occurred.

The finding of spermatozoa is useful for three reasons:

1. It is positive indication that ejaculation occurred and •that semen is present.
2. The survival time of spermatozoa in the vaginal, oral and rectal orifices following ejaculation varies considerably in scientific studies. Most experts agree spermatozoa may remain for up to 72 hours or longer in the vagina (persisting longer in the cervical mucosa) and up to several hours or more in the rectal cavity (particularly if the victim has not defecated since the assault).

   The genital swabbing sample is a good indicator of recent sexual activity and should always be collected.

   Spermatozoa may persist even after bathing or showering.
3. Spermatozoa are the primary source of DNA (deoxyribonucleic acid) and can be identified to a possible donor.

Seminal plasma is also useful for two purposes:

1. In the absence of spermatozoa, seminal plasma components such as p30 and choline can be used to identify semen. p30 is a prostatic antigen known to exist in the semen of humans. Its presence is regarded as a conclusive indication of semen. Traces of DNA may be recovered from seminal fluid and identified with a donor even though intact sperm cells are not observed.
2. The seminal plasma can be used as a possible source of DNA from aspermic, azoospermic, or vasectomized donors.

Many sexual assault offenders are sexually dysfunctional and do not ejaculate during the assault. Offenders may use a prophylactic; have a low sperm count (frequent with heavy drug or alcohol use); ejaculate other than in a victim's orifice or on the victim's clothes or body; or fail to ejaculate. The absence of spermatozoa is not conclusive evidence that an assault did not occur. This only means spermatozoa may have been destroyed after being deposited or that spermatozoa was never present.

The absence of semen **could mean** no ejaculation occurred or that various other factors contributed to the absence of detectable amounts of semen in the specimen. For example, there could have been a significant time delay between the assault and the collection of specimens. Penetration of the victim could have been made by an object other than the penis. The victim could have inadvertently cleaned or washed away the semen or the specimens could have been collected improperly.

The presence of semen, with or without spermatozoa, may corroborate the fact that sexual contact did take place but semen is not an absolute necessity for the successful prosecution of a sexual assault case.

Clothing Evidence

Frequently, clothing contains the most important evidence in a case of sexual assault. The reasons are twofold:

1. Clothing provides a surface upon which traces of foreign matter may be found such as the assailant's semen, saliva, blood, hairs, and fibers, as well as debris from the crime scene. While foreign matter can be washed off or worn off the body of the victim, the same substances often can be found intact on clothing for a considerable length of time following the assault.

2. Damaged or torn clothing may be evidence of force and can provide laboratory standards for comparing trace evidence from the clothing of the victim when trace evidence is collected from the suspect and/or the crime scene.

Common items of clothing collected from victims and submitted to forensic laboratories for analysis are underwear, hosiery, blouses, shirts and slacks. There also are instances when coats and shoes must be collected. Due to the possibility of seminal fluids being present in vaginal drainage, panties worn **during** or immediately after the assault should always be collected and placed in a paper bag. **Package sanitary pads, tampons, and/or condoms separately from the panties and each other.**

Different garments may have contact with different surfaces and debris from both the crime scene and assailant. Keeping the garments separate from one another permits the forensic scientist to reach certain pertinent conclusions regarding reconstruction of criminal actions. For example, if semen in the female victim's underpants is accidentally transferred to her bra or scarf during packaging, the finding of semen on those garments might appear contradictory to the victim's own testimony in court of what events actually occurred in the assault. Therefore, each garment should be placed separately in its own paper bag or individually wrapped to prevent cross-contamination from occurring.

Prior to the full examination, great care must be taken by the attending physician or nurse to determine if the patient is wearing the same clothing worn during or immediately following the assault. If so, those items should be collected and placed in paper bags after obtaining the victim's consent.

If it is determined that the victim is not wearing the same clothing, the attending physician or nurse should inquire as to the location of the original clothing, such as at the victim's home or at the laundry for cleaning. This information should then be given to the investigating officer so arrangements may be made to retrieve the clothing before any potential evidence is destroyed. *****At a minimum, panties should always be collected during the examination.**

Collection Procedures

The victim should disrobe over a sheet of examination table paper to minimize loss or contamination of evidence. Care should be taken not to cut through existing rips, tears, or stains if it is necessary to cut off items of clothing. Necessary cutting should be documented with accurately depicted locations.

Any foreign materials found should be collected and put into **the foreign material bag, the debris collection envelope or other envelope from supply. Seal with tamper evident tape or the hospital label.** If the victim consents, the clothing should then be collected and packaged in accordance with the following procedures:

1. Items should be air dried **prior to packaging**. After air drying, items such as undergarments, hosiery, slips, or bras should be put into paper bags labeled "undergarments." It is important to remember that diapers may also be valuable as evidence because they may contain semen or pubic hairs. Items such as pants, dresses, blouses or shirts should be put into the paper bags labeled "For Outer Clothing." Upper and lower body garments should be separated and individually packaged to permit the proper interpretation of the significance of laboratory findings.

2. Any wet stains, such as blood or semen, should be allowed to completely air dry before being placed into paper bags. It is preferable that each piece of clothing be folded inwardly, placing a piece of paper against any stain so that the stains are not in contact with the bag or other parts of the clothing.

3. If, after air drying as much as possible, moisture is still present on the clothing and might leak through the paper bag during transportation to the forensic laboratory, the labeled and sealed clothing bags should be placed inside a larger plastic bag with the top of the plastic bag left open. In these instances, a label should be affixed to the outside of the plastic bag to alert the law enforcement agency and the forensic laboratory that wet evidence is present inside the plastic bag. This will enable the removal of clothing and avoid loss of evidence due to putrefaction.

4. The items of evidence must be submitted as quickly as possible to the forensic laboratory. Forensic laboratory personnel must be informed of the condition of the clothing.

Swabs and Smears

Smear slides allow the forensic analyst to examine microscopically for the presence of spermatozoa. The analyst will use the swab(s) to identify the seminal plasma components for confirmation of the presence of semen and to isolate and analyze DNA for identification purposes.

The number of tests which forensic laboratories can perform is limited by the quantity of semen or other fluids collected. Therefore, four swabs should be used when collecting vaginal and rectal specimens. Two swabs should be used when

collecting oral specimens. When collecting these specimens. Never **collect** more than two swabs at a time in order to minimize patient discomfort.

Depending upon the type of sexual assault, semen may be detected in the mouth, vagina, and rectum. However, embarrassment, trauma, or a lack of understanding of the nature of the assault may cause a victim to be vague or mistaken about the type of sexual contact which actually occurred. Because of these reasons, and because there also can be leakage of semen from the vagina or penis onto the anus, even without rectal penetration, **it is recommended that the patient be encouraged to allow examination of all three orifices and specimens collected from them. Always collect from all three orifices from patients that are unconscious, mentally impaired, juveniles, and/or elderly patients, unless they refuse.**

In cases where a victim insists that contact or penetration involved only one or two orifices (or in some circumstances, no orifices at all), it is important for the victim to be able to refuse these additional tests. This "right of refusal" also will serve to reinforce a primary therapeutic principle – that of returning control to the victim.

The examiner should take special care not to contaminate the individual collections with secretions or matter from other areas, such as vaginal to rectal or penile to rectal when taking swabs. Such contamination may preclude proper interpretation of the evidence and unnecessarily jeopardize future court proceedings.

Victims who must use bathroom facilities prior to the collection of these specimens should be cautioned that semen or other evidence may be present in their pubic, genital, and anal areas. They should to take special care not to wash or wipe away those secretions until after the evidence has been collected.

Oral Collection Procedures

The oral swabs and smears can be as important as the vaginal or rectal smears. The purpose of this collection is to recover seminal fluid from the recesses of the oral cavity where traces of semen may exist. This collection should be done first so the patient may rinse his/her mouth as soon as possible. Such a practice will reduce a significant source of unnecessary patient distress.

The oral swabs are prepared by using two cotton swabs together and swabbing the mouth. Attention should be given to those areas of the mouth, such as between the upper and lower lip and gum where seminal material might remain for the longest amount of time.

The oral swabs should be gently rolled onto the glass slide contained in the slide **holder** from the "Oral Swabs and Smears" envelope and allowed to air dry before sealing. The slide should not be fixed or stained.

After the slide has been placed back into **the slide holder, the slide holder** should be sealed closed with a white sealing dot provided in the kit and returned to the "Oral Swabs and Smear" envelope.

The air-dried swabs should be inserted into the swab box provided in the "Oral Swabs and Smear" envelope. The end flaps should be sealed with tape. Care must be taken not to cover the air hole. The label on the swab box should be completed. The swab box and swabs should be returned to the "Oral Swabs and Smear" envelope. The envelope should be taped and the collector's initials placed across the sealing tape.

Vaginal Collection Procedures

It is important to not aspirate the vaginal orifice or to dilute the secretions in any way when collecting the vaginal specimen.

The vaginal swabs are prepared by using four cotton swabs together and swabbing the vaginal vault using two swabs at a time.

The swabs should be gently rolled onto the glass slide contained in the **slide holder** from the "Vaginal/Penile Swabs and Smear" envelope and allowed to air dry before sealing. Again, the smear slide should not be fixed or stained.

After the slide has been placed back into the **slide holder**, the slide holder should be sealed with a white sealing **dot** and returned to the "Vaginal/Penile Swabs and Smear" envelope.

The vaginal swabs must be completely air dried before being placed in the swab box from the "Vaginal/Penile Swabs and Smear" envelope. The swab box ends are sealed with tape and initialed before returning to the envelope. The envelope should be taped and the collector's initials placed across the sealing tape. The envelope should be marked as "Vaginal."

The pelvic examination should be performed and medical cultures taken immediately following the collection of the vaginal specimens.

Penile Collection Procedures

For the male victim **or suspect** (both adult and child), the presence of saliva on the penis could indicate that oral-genital contact was made. The presence of vaginal

secretions can corroborate the penis was introduced into a vaginal orifice. Feces or lubricants may be found if rectal penetration occurred.

The proper method of collecting a penile smear is to slightly moisten two cotton swabs with distilled water and thoroughly swab the external surface of the penile shaft and glans. All outer areas of the scrotum and penis where contact is suspected should be swabbed with additional swabs.

These swabs are not for use in the medical diagnosis of sexually transmitted disease and should not be used to swab the inside of the penile opening.

The swabs should be gently rolled onto the glass slide contained in the **slide holder** from the envelope labeled "Vaginal/Penile Swabs and Smear." The slide should be air dried before sealing the **slide holder.** Follow the instructions given for sealing and labeling the oral and vaginal smears, being sure to indicate "Penile" on the label of the envelope. Again, do not fix or stain the slide.

The air-dried penile swabs should be placed into the swab box from the "Vaginal/Penile Swabs and Smear" envelope, the end flaps sealed with tape, and labeled appropriately.

At this time additional swabs should be taken for detection of sexually transmitted disease.

Rectal Collection Procedures

Rectal swabs must be collected by a method that prevents the transfer of semen present on the perianal area into the rectum.

The rectal smear is prepared by using four cotton swabs and swabbing the rectum. To minimize patient discomfort, swabs **can** be used two at a time and can be moistened slightly with distilled water. The swabs should be inserted to a depth of approximately 2 centimeters into the rectum and slowly rotated 360 degrees.

The swabs should be gently rolled onto the glass slide contained in the **slide holder** from the "Rectal Swabs and Smear" envelope, allowed to air dry, then sealed in the **slide holder** and placed back into the envelope. Again, do not fix or stain the slide.

The air-dried rectal swabs should be placed in the swab box from the "Rectal Swabs and Smear" envelope and the box sealed and labeled in a similar manner as the oral and vaginal/penile swabs.

At this time, any additional tests or examination involving the rectum should be conducted.

Genital Swabbing/Collection Procedures

The assailant may ejaculate without complete penetration of the vaginal/rectal orifice. A genital swabbing allows for the collection of body fluids located on the perineum and should be performed along with the collection of swabs.

To collect the genital swabbing, **slightly** moisten the steripad from the "Genital Swabbing" envelope, swab the external genitalia, air dry, return to the envelope, seal the envelope, and initial the seal.

Other Dried Fluids/Debris/Foreign Objects/Collection Procedures

Semen and blood are the most common secretions deposited on the victim by the assailant. There also are other secretions, such as saliva, which can be analyzed by laboratories to aid in the identification of the perpetrator.

It is important that the medical team examine the victim's body for evidence of foreign matter. If secretions are observed, the material should be collected by taking a swab. A different swab should be used for each secretion, although they may have to be obtained from the hospital's supply.

Dried secretions are collected by slightly moistening the cotton swab with distilled water and swabbing the identified area.

The swab should be completely air dried and placed in the "Debris Collection" envelope. Mark the envelope with the location on the patient's body from which the specimen was obtained. The envelope should be **properly sealed**.

Occasionally, foreign objects such as tampons, condoms, etc. may be encountered during the examination. These should be recovered, air dried, and individually packaged **in the foreign material bag or other envelope(s).**

Bite Mark/Suck Mark Evidence

Bite marks/**suck marks** may be found on patients as a result of sexual assault and other violent crimes and should not be overlooked as important evidence. Bite mark impressions can be compared with the teeth of a suspect. These can sometimes be as important as fingerprint evidence for identification purposes. The collection of saliva and taking of photographs are the minimum procedures when a bite mark is present.

Saliva, like semen, may be a source of DNA and may be used to identify their donor. **Therefore, the collection of saliva from the bite mark area should be**

made prior to the cleansing or dressing of the wound. Swabbing the actual punctures should be avoided when collecting dried saliva if the skin is broken.

Photographs of bite marks must be properly taken to be useful. For example, to demonstrate the size of a bite mark, a ruler should be placed adjacent to, but not touching or covering the bite mark, and then photographed. In all cases, with the victim's consent, photographs of bite marks and/or other wounds or injuries should be made by a qualified evidence technician from the law enforcement agency charged with investigating the case.

Any photographs made by the attending physician or nurse should be labeled or marked with the photographer's name and date and time taken. Place the photographs in an envelope and attach the envelope to the outside of the sexual assault evidence kit. These photographs should be brought to the attention of the investigating law enforcement agency.

In many bite mark cases a three-dimensional cast may be useful. **When possible, a dentist or forensic odontologist should be called in to examine the bite mark, make the cast, and further document the findings.** Hospitals may contact their nearest forensic laboratory for a recommendation of a qualified forensic odontologist who can assist in the process.

Collection Procedures

Saliva is collected from the bite mark area by slightly moistening one swab with distilled water. Gently swab the affected area. Care should be taken not to collect blood on the swab.

The air-dried cotton swab should be placed in an envelope which has been pre-labeled and then sealed.

Again, the extra swab and envelope may have to be provided by the hospital's supply.

Hair Evidence

It is not necessary to collect head hair combings.

There are subtle morphological differences in the hairs from different individuals which can be detected by a trained forensic microscopist. These differences may permit a determination as to the possible source of a hair.

Hairs may be transferred from suspect to victim or victim to suspect during an assault. Hairs may be pulled out by friction or other means of forcible removal. These hairs may provide a source of DNA for identification purposes.

Ideally, reference hair standards from the victim should be taken at the time the Sexual Assault Evidence Collection Kit is administered. However, some victims may object due to the possible cosmetic effects of cutting hairs as close to the skin as possible. **Head hair specimens should be taken only with the victim's consent.**

If the victim objects and hair standards are not taken during the initial examination, it may be necessary to request a standard at a later date if the laboratory examination determines such reference standards are necessary to complete their microscopic and/or biological analyses.

Pubic Combing/Collection Procedures

Pubic hair combings must be performed prior to the collection of any pubic reference standards.

Combing: The comb provided in the envelope marked "Pubic Hair Combings" is used to collect any loose hairs or fibers from the patient's pubic hair area. The paper provided in the envelope should be placed under the patient's buttocks prior to this procedure. Combing should be done vigorously and thoroughly to lessen the chance that valuable evidence may be missed. Patients may prefer to do this procedure themselves to reduce embarrassment and to increase their sense of control. The comb is placed in the paper and the paper carefully folded and returned to the previously labeled envelope. The envelope is sealed and initialed.

Head/Pubic Hair Standard/Collection Procedures

The preferred hair reference standard consists of a minimum of 15-20 pubic hairs and 25-35 head hairs which have been cut. The hairs **should be** collected by cutting as close to the skin as possible.

Cutting: The examiner should cut 15-20 pubic hairs from various locations in the pubic area. Cut the hairs as close to the root as possible. The white sheet of paper contained in the envelope marked "Pubic Hair Standards" should be used to collect these hairs, then carefully folded, reinserted into the previously labeled envelope, and the envelope should then be sealed and initialed.

Following this procedure, the examiner should cut 25-35 hairs from various locations on the head. Take care to cut as close to the root as possible but avoid cosmetic damage to the patient during this procedure. After the hairs have been collected on the white sheet of paper contained in the envelope marked "Head Hair Standards," the paper should be carefully folded, reinserted into the previously labeled envelope, and the envelope should then be sealed.

Fingernail Scrapings

The purpose of fingernail scrapings is to collect potentially useful evidence of cross-transfer. During the course of a physical crime, the victim will be in contact with the environment as well as the assailant. Trace materials such as skin, blood, hairs, soils, and fibers (from upholstery, carpeting, blankets, etc.) can collect under the fingernails of the victim.

Collection Procedure

Victims should be asked whether they scratched the assailant. If so, the nails should be scraped over the piece of paper provided in the "Fingernail Scrapings" envelope. The scraper should be placed in the paper with the scrapings. The paper containing the scrapings should be folded and placed back into the envelope. The envelope should be sealed and initialed.

This procedure should not be done if the victim does not indicate s/he scratched the assailant.

It is important that patients not use their own nail files as this could provide contaminated evidence.

DNA Reference Sample

The DNA reference sample is used to determine the victim's DNA profile. Sexual assault cases often result in DNA profiles with mixtures of two or more individuals. The victim's DNA reference sample is used to help the forensic biologist resolve mixture interpretations.

Blood may be found on the assailant, the assailant's clothes, and/or at the crime scene. Blood may also be found on the victim or the victim's clothing. The victim's reference sample must be available for comparison or the significance of blood stains can not be determined.

Collection Procedures

Carefully swab the interior lining of the cheek of all four (4) quadrants of the mouth (upper/lower left and upper/lower right) using both swabs simultaneously. The swabbing of the oral cavity should transfer the patient's buccal cells onto the DNA reference swabs. Allow both swabs to completely air dry. Place swabs in swab box, then mark "DNA Reference Sample" on

swab box. Return to the DNA Reference Sample envelope. Seal and fill out all information requested on envelope.

Note: The patient should be allowed to brush the oral cavity, rinse and repeat, ***prior*** *to the collection of the DNA Reference Sample if an oral assault is suspected.*

Sexual Assault Information Form

Many hospitals have been encouraged to include a copy of the victim's medical report form with any evidence that was collected to provide information needed by the forensic examiner to assist in the analysis of specimens submitted.

Certain written information needs to be included with evidence submitted to the forensic laboratory. However, hospital medical report forms contain confidential information which is not relevant for forensic purposes, such as:

1. Information concerning gynecological history, e.g., miscarriages, abortions, past or current pregnancy, hysterectomy, and tubal ligation;
2. Information on the victim's emotional status, drug allergies, or past medical problems, e.g., cancer.

Therefore, in the interest of protecting and maintaining patient confidentiality, a separate form for the purpose of providing information required for forensic analysis of evidence should be used.

The following information should be included on the form:

1. Date and Time of Collection and Time of Assault

   It is essential to know the period of time which has elapsed between the assault and the collection of evidence. The presence or absence of semen may correspond with the interval since the assault.

2. Gender and Number of Offenders

   Forensic biologists seek evidence of cross-transfer of trace materials between the victim, assailant(s), and scene of the crime. These trace materials include foreign hairs and the deposit of secretions from the assailant(s) on the victim or vice versa. The gender of the assailant may determine the type of foreign secretions which might be found on the victim's body and clothing. Therefore, the biologist should be informed whether to search for foreign semen or vaginal secretions, and to focus the analysis on the relevant stains. **Information regarding recent (within 72 hours) consensual sexual activity should be documented.**

3. Action of the Victim Since Assault

   The quality of evidence is critically affected both physically and chemically by actions taken by the victim and the passage of time. For example, the length of time which elapses between the assault and the collection of evidence, as well as the self-cleansing efforts of the victim, can affect the rate of drainage of semen from the vagina or rectum. Trace evidence such as foreign hairs, fibers, plant material, or other microscopic debris deposited on the victim by the assailant or transferred to the victim at the crime scene can also be lost.

   It is important for the analyst to know what activities, if any, were performed prior to the examination. These include bathing, urination, brushing teeth, and changing of clothes. Any of these actions could help explain the absence of secretions or other foreign materials. For example, douching would have an obvious chemical effect on the quantity and quality of semen remaining in the vagina. Failure to explain the circumstances under which semen could have been destroyed might jeopardize criminal prosecution if apparent contradictions can not be accounted for in court.

4. Contraceptive/Menstrual Information

   Certain contraceptive preparations can interfere with accurate interpretation of the preliminary chemical test frequently used by forensic laboratories in the analysis of potential semen stains. In addition, contraceptive foams or creams can destroy spermatozoa. Lubricants of any kind, including oil or grease, are trace evidence and may be compared with potential sources left at the crime scene or recovered from the body of the assailant. Knowing whether a condom was used also may be helpful in explaining the absence of semen.

   Tampons and sanitary napkins can absorb all of the assailant’s semen as well as any menstrual blood present. Additionally, the presence of blood on the vaginal swab could be from trauma or menstruation.

5. History of Assault

   An accurate and brief description of the assault is crucial to the proper collection, detection, and analysis of physical evidence. This includes the oral, rectal, and vaginal penetration of the victim; oral contact of the offender; ejaculation (if known by the victim); and penetration digitally or with foreign object(s). Analytical findings of the forensic laboratory which corroborate the victim’s account support the victim’s testimony in court.

6. Physical Examination Details

   In the search for cross-transfer of trace evidence, it is essential to know the location and extent of the injuries sustained by the victim. For instance, blood from the victim's injuries could be found on the body or clothing of the assailant or at the crime scene. If the victim did not bleed at all, the blood located on his/her clothing could be from the assailant.

   Sometimes saliva and semen stains are more easily visualized under ultraviolet light. The use of a hand-held UV lamp (Woods Lamp) assists in locating the presence of such stains on the body of the victim during the medical examination.

   If the victim was bitten, sucked, or licked, saliva may be on the victim's body or clothing. However, in order to effectively search the clothing for saliva stains, the forensic laboratory must know precisely where the bite occurred.

G. Medical Examination and Documentation

Body Diagrams/Photographs

General photographs of sexual assault victims should not be taken on a routine basis. Instead, drawings of the human figure should be used to show the location and size of the injury as well as contain a written description of the trauma. Drawings should consist of both adult and child figures and contain genitalia for males and females. Forms are provided in the Sexual Assault Evidence Collection Kit to facilitate this documentation.

Photographs of extremely brutal injuries and of bite marks can prove quite beneficial in court. However, injuries such as bruises will become apparent only after several days. There is no guarantee that photographs will show the actual severity of the injury. Also, photographs can be subpoenaed into evidence and may hurt the case if actual injuries appear minimal or cannot be seen.

Therefore, any photographs taken should be limited to those instances where there is an opportunity to produce clear pictorial evidence of injury, such as bruises or lacerations. Photographs should be taken only with the specific consent of the patient.

Routine photographs should not be taken of the genital areas unless they are of a culposcopic nature. This procedure could induce added trauma at the time of the examination and, in the future, cause unnecessary embarrassment

in court. Drawings accompanied by accurate written descriptions can be as effective as photographs in court.

It is vital that all photographs be taken by a competent photographer, preferably the same sex as the patient, and that a ruler and color chart is used to indicate the size and nature of each injury.

Terminology

Findings from the physical examination should be documented as completely as possible on the medical record. Sexual assault prosecutions may not always require the presence or testimony of the attending physician or nurse. However, there will be times when it is necessary. If testimony is needed, a thoroughly completed and legible medical record and accompanying body diagram will assist medical staff in recalling the incident.

When gathering information necessary to perform the medical and evidentiary examination, the attending physician must be careful not to include any subjective opinions or conclusions as to whether a crime occurred. **The indiscriminate use of the word "rape" or "sexual assault" on a medical document is a conclusion that may prejudice future legal proceedings. Instead, the medical chart should reflect that a sexual assault examination was conducted and should include only pertinent medical findings within the scope of that examination.**

An important distinction must be made between information gathered for the purpose of providing medical treatment, and that which is gathered for follow-up investigation and potential prosecution. Hospital personnel should not be expected to expand their role to act as "investigator" for law enforcement. They should not ask for details beyond those necessary to perform the medical and evidence collection tasks. It is the responsibility of the follow-up investigator to ask the more detailed questions.

Date of Last Voluntary Coitus

When analyzing specimens in sex-related crimes, forensic analysts sometimes find genetic markers which are inconsistent with a mixture from only the victim and suspect. A DNA mixture from a defendant and the victim's previous consensual sexual partner could lead to **DNA profiling** results which appear to conflict with the victim's account of the assault. Victims should be asked whether they had sexual intercourse within the 72-hour period prior to the assault. They should not be asked the identity of the prior sexual contact. This can be asked by the law enforcement investigator on a need-to-know basis when DNA mixtures can not be resolved with the victim's and suspect's DNA reference samples.

For medical purposes, the date of the victim's last voluntary coitus and menstrual history should be solely for determining the possibility of pre-existing pregnancy in females who are of child-bearing age and who may be at risk for pregnancy.

Please refer to Section IV., Pregnancy Information, of this Protocol.

Toxicology Blood/Urine Screen

Exercise great care to ensure toxicology screens do not become routine for victims of sexual assault.

Some hospital protocols include the procedure of testing for the presence of alcohol and other drugs in the systems of sexual assault victims. Others allow for the recording of any odor of alcohol on the victim's breath.

Blood/urine screens for the purpose of determining toxicology in cases of sexual assault should be done only in the following situations:

> If the victim or accompanying person (such as a family member, friend, or police officer) states that the victim was drugged by the assailant(s),
>
> and/or
>
> If, in the opinion of the attending physician, the victim's medical condition appears to warrant toxicology screening for optimal patient care.

Collect the blood sample in a gray top (NaF) tube and the urine in a urine specimen container taken from hospital supply. Package separately from the sexual assault kit. Properly seal and initial the seal.

Medical Information to be Contained

On the Sexual Assault Information Form

Throughout the evaluation and medical examination, the attending physician should explain to the victim why questions are being asked, why certain medical and evidentiary tests may need to be performed, and what treatment, if any, may be necessary.

1. Vital signs and other initial information such as date and time of both the examination and the assault should be recorded.

2. A brief description of the medical details of the assault should be recorded including any oral, rectal, or vaginal penetration and whether ejaculation occurred (if known). The victim's account of what happened should be recorded accurately, briefly, and in the victim's own words as much as possible.

3. Information regarding the physical location of the assault should be recorded (e.g., car, rug, grass, and/or alley). This information will assist the physician and the forensic biologist with where to look for evidence and what evidence to collect, such as hairs, fibers, or other trace material.

4. Significant medical history of the victim should be recorded including allergies, current medication, acute or chronic illnesses, surgery, and any post-assault symptoms such as bleeding, pain, loss of consciousness, nausea, vomiting, or diarrhea.

5. Gynecological history information including menstrual history (last menstrual period, date and duration, menstrual cycle), pregnancy history (including evaluation of possible current pregnancy), and contraceptive history should be evaluated and recorded. A urine pregnancy test should be done to establish a baseline for possible pre-existing pregnancy for victims at risk of pregnancy. (The urine sample can also be examined for trichomonas.)

6. During the general physical examination, record all details of trauma, such as bruises, abrasions, lacerations, bite marks, blood and other secretions. Pay particular attention to the genital and rectal areas of both male and female patients. Common sites and types of injury, even if not yet visible, include: the neck and breasts; the upper portions of the inner thighs; grab or restraining marks on the arms, wrists, or legs; and injuries or soreness to the scalp area, back, or buttocks as a result of being thrown against an object or onto the ground.

NOTE: Information concerning sexually transmitted diseases is contained in Section III of this report. It is recommended when penicillin is given as prophylaxis, it should not be delayed until the very end of the patient's hospital examination. Some patients may be allergic to penicillin but unaware of their allergy. This treatment should be administered in time to allow a minimum of 30 minutes of patient observation.

Analysis of Specimens

Unlike the clinical laboratories in most hospitals, forensic laboratories generally have more sophisticated equipment, specialized training, and ultra-sensitive techniques which enable detecting minute traces of semen and spermatozoa. Forensic scientists conduct a genetic marker analysis of semen which the majority of hospital technicians are not qualified to perform. It is not uncommon for forensic laboratories to detect traces of semen despite reports from the hospital of negative test results for spermatozoa and seminal acid phosphatase. The forensic scientist may need to explain in court the apparent contradiction with the hospital laboratory findings. **All specimens collected for evidence purposes should be sent via law enforcement officials to a forensic laboratory for analysis.**

Medical and forensic specimens collected during the sexual assault examination must be kept separate in collection and processing. Those required for medical purposes are retained and processed at the examining hospital. Those required strictly for forensic analysis are transferred with the evidence collection kit to the forensic laboratory for analyses.

H. Procedures for Release of Evidence

Preliminary Procedures

All evidence specimens collected should be placed back into the kit. Make certain every item is **properly labeled and sealed with tamper evident tape and initialed**. Medical specimens collected for non-evidentiary purposes should not be included in the kit.

An explanation should be documented by the examiner if some components of the kit were not used.

The original copy of the Sexual Assault Information Form is to be included in the completed kit. The second copy is retained for the hospital records. **The third copy is given to the investigating law enforcement officer**.

Transportation of Evidence

Victims should never handle evidence after it has been collected. **Only a law enforcement official or duly authorized agent should transfer physical evidence from hospitals to forensic laboratories for analysis.** Evidence can be inadvertently lost or destroyed by being improperly stored or handled. The defense

may challenge the admission into court of any evidence which does not follow a proper chain of custody.

Release of Evidence

Evidence collection items should not be released from a hospital without the written authorization and consent of the informed adult victim or an authorized third party acting on the victim's behalf if the patient is unable to understand or execute the release. An Authorization for Release of Information which is contained on the Sexual Assault Information Form should be completed prior to collecting the evidence. In addition to obtaining the signature of the patient or authorized third party on this form, signatures must be obtained from the hospital staff person turning over the evidence as well as from the law enforcement representative who picks up the evidence.

One copy of the Sexual Assault Information Form which contains the release form should be kept at the hospital, another copy given to the law enforcement representative, and the original copy placed in the Evidence Collection Kit. The law enforcement representative should print and sign his or her name on the outside box of the Sexual Assault Evidence Collection Kit and bags of clothing. The time of transfer should be documented.

Non-Authorization of Release

Although the vast majority of sexual assault victims consent to have their evidence specimens released to law enforcement subsequent to the medical examination and evidence collection process, there may be instances when a victim will not authorize such a release. Hospital and/or law enforcement personnel should not react negatively to a victim's initial decision not to release evidence. They should inform the victim that the release of evidence is not a commitment to prosecute. Although the lack of authorization on the date of collection could be questioned if the case goes to court, such reluctance can be explained and is not considered by prosecutors to be a serious problem.

If consent is not initially received, kits and clothing bags should be stored on a temporary basis in a locked, secured area. The sexual assault evidence should be retained until destruction is authorized by the District Attorney's office or law enforcement agency. **The permission for destruction should be noted in the medical records, including:**

(1) By whose authority permission was granted

(2) The name of the agency the destroyer works for

(3) Date of permission

(4) Date and time of the destruction

(5) Name of who destroyer

I. Post-Examination Information

Survivor Support Form

The discussion of follow-up services for both medical and counseling purposes is an important treatment aspect for sexual assault victims. A Survivor Support Form, provided in the Sexual Assault Evidence Collection Kit, should be given to the victim prior to leaving the hospital. The victim should also be provided with information concerning the type and dosage of any medication prescribed or administered.

Many hospitals report the majority of sexual assault victims do not return to the facility for follow-up tests. Denial of the assault and the need for follow-up testing, especially if no unusual symptoms are experienced, and inadequate information provided by many hospitals concerning the necessity for follow-up treatment, are common reasons for a failure to return.

Victims should be encouraged to obtain follow-up tests for possible pregnancy, sexually transmitted disease, and urinary tract or other infections within four to six weeks after the initial hospital visit.

It is vital that written and verbal information be provided, including the locations of public health clinics or referrals to private physicians for medical follow-up if the victim does not wish to return to the hospital. Victim advocates can be helpful in explaining the need for a return visit and what types of tests should be performed.

The second portion of the Survivor Support Form records follow-up counseling information. The victim should be encouraged to seek follow-up counseling, but the decision to do so must be voluntary. Some victims may be reluctant to talk to a counselor. However, they are more likely to participate if counseling has been coordinated with the examination process. **Victim advocates provide that initial counseling contact and can emphasize the importance of following up with**

counseling and provide appropriate referrals or schedule such sessions at the rape crisis center.

Additional information for the victim is provided on the Survivor Support Form which should be reviewed and given to the patient.

Follow-up Contact

Any further contact with sexual assault victims must be carried out in a very discreet manner. In an effort to avoid any breach of confidentiality or unnecessary embarrassment, it is recommended that victims be asked, prior to leaving the hospital or SANE room, whether they can be contacted about follow-up services. If so, they should provide an appropriate mailing address and/or telephone number where they may be reached. **Generally, this follow-up contact will come from a trained victim advocate.**

Informational Brochures

Many victim advocacy agencies and individual hospitals have developed informational brochures about sexual assault and its aftermath. These brochures can be helpful in explaining to victims some common problems they may encounter such as disturbances in sleeping or eating patterns, flashbacks of the attack, and post traumatic stress syndrome. They also can provide reassurance that sexual assault victims are not responsible for the assault.

In addition, brochures should contain information about local or state resources such as victim compensation programs and counseling services. If at all possible, arrangements should be made to provide a copy of such publications to sexual assault victims and their families when they leave the hospital. **Most local rape crisis centers bring a packet of such information with them when providing support for rape victims in a hospital or SANE room.**

Clean-up/Chance of Clothing

Many victims want to wash after the examination and evidence collection process. The hospital should provide basic supplies such as mouth rinse, soap, and a towel.

The victim advocate from the local rape crisis center should have a change of clothes available when the victim's clothing is collected as evidence.

Law Enforcement Investigative Interview

Many law enforcement departments have investigators or detectives whose duties include sexual assault investigations. These officers do not answer the initial call but enter the case after the responding officer has written the initial report. The investigator should talk with the responding officer and/or attending hospital staff to obtain information about the assault and the condition of the victim.

The investigator may conduct the follow-up interview after the victim has already been interviewed by the responding officer and the hospital staff. It is important to explain to the victim the necessity of asking additional and detailed questions. Intimate details of the attack may be traumatic and embarrassing for the victim to recall. However, the details provide information the investigator must have to get an accurate picture of the circumstances surrounding the case and to prepare a report for the prosecutor.

General guidelines for this interview include the following:

1. The interview should be conducted after the medical examination and evidence collection procedures have been completed. It may be necessary to delay this interview for several hours or even longer. Delays at hospitals are often caused by the length of time necessary for the medical examination and determination by the emergency room staff as to the victim's "readiness" for such an interview. The follow-up investigator needs to understand the role of the hospital staff and the functions and priorities of the emergency room in coping with these delays.
2. The follow-up interview must be held in a private setting which is free of outside interruptions. If a suitable arrangement cannot be made, the investigator should schedule the interview at a later time and place (e.g., the police station or the victim's home).
3. The victim's advocate who was present during the medical examination and the evidence collection examination may be present during this interview with the victim's consent. The advocate will not take an active part in the interview unless asked to do so by the investigator.
4. The interviewer should be sympathetic and understanding of the victim's trauma and at the same time effective in collecting all information necessary to the case.

5. The interviewer should establish himself/herself as an ally of the victim. The interviewer should protect the victim from pressures by family, friends, and others as well as from possible threats made by the attacker.
6. The victim should tell his/her story without interruption from the interviewer. This will afford the victim an opportunity to ventilate pent-up feelings in describing the attack. A special note should be made to record anything the attacker might have said in order to help establish a modus operandi or crime pattern.
7. The interviewer should go back over the story, use the notes taken, and ask specific questions covering any areas of the narrative that may be incomplete or unclear.

Transportation

Transportation should be arranged when the victim is ready to leave the hospital. This may be provided by a family member, friend, or victim advocate called to the hospital for support. Transportation can be provided by the local law enforcement department as a community service.

II. CHILD PROTOCOL

A. General Information

Sexual abuse of children falls into three major categories:

1. Sexual abuse of a child by a stranger involving kidnapping and/or the use of a weapon: These assaults usually occur on a random basis, are more likely to result in severe physical injuries to the child, and account for a growing number of sex-related deaths of children.
2. Sexual abuse of a child through the use of pornographic materials and exploitation: Many are "runaway" or "throwaway" children dependent upon the exploiters for physical survival and in some cases, affection.
3. Sexual abuse of a child by a family member or other person whom the child trusts.

The abuser in intra-familial child sexual abuse is related to the child victim through blood, marriage, adoption, or common living arrangement and generally involves the following relationships:

1. The abuser is legally related and a member of the child's immediate family (e.g., natural or adoptive parent, sibling).
2. The abuser is a member of the child's extended family (e.g., grandparent, aunt/uncle, cousin).
3. The abuser is not legally related but is seen by the child as part of the immediate family because the abuser has daily contact with the family (e.g., stepparent, guardian/foster parent, male or female friend of parent who is commonly viewed as the "psychological parent").

The abuser in extra-familial child abuse is not considered a part of the child's family. However, this person usually has an opportunity for frequent contact with the child and/or represents an authority figure which the child may believe to be synonymous with trustworthiness. These relationships include, but are not limited to, neighbors, day care/school employees, clergy, scout leaders, friends of the family, and babysitters.

Many children are sexually abused over a period of years. Long-term abuse in intra-familial situations may begin when the child is three or four years of age or younger. The abuse may continue into adolescence or even after the victim leaves home.

Until recently, there has been little opportunity for many young children to learn what constitutes appropriate and inappropriate physical contact with an adult or older child. Secrecy associated with the sexual activity, or threats of personal harm to the child and/or the child's family, may cause the child to sense something is wrong. Unless educated about improper touching <u>and</u> the importance of telling someone when inappropriate behavior does occur, many children do not report the incident(s), or they are afraid to do so. The situation is made more complicated when the offender is someone whom the child loves and/or trusts (such as a parent or other close family member).

Intra-familial abuse may be restricted to fondling or gentle touching. Other instances begin this way and escalate to manual penetration or full intercourse after an extended period of time. The family member is often viewed as an authority who "must know what is best." This allows the perpetrator to convince the child that these types of sexual contacts are normal.

Some children become adolescents before realizing through normal discussions with friends about family life and events that the sexual contact they have experienced is wrong and does not occur in most households. By this time, the

child may have assumed a great amount of guilt about the sexual activities and will be reluctant to reveal the situation to an adult or other family member.

When an attempt is made to talk to someone about the abuse, many children are unable to communicate what is happening. Even when the child is quite verbal, the listener may dismiss the story as "make believe" or accuse the child of lying. The child may decline to initiate the subject again when no action is taken to protect the child from abuse.

B. Treatment Plan

Facility

The majority of sexually abused children do not receive immediate medical attention because of the inability of most children to secure medical treatment on their own. Any medical attention received is usually at the request of a third party. This request is frequently made by a parent who notices unusual genital soreness, discharge, or urinary problems; by a teacher who sees a sudden change in the child's behavior; by a relative who suspects physical abuse; or by a physician who discovers gonorrhea from a vaginal, urethral, or throat culture.

Ideally, each hospital designated to treat adult victims of sexual assault will have an on-call multi-disciplinary team for the evaluation and examination of child sexual abuse cases. This team should consist of a family practice physician or a pediatrician for the physical examination and a specially trained person to provide patient support and coordination with law enforcement and child protection agencies. An obstetrician/gynecologist should be on call to provide consultation and follow-up when necessary. Each team member must be trained in the management and psychodynamics of the sexually abused child. Specialist in the area of pediatric gynecology are available for consultation at, for instance, the Children's Hospital in Birmingham and the Huntsville Child Advocacy Center.

In the absence of a specialized team, the minimum requirements are a readily available physician and nurse trained in the medical and psychodynamic aspects of child sexual abuse.

Intake

Children are often brought to the hospital by a police officer and/or parents who are seeking examination and treatment. An officer accompanying a child should be immediately directed to the emergency/pediatric department so a brief history of the assault can be provided to the attending medical staff.

The child's parent or guardian should be asked for any additional information about the event which should be shared with the physician. In cases involving young children, the parent/guardian should provide the physician with the child's medical history.

Since children will tell health professionals things they may not tell in the presence of parents or other adults, adolescents and older children are encouraged to provide much of their own medical history. This interview is conducted in a private area and intonation regarding sexual history (of both males and females), menstrual history, and use of birth control is recorded.

Reporting

Any hospital, clinic, physician, etc., who suspects a child is the victim of sexual abuse is required to report the abuse to a duly constituted authority under Alabama law. (Code of Alabama, Title 26-14-3).

The child's sexual abuse should be considered a medical emergency. The child should be seen without delay only after other acute cases such as trauma or injury.

Support Personnel

The child should never be left alone. Arrangements must be made to provide a support person who can establish a good rapport with the child.

An important first step in intervention is to help children regain a sense of control over their bodies. Adolescents are allowed to choose the support person to be present during the physical examination. This support person could be a trained hospital social worker or nurse, a trained victim advocate, or a family member.

A support person of the same sex as the child can be quite reassuring and may be required by institutions for staff protection.

Consent

Consent to conduct a medical examination and collect physical evidence should be obtained from parents/guardians of all children under the age of **14 years.**

Unfortunately, there may be a parent/guardian who refuses consent to these procedures. If consent cannot be obtained from the child's parent/guardian and the child is in danger from his or her surroundings or requires immediate attention, Alabama law allows the treating physician to place the child in protective custody for a period not to exceed 72 hours. (Code of Alabama Title 26-24-6). This allows the medical staff to provide diagnosis and treatment, child protective and law

enforcement agencies to investigate the abuse, and protection of the child from further abuse on a short-term basis. Procedures established by policy or by law should be carefully followed in each jurisdiction for such cases.

C. Child Interviews

Many sexually abused children who are brought to a hospital for examination and treatment have not been interviewed by law enforcement or child protective service workers. The examining physician may be the first to interview the child about the event(s). The following guidelines will assist in this process:

- Interviewing children about abuse of any kind (physical or sexual) requires special skills. It may be difficult to get the child to talk or to understand what the child says. Some professionals are not comfortable with children and may be unaware of techniques for establishing a rapport with children.
- Children asked about their sexual activities may be unable or reluctant to answer questions due to embarrassment, shyness, a fear of being a "tattletale" or disloyal, or due to a lack of understanding of the question.
- Interviewers must be aware of the long-term ramifications of their questions with child abuse victims. The immediate goal is to elicit the clearest possible information from the child. The interviewer must be aware of his/her own feelings about child sexual abuse and not communicate any attitudes which may create or increase the child's trauma. This precaution is especially important in cases of sexual abuse involving a family member. The action may have been viewed by the child as affection.

Prior to the interview, it is important to determine what reactions the child has been exposed to following the disclosure of the abuse. The medical professional should try to ascertain if the child's family is supportive, panicked, ambivalent, disbelieving, angry, or blaming. Parents and others who have regular contact with the child should be questioned about any behavioral changes they have observed.

Indicators of child sexual abuse perpetrated by a family member or other trusted individual are not always concrete. Hospital staff should be alert for signals from the parent/guardian which may indicate sexual abuse, including but not limited to the following:

1. The child stays inside the house more frequently;
2. The child does not want to go to school;
3. The child cries without provocation;
4. The child bathes excessively; and/or

5. The child exhibits a sudden onset of bed wetting.

An assessment of the child's emotional state is a vital part of the interview process. This is an age-dependent interpretation, such as how the child relates his or her body posture and the language used. It is important to assess the child's verbal skills level and to use terms understandable to the child. This assessment can be accomplished by asking typical questions about family, school, television, and everyday events. After a degree of rapport has been established, the child can be asked to describe what happened.

Key Interviewing Techniques

The interviewer should be supportive and sensitive through tone of voice, body expression, and the maintenance of eye contact. The interviewer should sit eye-level with the child so the child is not intimidated and so the interviewer is perceived as genuinely interested.

The child must be allowed to tell the story in his/her own words in describing what happened and with as few interruptions as possible.

It is absolutely vital the child be believed at all times especially in cases of disputed accounts by adults. The child's story should be taken at face value.

Value judgments and expressions of shock or surprise should be avoided.

It must be made very clear to the child, as often as needed throughout the interview, that the child is not at fault for what happened and that medical staff are there to help and support him/her.

Statements made by the child must be recorded accurately. The child should not be led in such a manner that he/she answers questions to "please" the interviewer.

Younger children often have problems with times and dates. The interviewer may discuss the child's favorite events or activities to establish a time frame in which the abuse occurred. These include asking about television shows, a vacation or trip to see a relative, going to the zoo, or shopping.

Younger children are concrete thinkers and have a short attention span. The interviewer should avoid long and open-ended questions and provide short rest periods at appropriate intervals during the interview.

Drawings, pictures, and anatomical dolls are particularly effective interviewing aids.

It may be necessary for the interviewer to follow up the child's description with clarifying questions to learn exactly what happened. In situations where penetration did not occur but where there was other sexual contact, the child may not differentiate between oral and manual stimulation.

All interviewers must be aware it is often necessary to conduct more than one interview over a period of days to ascertain the circumstances of the abuse.

Medical History Interview

The most experienced medical staff person available should conduct a preliminary medical history interview of the child. This interview is to obtain the necessary information necessary to conduct a proper medical examination and possible collection of physical evidence. A more thorough, detailed investigative history will be obtained by law enforcement and child protective agency personnel at a later time.

The interview should be held in a private room adjacent to the emergency or pediatrics department and must be free from interruptions. The interviewer should explain the need to know what happened and what procedures will be done. He/she should also use simple terms, including the child's vocabulary for body parts, acts, and people.

Attending Personnel

As few persons as possible should be present during the medical interview/evaluation or examination/evidence collection process. Attending personnel should consist of the examining physician, an authorized support person, and/or a nurse. Those persons involved in the investigation, such as law enforcement or child protective service representatives, should not be in attendance during these procedures.

Presence of Parent/Guardian

In all cases of known or suspected child sexual abuse, the medical person in charge must decide whether the presence of the parent/guardian is desirable during the evaluation or medical examination.

Many times it is not preferable to have a family member present during the medical history interview or physical examination of the child in order to minimize confusion and additional trauma to the child and for the purpose of obtaining information that might otherwise be censored. Some parents may be so emotionally distraught or disbelieving upon hearing the child's narrative that their

presence has a negative impact upon the child and the interview/examination process. The parent should be taken to a private area and provided with support and comfort. If the child expresses a need for support from a parent/guardian, and that parent/guardian is not suspected of perpetrating the abuse, their presence may be appropriate if they are supportive of the child.

The interview/evaluation should never be held in the presence of a parent/guardian who is suspected of perpetrating the abuse.

Medical/Evidentiary Examination

The medical examination should consist of a general physical examination, a genital examination, and, where appropriate, the collection of physical evidence.

All equipment, containers, and other materials necessary for the examination and evidence collection procedures should be in the room prior to the child's entry.

Basic equipment includes the following:

1. Routine examination equipment;
2. Appropriate lab slips and cultures;
3. Blood collection equipment;
4. Speculum for adolescent females;
5. Woods Lamp (ultraviolet illuminator);
6. Evidence collection kit (if appropriate); and
7. All medical and evidence collection paperwork.

In preparation for the examination, the child should be undressed except for underpants and should be wearing an examination gown. Help with this process can be provided by the attending nurse, support person, and/or parent/guardian (if present). Special considerations to increase the child's sense of well-being include:

1. Throughout the examination, great care must be taken to minimize additional trauma to the child. Many children have never been in a hospital environment. The presence of unfamiliar equipment can be alarming in appearance. The necessity of darkening the examining room to properly conduct the Wood's Lamp procedure can be extremely disconcerting to the child. Each step in the examination process should be explained to the child prior to being performed.

2. It is important for the examiner to be aware that children interpret statements literally. Statements such as “I’m doing cultures to see if there are bugs in there” should be avoided. Children may think this means they are dirty or have something alive inside of them.
3. The examiner should reinforce the idea the child is not “damaged goods” or irrevocably marked in some obvious way.
4. The child should not be restrained to do the examination and/or to gather evidence. The physician should determine what measures are to be taken to reduce the child’s anxiety.

Some cases may require the use of sedation. However, it is recommended that general anesthesia be administered only in the most extreme cases such as in a life-threatening situation or when the removal of a foreign object may cause undue pain and trauma to the child. Careful explanation of any sedation or anesthetic should be provided to the family and the child.

Evidence Collection

Regardless of when the assault or last sexual contact occurred, valuable evidence may still be obtained through a medical examination and interview of the child. It is vital that an examination be performed and all paperwork completed even if evidence specimens are not collected.

Careful consideration should be given as to whether an Evidence Collection Kit or a full pelvic examination should be done. If the last sexual contact was more than 72 hours prior to the hospital visit, there is little benefit from the examination to outweigh the trauma a child may experience from the examination. There is almost no possibility that DNA evidence or trace evidence is still present after 72 hours. Cultures of the throat, vagina or penis, and the rectum should be done in all cases where sexual abuse is suspected.

If the last sexual contact took place within 72 hours or if the time frame could not be determined, then evidence collection procedures should be implemented according to the instructions given for adults on pages ___ through ___ of this report. The following modifications should be implemented:

- A suitable reference sample for DNA may be collected with an oral swab.
- With young children, the amount of blood collected for forensic purposes should be limited to only 3 milliliters.
- Rectal swabs should be used one at a time.

- Evidence specimens can be obtained by gently swabbing the exterior vaginal areas using a swab moistened with sterile water or a pipette for the young female child or for the adolescent female who is too traumatized to have a full pelvic examination.
- Head hair standards are not to be taken from children at the time of the initial examination. Only under the most extreme circumstances, and only after it has been determined that hair evidence is crucial to the successful prosecution of the offender, should a child's head hair be pulled. Pubic hairs are not to be pulled from any minor child under any circumstances. Cuttings of children's pubic and head hairs should not be done.

D. Medical Examination

General Information

An immediate assessment of the child's status must be made to determine the presence of any significant vaginal, rectal, penile, or other major trauma/sites of bleeding. If present, their control/stabilization must be the priority.

The common medical indicators of child sexual abuse are

1. The presence of sexually transmitted disease;
2. Unexplained vaginal bleeding, discharge, or trauma;
3. Inappropriate sexual behavior for the child's age;
4. Suspicious stains or blood in the underwear;
5. Lesions, bruising, or swelling of the genital area not consistent with history;
6. Pain in the genital or anal area; and/or
7. Unexplained pain or soreness in the abdominal area.

The presence of genital and/or other types of physical injuries or abnormalities can serve as corroborative evidence and should be carefully recorded in the medical record. The location of these injuries should be recorded on drawings of the young female and male body. Any specific explanations given by the child for the injury should be included in the medical record, using the child's exact words if possible.

The medical examination of a sexually abused child may be negative. Nonetheless, the lack of any specific injury/finding in no way detracts from the likelihood that the abuse occurred. A lack of physical finding may be due to many factors, such

as the degree of force used, the type of activity perpetrated upon the child, and the diagnostic skill of the examiner.

Prior to the full examination, a Wood's Lamp should be passed over the child. Any seminal fluid present may fluoresce a characteristic light blue color. These specimens from these areas should be collected for analysis by the forensic laboratory. The presence of bruises, abrasions, lacerations, burns, or other dermatologic lesions should be recorded. Note the color of a hematoma or the degree of healing of an abrasion to assist in the estimation of the time of injury. Any fractures, loose or absent teeth, grab marks, suction or bite marks should be recorded. These help provide confirmation of victimization.

Examination of Anal, Perianal, Perineal Areas

The attending physician must decide, on a case-by-case basis, the extent to which rectal examinations should be performed with both female and male children during the initial examination.

An appropriate examination of the anal, perianal, and perineal areas may require the child be placed in the "knee-chest position." In this position, the child will be on his/ her knees with his/her back swayed and his/her face be on the table. A pillow should be placed under the child's abdomen for the child's comfort.

Recent anal trauma may manifest itself by perianal erythema, edema or contusions, and spasm of the anal sphincter. Any skin tags present should be noted and differentiated between scarring versus congenital variation.

An examination of the sphincter tone for spasm or laxity is important and findings should be noted. An accurate assessment of the sphincter is difficult with stool in the rectal vault. The child should be asked to evacuate before the examination if completed if stool is present.

Use of a colposcope has been of value in detecting small scars and striations not visible to the unaided eye. The colposcope is generally not available to most ER physicians. The use of the otoscope can be valuable as it provides the physician with a light source and magnification of the genitalia. A magnifying glass can assist in the examination when an otoscope or colposcope are not available.

An anoscopy should be performed when anal tears or bleeding are present.

"Gaping" of the anus can be the result of certain chronic medical conditions such as constipation and can also be an indicator of chronic sexual abuse of the rectum.

Genitalia

It is helpful at the beginning of the genital examination to record Tanner Staging (a method to estimate the level of sexual maturation in children).

Female Genitalia Examination

The attending physician must decide, on a case-by-case basis, the extent to which a vaginal examination should be performed.

A complete gynecological examination is not recommended for the young female child unless there is evidence or reasonable suspicion of genital trauma. However, a careful visual inspection should still be made.

A small speculum should always be used when a pelvic examination is conducted. For patient comfort, the speculum can be moistened with warm water. No lubricants of any kind should be used. Use of a colposcope is helpful in that it provides light, magnification, and a method of photographing injuries to the areas being examined.

With the young child present on the mother's/caretaker's lap (if appropriate), or supine on the examining table, the vaginal and perineal areas are inspected. The presence of erythema, hematomas, excoriations, abrasions, old scars, and bleeding as well as the overall appearance of the introitus and the interlabial spread should be recorded. The urethral meatus should be examined for any signs of trauma or abnormal dilation.

An attempt to visualize the hymen is usually successful in prepubescent girls. When the examination is being done, provide gentle downward and outward traction on the labia majora to allow better visualization of the hymen. The hymen is a thin circular membrane originating from the edge of the vaginal entrance. Most frequently there is a central opening or openings.

There are anatomical variations in both the size and types of openings ranging from unusually small and/or imperforate to absent. Hymenal damage can occur from causes other than intercourse or manipulation such as athletic activities or falls.

Conversely the presence of the untraumatized hymen does not preclude ejaculation through the intact hymen.

Inspection should be directed to any discharge (seminal or purulent), as well as odors, evidence of a foreign body, tears, skin tags, and tenderness. Toluidine blue has been demonstrated to be a useful agent in the examination of the genital area.

Male Genital Examination

Both the glans and the scrotal area are targets of trauma in acute sexual assault.

Evidence of erythema, bruises, suction marks, excoriations, burns, or lacerations of the glans and frenulum should be recorded. The presence of testicular or prostatic tenderness or discharge from the urethra are important signs and may reflect trauma or infection.

E. Non-Authorization to Release Evidence

The actual incidents of a parent or guardian, acting on behalf of the child, refusing to authorize the release of evidence to law enforcement has been very low.

The examining physician may be able to sign for the release of evidence in the best interests of the child if this does happen. The local child protective service or law enforcement agency should be contacted for assistance by hospital personnel. Each individual hospital should ascertain policy in their particular legal jurisdiction.

F. Post-Examination Information

Survivor Support Form

A Survivor Support Form should be filled out and provide the same information as is given to the adult victim. The victim's parent/guardian should sign the form at the bottom and be given the carbon copy.

The provision of psychological services for children and the parents/guardians is just as important as for adults. A referral should be made to an appropriate agency or individual with approved credentials and training in the field of child sexual abuse if this service is not available through the hospital.

It is extremely important that children return for a follow-up visit within one week to re-evaluate any genital or other injuries and to perform any necessary follow-up cultures.

This visit will also provide the examining team an opportunity to assess how well the child and/or family are handling the stress and whether counseling has been received or is necessary.

Law Enforcement Interview

It is the responsibility of the investigating officer to ascertain the most supportive environment for the child during the follow-up law enforcement interview. When possible, a child advocacy center or other place specifically designed for the purpose of interviewing children should be used.

The goal of the juvenile officer's/investigator's interview with the child victim of sexual abuse is twofold:

1. To obtain accurate information needed for case investigation; and
2. To avoid further trauma to the child.

Ideally, the law enforcement interview should include the child protective services representative so the trauma of multiple interviews is curtailed. It is helpful to have a support person present who established good rapport with the child during the medical examination/interview. It is important that only one person be the primary interviewer to avoid confusion. In all cases, those present during the interview must be there for a specific purpose and must be psychologically supportive of the child.

Depending upon the case circumstances, some child victims will be interviewed by law enforcement and/or child protective service representatives at a location away from the hospital, such as the child's home, school, or an agency facility. Space adjacent to the emergency room or pediatrics unit of the examining hospital should always be provided for those situations where the interview must be held immediately after the medical examination. Privacy is crucial to the success of this interview.

Great care should be taken by the juvenile officer/investigator to minimize visibility of weapons and standard equipment (such as handcuffs and nightsticks) carried during the interview so that the child is not further intimidated or traumatized.

Presence of Parent/Guardian

Some children are more relaxed and informative without a parent/guardian present. Others, particularly very young children, may not be willing to cooperate in an interview without such support. Parents or relatives may be the only adults to

whom the child will talk. Questions can be directed to the child through these family members but only after initial efforts of the interviewer to talk directly with the child are unsuccessful.

If a parent/guardian is present, the purpose of the interview should be explained in a straight-forward manner and cooperation should be elicited to reassure the child it is safe to talk with the interviewer. The parent/guardian should be told any facial expressions of shock, disbelief, or disapproval or any verbal or physical signs to the child could impede the investigation.

When the parent/guardian is the suspected perpetrator, under no circumstances should the interview of the child be held in the suspect's presence.

III. SEXUALLY TRANSMITTED DISEASE (STD)

The risk of contracting a sexually transmitted disease as a consequence of sexual assault is not known. However, it is accepted practice **not** to establish a baseline for STDs at the time of the initial hospital or SANE room examination.

It is helpful to have information on the presence or absence of STDs at the time of initial examination so an informed decision could be made to order additional tests of the victim and the offender at some future date. The presumption is that the disease was contracted from the assailant if initial tests are negative but the follow-up examination yields positive results. Every effort should be made to ascertain whether the assailant is infected but few suspects are apprehended by the time the victim receives initial hospital examination and testing. Some adult victims will request immediate treatment as a precautionary measure and, unless contraindicated, prophylaxis can be given at the time.

In the case of children, the presence of an STD is a strong indication of sexual abuse. The presence of STDs may link the offender to the crime. Although many infections, including gonorrhea and Herpes Simplex, can be transmitted to an infant at birth by an infected mother, all children beyond the first few months of infancy should be considered as having been sexually abused if an STD is present. All cases of STDs in children should be reported to the appropriate law enforcement and child protective services and to the local department of health.

Due to continuing research and discussion of the most effective treatment of STDs specific to sexual assault victims, treatment regimens are not included in this report. The reader should consult the latest publication of the U.S. Department of Health and Human Services, Centers for Disease Control, for their latest treatment recommendations: Centers for Disease Control and Prevention, 1998 Guidelines

for Treatment of Sexually Transmitted Diseases, MMWR l998;47 (No. RR 1) or website www.cdc.gov.

Traditionally, tests for STDs in sexual assault and abuse victims have been focused on screening tests for syphilis and gonorrhea. There are many types of STDs. The following represents a brief overview of those most likely to be seen in the sexually abused patient:

Chlamydia

In the past few years, the incidence of *Chlamydia trachomatous* has escalated dramatically within the general population and is the most prevalent STD in the United States.

Chlamydial organisms are unusual as they are completely dependent upon their host cell for energy and are only able to survive outside of their host environment for the briefest period of time. Transmission of the organism, except in the newborn who can acquire *Chlamydial conjunctivitis* and/or pneumonitis during passage through the birth canal, is almost always through sexual contact.

In adults, Chlamydial infections may be asymptomatic but more frequently are manifested in a wide variety of symptoms ranging from nonspecific urethritis to PID, orchitis, epididymitis, perihepatitis, and proctitis.

Chlamydia is being diagnosed with increasing frequency in cases of child sexual abuse. Moreover, children appear to be asymptomatically infected more often than adults especially when the infection is oral or rectal. Cultures for Chlamydia are recommended when there is a suspicion the child may have contracted the disease. The recommended areas to culture are the vagina and penis.

When symptomatic, common clinical manifestations in females, other than those in PID, are vaginal irritation, itching, and discharge. In males, a whitish urethral discharge, with or without painful urination, is a most common clinical picture.

In the past, hospitals were reluctant to test routinely for Chlamydia because the method for detection was expensive and time consuming. Recently, inexpensive fluorescent antibody tests have become available and are adequate for screening although not as sensitive as cultures. Fluorescent antibody tests have been known to produce false positives. A positive finding with vaginal specimens should be confirmed with a Chlamydial culture before a final diagnosis is made.

Unlike many other STDs, tests are available to detect circulating antibodies to Chlamydia. The presence of these specific antibodies can provide corroborating evidence of Chlamydial infection.

This test should be routine for all victims of sexual assault due to the prevalence and severity of the infection.

Gonococcal Infections

Gonococcal infections are caused by *Neisseria gonorrhea*. Newborns may acquire gonococcal infections during passage through the birth canal but older children and adults almost always become infected with this organism through sexual contact. Clinical symptoms are myriad and include, but are not limited to, newborn conjunctivitis, PID, orchitis epididymitis, urethritis, perihepatitis, proctitis, pharyngitis, vaginitis, and disseminated gonococcaemia.

The diagnosis of gonorrhea in the male can tentatively be made with a gram stain. However, a definitive diagnosis of gonorrhea in males or females is dependent on a positive culture using Thayer Martin media and a differential sugar fermentation test. Asymptomatic infections are common and should be treated. It is important to recognize that chlamydial infections and gonorrhea frequently occur together.

Syphilis

Syphilis is caused by a bacterium, *Treponema pallidum*, and is transmitted through sexual contact. The infection is tested by measuring antibodies to the bacteria in the victim's blood. These antibodies are produced by the victim's immune system weeks after exposure to the bacteria. Syphilis cannot be detected or diagnosed at the time of the sexual assault examination. It is important that the victim have an initial syphilis test to establish a baseline at the time of the examination and to return six weeks later for follow-up blood tests for syphilis at the hospital or local health department.

It is important to know the initial symptoms of syphilis (genital sores, body rash, etc.) resolve without treatment but the infection continues, causing permanent damage to vital organs. The only way to be sure that syphilis is not present is to repeat blood tests. The victim should be advised of this initially and, if possible, reminded later by a sexual assault counselor, social worker, etc.

Genital Herpes Simplex Virus Infection (HSV)

Genital herpes is the result of an infection with HSV type 1 or 2. This infection can be symptomatic or asymptomatic and can reflect a primary, latent, or recurrent process. Over 90% of genital herpes infections are due to type 2 with the remaining 10% due to type 1.

Symptoms can be limited to several localized and painful vesicles or can be systemic and associated with fever, malaise, and swollen lymph nodes in addition to the local herpetic vesicles.

Transmission of the virus occurs during its active and latent phases. The diagnosis of genital herpes is usually obvious from the clinical picture but immunofluorescent and serologic tests, as well as cultures, can be used to confirm the diagnosis. It is important to recognize the presence of HSV-2 is almost always acquired through sexual contact and that HSV-1, when present in the genital area, should also arouse suspicion of sexual activity.

Trichomonas Vaginalis

Trichomonads are protozoans which can infect the genito-urinary tract of males and females. The presence of these organisms, except in newborns which can become infected during passage through the birth canal, should be considered as indicators of sexual activity.

These organisms are easily identified by microscopically examining a fresh sample of urine or vaginal/urethral discharge. Trichomonads are approximately the size of white blood cells and are easily recognized by their unusual means of motility.

Symptoms of Trichomonas are usually localized to the site of the infection and consist of pruritus, pain with urination, urethral discharge in males, and vaginal or urethral discharge in females.

Males usually have no symptoms but are capable of transmitting the disease.

Genital and Anal Warts

These warts are due to infection with human papilloma virus (HPV) and, except for newborns who can become infected during passage through the birth canal, transmission is almost always through sexual activity.

Condyloma acuminatum may occur as single or multiple lesions and are often located on the glans area of the penis or in the female on the labia, vagina, and/or cervix. They can be found in the anal canal and occasionally in the mouth, on the lips, or on the breast nipples.

Condyloma usually appears as polyp-like with irregular bright red surfaces . They produce few acute clinical manifestations other than obstruction (blockage of the urethra or the cervical outlet). The chronic presence of the lesions has been associated with malignant transformation. A diagnosis is usually made from the

clinical appearance and location but a tissue biopsy may occasionally be needed to differentiate these from other warts.

Autoinoculation has been identified rarely and should be a diagnosis of exclusion.

Nonspecific Vaginitis

This is probably the most common form of vaginal infection in post-pubescent sexually active females and represents the complex interaction of several organisms.

Gardnerella vaginalis is the organism most frequently identified in women with nonspecific vaginitis; and it is often accompanied by anaerobes, *Mycoplasma hominis*, and *Ureaplasma urealyticum*.

Infections may be either asymptomatic or associated with local vaginal/urethral discharge, pruritus, and burning with urination. The vaginal discharge is usually whitish gray and is striking because of its fish-like odor especially when hydrogen peroxide is added to it.

AIDS

AIDS (Acquired Immune Deficiency Syndrome) is a condition caused by the human immunodeficiency virus (HIV), sometimes called the AIDS virus. It is transmitted by blood or bodily fluids such as semen or saliva. Receptive anal intercourse and direct blood inoculation appear to pose the greatest possibility for transmission of the virus although infection has been reported to occur from a single sexual exposure. Although it is unlikely, sexual assault and abuse victims could be exposed to the HIV virus. Sexual assault victims are justifiably concerned about this possibility although there is little chance someone could contract the virus from a single sexual exposure.

When a person is infected, the body begins to develop antibodies to the virus. This normally occurs from two to twelve weeks after infections but some people may take up to six to twelve months to develop antibodies. A blood test will show if the antibodies are present after this waiting period.

Child victims of sexual abuse or assault are at higher risk due to the possible length of abuse or tearing of tissue due to disproportionate size of genitalia and orifices. A referral for a baseline HIV test should be made in these situations. AIDS testing done by the County Health Department is anonymous and free for the victim. The test is also available through private physicians and hospitals. Subsequent tests should be administered at three, six, and twelve months to allow for the incubation period of the virus even if the initial test is negative.

A known assailant should be screened for the presence of the HIV antibody. A person who tests positive for the HIV antibody should be referred for further medical evaluation and services.

IV. PREGNANCY INFORMATION

In the course of treating female victims it should be determined whether there is a possibility of the assailant impregnating the victim. When the medical interview indicates that pregnancy is not probable (a history of tubal ligation, hysterectomy, known infertility, etc.), the possibility of pregnancy need not be discussed with the victim. If pregnancy is a possibility, a baseline test for pre-existing pregnancy should be administered since a victim could be unknowingly pregnant. It is essential that all victims at risk of pregnancy not be given any drugs until the possibility of a pre-existing pregnancy is eliminated.

The possibility of a pregnancy resulting from a sexual assault should be discussed with at-risk sexual assault and abuse victims. Victims should be informed of available treatments. The hospital may prescribe medication or may refer the victim to a private physician. Treatment must begin within 72 hours of unprotected intercourse. There can be side effects such as nausea, headaches, etc. This should be discussed with the victim in addition to the importance of taking all the medication. An anti-nausea medication may be prescribed. The role of the physician is to make the victim aware of the possibility of pregnancy and to inform her treatment is available.

V. RECOVERY OF PRODUCTS OF CONCEPTION

Hospitals may encounter spontaneous abortion cases involving suspected incest, statutory rape, or other possible criminal offenses. It is necessary for the hospital to collect and retain the Product of Conception (POC) for forensic analysis as evidence in a subsequent criminal proceeding.

The POC is collected in a large white specimen container labeled with the victim's name, date and time of collection, and pertinent hospital information. Seal and initial the container and **freeze** the sample until transferred to the proper law enforcement agency.

A **known DNA reference sample** should be collected from the mother/victim according to procedures described in **Section I. Adult Protocol - F. Evidence Collection and Documentation**: Whole blood specimen or Buccal swab.

APPENDIX A

FORMS

Dear Survivor:

You have just been through a confusing and frightening event. Surviving a sexual assault and going to the hospital emergency room are overwhelming experiences. You may not be able to remember all of the information and instructions given at the hospital. This is a normal reaction. There is no need to worry about it. It is important to carefully follow the doctor's instructions about the follow-up medical tests that you must have later to protect your health. The purpose of this form is to help you to follow up on the medical tests and to protect and support yourself through your recovery.

<u>Sexually Transmitted Disease</u> – There is a possibility that you have contracted a sexually transmitted disease from the assailant. It is important for you to be tested in six (6) weeks following the assault for syphilis, gonorrhea and chlamydia. You may be tested at a county health department for a small fee, or your private physician can perform the tests. Many have no symptoms of sexually transmitted diseases until complications have begun. The only sure way to know if you do not have these infections is to be tested.

<u>AIDS</u> – AIDS is a concern of many sexual assault victims. Your actual risk to the virus is small. You may be tested six (6) months and twelve (12) months after the exposure if you are concerned about AIDS.

<u>Pregnancy</u> – You may be concerned about a pregnancy resulting from this assault. Within 72 hours of sexual intercourse in which birth control was not used, you can be prescribed the "morning after pill." It is more than one pill and instructions have to be followed completely for it to be effective and to avoid complications. Contact your personal physician as soon as possible if the hospital did not provide information on this and you wish to receive this medication.

<u>Counseling and Assistance</u> – Sexual assault is a traumatic experience. You may want to talk about the strange or painful feelings you are having. Many times it helps to know you are not alone. Support and understanding are as close as your telephone. Listed on the back of this page are telephone numbers and addresses of the Rape Crisis Centers in Alabama. There are a number of agencies which offer counseling to sexual assault victims and their families. These agencies also may help answer questions about your hospital visit, the police investigation, or the legal system. Please contact the Rape Crisis Center nearest you if you desire counseling and/or additional assistance.

<u>Compensation</u> – As a crime victim, you may be entitled to reimbursement for any out-of-pocket expenses such as medical bills, lost wages, property damage, etc. Contact the Alabama Crime Victims Compensation Commission, P.O. Box 1283, Montgomery, AL 36104 or call toll-free 1-800-541-9388 for more information.

<u>Attorney General's Victims' Hotline</u> – The Alabama Attorney General's Office also provides a staff to assist victims with needs. The office is available to help you. Contact them at their toll-free victims' hotline number, 1-800-626-7676, for assistance.

Alabama Coalition Against Rape
Post Office Box 4091, Montgomery, Alabama 36102-4091
Tim Roth, Executive Director
Crisis Line: 1-888-725-RAPE
Office: (334) 264-0123 Fax: (334) 264-0128

To automatically be connected to a local rape crisis center, please call RAINN at 1-800-656-HOPE.

Rape Response
3600 – 8th Avenue, South, Suite 501
Birmingham, Alabama 35222
Emily Payne, Coordinato
Office: (205) 323-7782 Fax: (205) 328-6225
Crisis Line: (205) 323-7273

Rape Response
Post Office Box 1502
Decatur, Alabama 36302
Sue Brantley, Executive Director
Office: (205) 353-1160 Fax: (205) 353-1163
Crisis Line: (205) 353-fl ????

Rape Response
Post Office Box 2752
Florence, Alabama 35630
Walker J. Thornton, Executive Director
Office: (205) 765-0025 Fax: (205) 767-1151
Crisis Line: (205) 767-1100

Rape Crisis Center of Mobile
1102 Government Street
Mobile, Alabama 36604
Jackie Slaughter, Coordinator
Office: (334) 431-0743/(800) 718-7273
Crisis Line: (334) 473-7273

Rape Counselors of East Alabama, Inc.
2133 Executive Park Drive
Opelika, Alabama 36801
Sandra Newkirk, Director
Office: (334) 844-1452 Fax: (334) 844-1467
Crisis Line: (334) 745-8634

SafeHouse of Shelby County
Post Office Box 574
Pelham, Alabama 35124
Aimee Johnson, Executive Director
Office: (205) 664-5930 Fax: (**205) 664-4747**
Crisis Line: (205) 664-4357

Victim Services of Cullman
Post Office Box 416
Cullman, Alabama 35056
Deborah Tucker
Office: (205) 775-2600 Fax: (205) 739-6694
Crisis Line: (205) 734-6120

House of Rush, Inc.
Post Office Box 988
Dothan, Alabama 36302
Beverly Youse, Executive Director
Office: (334) 793-5214 Fax: (334) 671-1023
Crisis Line: (334) 793-2232

Helpline Rape Response
Post Office Box 92
Huntsville, Alabama 35804
Pat Peterson, Coordinator
Office: (205) 534-1779 Fax: (205) 534-6219
Crisis Line: (205) 639-8161/539-1000

Council Against Rape
1415 East South Boulevard
Montgomery, Alabama 36116
Julie Lindsey, Coordinator
Office: (334) 286-5980 Fax: (334) 288-5993
Crisis Line: (334) 286-5987

Daybreak Crisis Recovery
Post Office Box 3933
Oxford, Alabama 36203
Rhonda Hardegree, Coordinator
Office: (205) 237-6300 Fax: (205) 238-0910
Crisis Line: (205) 237-6300

Turning Point
Post Office Box 1165
Tuscaloosa, Alabama 35403
Stacy Brewer, Executive Director
Office: (205) 758-0808 Fax: (205) 759-8042
Crisis Line: (205) 768-Q ????

APPENDIX B

LEGAL INFORMATION

ALABAMA CRIMINAL LAWS
RELATED TO VICTIMS OF SEXUAL ASSAULT

Sexual Offenses

Definitions (13A-6-60):

The following definitions apply in this article:

1. SEXUAL INTERCOURSE. Such term has its ordinary meaning and occurs upon any penetration, however slight; emission is not required.

2. DEVIATE SEXUAL INTERCOURSE. Any act of sexual gratification between persons not married to each other involving the sex organs of one person and the mouth or anus of another.

3. SEXUAL CONTACT. Any touching of the sexual or other intimate parts of a person not married to the actor, done for the purpose of gratifying the sexual desire of either party.

4. FEMALE. Any female person.

5. MENTALLY DEFECTIVE. Such term means that a person suffers from a mental disease or defect which renders him incapable of appraising the nature of his conduct.

6. MENTALLY INCAPACITATED. Such term means that a person is rendered temporarily incapable of appraising or controlling his conduct owing to the influence of a narcotic or intoxicating substance administered to him without his consent, or to any other incapacitating act committed upon him without his consent.

7. PHYSICALLY HELPLESS. Such term means that a person is unconscious or for any other reason is physically unable to communicate unwillingness to an act.

8. FORCIBLE COMPULSION. Physical force that overcomes earnest resistance or a threat, express or implied, that places a person in fear of immediate death or serious physical injury to himself or another person.

Rape in the first degree (13A-6-61)

a. A person commits the crime of rape in the first degree if:

1. He or she engages in sexual intercourse with a member of the opposite sex by forcible compulsion; or

2. He or she engages in sexual intercourse with a member of the opposite sex who is incapable of consent by reason of being physically helpless or mentally incapacitated; or

3. He or she, being 16 years or older, engages in sexual intercourse with a member of the opposite sex who is less than 12 years old.

b. Rape in the first degree is a Class A felony.

Rape in the second degree (13A-6-62):

a. A person commits the crime of rape in the second degree if:

1. Being 16 years old or older, he or she engages in sexual intercourse with a member of the opposite sex less than 16 and more than 12 years old; provided, however, the actor is at least two years older than the member of the opposite sex.

2. He or she engages in sexual intercourse with a member of the opposite sex who is incapable of consent by reason of being mentally defective.

b. Rape in the second degree is a Class B felony.

Sodomy in the first degree (13A-6-63):

a. A person commits the crime of sodomy in the first degree if:

1. He engages in deviate sexual intercourse with another person by forcible compulsion; or

2. He engages in deviate sexual intercourse with a person who is incapable of consent by reason of being physically helpless or mentally incapacitated; or

3. He, being 16 years old or older, engages in deviate sexual intercourse with a person who is less than 12 years old.

b. Sodomy in the first degree is a Class A felony.

Sodomy in the second degree (13A-6-64):

a. A person commits the crime of sodomy in the second degree if:

1. He, being 16 years old or older, engages in deviate sexual intercourse with another person less than 16 and more than 12 years old.

2. He engages in deviate sexual intercourse with a person who is incapable of consent by reason of being mentally defective.

b. Sodomy in the second degree is a Class B felony.

Sexual misconduct (13A-6-65):

a. A person commits the crime of sexual misconduct if:

1. Being a male, he engages in sexual intercourse with a female without her consent, under circumstances other than those covered by Sections 13A-6-61 and 13A-6-62; or with her consent where consent was obtained by the use of any fraud or artifice; or

2. Being a female, she engages in sexual intercourse with a male without his consent; or

3. He or she engages in deviate sexual intercourse with another person under circumstances other than those covered by Sections 13A-6-63 and 13A-6-64. Consent is no defense to a prosecution under this subdivision.

b. Sexual misconduct is a Class A misdemeanor.

Sexual torture (13A-6-65.1):

a. A person commits the crime of sexual torture:

1. By penetrating the vagina or anus or mouth of another person with an inanimate object by forcible compulsion with the intent to sexually torture or to sexually abuse.

2. By penetrating the vagina or anus or mouth of a person who is incapable of consent by reason of physical helplessness or mental incapacity with an inanimate object, with the intent to sexually torture or to sexually abuse.

3. By penetrating the vagina or anus or mouth of a person who is less than 12 years old with an inanimate object, by a person who is 16 years old or older with the intent to sexually torture or to sexually abuse.

b. The crime of sexual torture is a Class A felony.

Sexual abuse in the first degree (13A-6-66):

a. A person commits the crime of sexual abuse in the first degree if:

1. He subjects another person to sexual contact by forcible compulsion; or

2. He subjects another person to sexual contact who is incapable of consent by reason of being physically helpless or mentally incapacitated.

b. Sexual abuse in the first degree is a Class C felony.

Sexual abuse in the second degree (13A-6-67):

a. A person commits the crime of sexual abuse in the second degree if:

1. He subjects another person to sexual contact who is incapable of consent by reason of some factor other than being less than 16 years old; or

2. He, being 19 years old or older, subjects another person to sexual contact who is less than 16 years old, but more than 12 years old.

b. Sexual abuse in second degree is a Class A misdemeanor, except that if a person commits a second or subsequent offense of sexual abuse in the second degree within one year of another sexual offense, the offense is a Class C felony.

Indecent exposure (13A-6-68):

a. A person commits the crime of indecent exposure if, with intent to arouse or gratify sexual desire of himself or of any person other than his spouse, he exposes his genitals under circumstances in which he knows his conduct is likely to cause affront or alarm in any public place or on the private premises of another or so near thereto as to be seen from such private premises.

b. Indecent exposure is a Class A misdemeanor.

Enticing child to enter vehicle, house, etc., for immoral purposes (13A-6-69):

a. It shall be unlawful for any person with lascivious intent to entice, allure, persuade, or invite, or attempt to entice, allure, persuade, or invite, any child under 16 years of age to enter any vehicle, room, house, office, or other place for the purpose of proposing to such child the performance of an act of sexual intercourse or an act which constitutes the offense of sodomy or for the purpose of proposing the fondling or feeling of the sexual or genital parts of such child or the breast of

such child, or for the purpose of committing an aggravated assault on such child, or for the purpose of proposing that such child fondle or feel the sexual or genital parts of such person.

b. A violation of this section is a Class C felony.

Sexual abuse of a child less than 12 years old (13A-6-69.1):

a. A person commits the crime of sexual abuse of a child less than 12 years old if he or she, being 16 years old or older, subjects another person who is less than 12 years old to sexual contact.

b. Sexual abuse of a child less than 12 years old is a Class B felony.

Lack of consent (13A-6-70):

a. Whether or not specifically stated, it is an element of every offense defined in this article, with the exception of subdivision (a)(3) of Section 13A-6-65, that the sexual act was committed without consent of the victim.

b. Lack of consent results from:

1. Forcible compulsion; or

2. Incapacity to consent; or

3. If the offense charged is sexual abuse, any circumstances, in addition to forcible compulsion or incapacity to consent, in which the victim does not expressly or impliedly acquiesce in the actor's conduct.

c. A person is deemed incapable of consent if he is:

1. Less than 16 years old; or

2. Mentally defective; or

3. Mentally incapacitated; or

4. Physically helpless.

Stalking and Aggravated Stalking

Stalking (13A-6-90):

a. A person who intentionally and repeatedly follows or harasses another person and who makes a credible threat, either expressed or implied, with the intent to place that person in reasonable fear of death or serious bodily harm is guilty of the crime of stalking.

b. The crime of stalking is a Class C felony.

Aggravated stalking (13A-6-91):

a. A person who violates the provisions of Section 13A-6-90(a) and whose conduct in doing so also violates any court order or injunction is guilty of the crime of aggravated stalking.

b. The crime of aggravated stalking is a Class B felony.

Definitions (13A-6-92):

As used in this article, the following terms shall have the following meanings, respectively, unless the context clearly indicates otherwise.

a. COURSE OF CONDUCT. A pattern of conduct composed of a series of acts over a period of time which evidences a continuity of purpose.

b. CREDIBLE THREAT. A threat, expressed or implied, made with the intent and the apparent ability to carry out the threat so as to cause the person who is the target of the threat to fear for his or her safety or the safety of a family member and to cause reasonable mental anxiety, anguish, or fear.

c. HARASSES. Engages in an intentional course of conduct directed at a specified person which alarms or annoys that person, or interferes with the freedom of movement of that person, and which serves no legitimate purpose. The course of conduct must be such as would cause a reasonable person to suffer substantial emotional distress, and must actually cause substantial emotional distress. Constitutionally protected conduct is not included within the definition of this term.

Harassment or Harassing Communication (13A-11.-8):

a. 1. Harassment. A person commits the crime of harassment if, with intent to harass, annoy, or alarm another person, he or she either:

a. Strikes, shoves, kicks, or otherwise touches a person or subjects him or her to physical contact.

b. Directs abusive or obscene language or makes an obscene gesture towards another person.

2. For purposes of this section, harassment shall include a threat, verbal or nonverbal, made with the intent to carry out the threat, that would cause a reasonable person who is the target of the threat to fear for his or her safety.

3. Harassment is a Class C misdemeanor.

b. 1. Harassing Communications. A person commits the crime of harassing communications if, with intent or harass or alarm another person, he or she does any of the following:

a. Communicates with a person, anonymously or otherwise, by telephone, telegraph, mail, or any other form of written or electronic communication, in a manner likely to harass or cause alarm.

b. Makes a telephone call, whether or not a conversation ensues, with no purpose of legitimate communication.

c. Telephones another person and addresses to or about such other person any lewd or obscene words or language.

Nothing in this section shall apply to legitimate business telephone communications.

2. Harassing communications is a Class C misdemeanor.

"Rape Shield Law"

Admissibility of evidence relating to past sexual behavior of complaining witness in prosecutions for criminal sexual conduct (12-21-203):

b. In any prosecution for criminal sexual conduct or for assault with intent to commit, attempt to commit or conspiracy to commit criminal sexual conduct, evidence relating to the past sexual behavior of the complaining witness . . . shall not be admissible, either as direct evidence or on cross-examination of the complaining witness or of other witnesses, except as otherwise provided in this section.

c. In any prosecution for criminal sexual conduct, evidence relating to the past sexual behavior of the complaining witness shall be introduced if the court . . . finds that such past sexual behavior directly involved the participation of the accused.

Crime Counselor Confidentiality

Confidentiality of communications with victim counselor (15-23-42):

a. A victim, a victim counselor without the consent of the victim, or a minor or incapacitated victim without the consent of a custodial guardian or a guardian ad litem appointed upon application of either party, cannot be compelled to give

testimony or to produce records concerning confidential communications for any purpose in any criminal proceeding.

b. A victim counselor or a victim cannot be compelled to provide testimony in any civil or criminal proceeding that would identify the name, address, location, or telephone number of a safe house, abuse shelter, or other facility that provided temporary emergency shelter to the victim of the offense or transaction that is the subject of the proceeding unless the facility is a party to the proceeding.

Alabama Sex Offender Registration And Community Notification Statutes
(as amended by Ala. Act No. 2005-301, effective October 1, 2005)

13A-11-200

(a) The Legislature declares that its intent in imposing certain reporting and registration requirements on criminal sex offenders is to protect the public, especially children, from the dangers posed by criminal sex offenders and not to further punish such offenders.

(b) If any person, except a delinquent child, as defined in Section 12-15-1, residing in Alabama, has heretofore been convicted, or shall be convicted in any state or municipal court in Alabama, or federal court, or so convicted in another state in any court having jurisdiction similar to the jurisdiction of state and municipal courts in Alabama for any of the offenses hereinafter enumerated, such person shall, upon his or her release from legal custody, register with the sheriff of the county of his or her legal residence within seven days following such release or within 30 days after September 7, 1967, in case such person was released prior to such date. For purposes of this article, a conviction includes a plea of nolo contendere, regardless of whether adjudication was withheld. The offenses above referred to are generally any act of sexual perversion involving a member of the same or the opposite sex, or any sexual abuse of any member of the same or the opposite sex or any attempt to commit any of these acts, and without limiting the generality of the above statement shall include specifically: Rape, as proscribed by Sections 13A-6-61 and 13A-6-62; sodomy, as proscribed by Sections 13A-6-63 and 13A-6-64; sexual misconduct, as proscribed by Section 13A-6-65; indecent exposure, as proscribed by Section 13A-6-68; promoting prostitution in the first or second degree, as proscribed by Sections 13A-12-111 and 13A-12-112; obscenity, as proscribed by Section 13A-12-131; incest, as proscribed by Section 13A-13-3; or the attempt to commit any of the above offenses.

(c) Any person having been so convicted shall upon moving his legal residence from one county to another register with the sheriff of the county to which he has moved within seven days after such removal. It shall be unlawful for a convicted sex offender as described in this article to fail or refuse to register as required in this section and failure to do so is a Class C felony.

13A-11-201

The sheriff of each county in Alabama shall maintain a register or roster of the names of all persons registered by him under this article, which register shall only be open to inspection by duly constituted law enforcement officers. The information contained in the register or roster, however, shall be made available if disclosure is necessary for the administration, implementation, or enforcement of the Community Notification Act, Chapter 20 of Title 15. The sheriff shall also notify the State Department of Public Safety of the name of each person registered by him and at the same time supply to such department information relative to the conviction of each person so registered.

13A-11-202

The State Department of Public Safety shall maintain a register or roster of the names of all persons registered under this article by the several sheriffs of the state. Such register or roster shall be open only to inspection by duly constituted law enforcement officers or agencies. The information contained in the register or roster, however, shall be made available if disclosure is necessary for the administration, implementation, or enforcement of the Community Notification Act, Chapter 20 of Title 15.

15-20-20

This article shall be known and cited as the Community Notification Act.

15-20-20.1

The Legislature finds that the danger of recidivism posed by criminal sex offenders and that the protection of the public from these offenders is a paramount concern or interest to government. The Legislature further finds that law enforcement agencies' efforts to protect their communities, conduct investigations, and quickly apprehend criminal sex offenders are impaired by the lack of information about criminal sex offenders who live within their jurisdiction and that the lack of information shared with the public may result in the failure of the criminal justice system to identify, investigate, apprehend, and prosecute criminal sex offenders.

The system of registering criminal sex offenders is a proper exercise of the state's police power regulating present and ongoing conduct. Comprehensive registration and periodic address verification will provide law enforcement with additional information critical to preventing sexual victimization and to resolving incidents

involving sexual abuse and exploitation promptly. It will allow them to alert the public when necessary for the continued protection of the community.

Persons found to have committed a sex offense have a reduced expectation of privacy because of the public's interest in safety and in the effective operation of government. In balancing offender's due process and other rights, and the interests of public security, the Legislature finds that releasing information about criminal sex offenders to law enforcement agencies and, providing access to or releasing such information about criminal sex offenders to the general public, will further the primary government interest of protecting vulnerable populations and in some instances the public, from potential harm. The Legislature further finds that residency and employment restrictions for criminal sex offenders provide additional protections to vulnerable segments of the public such as schools and child care facilities.

Juvenile sex offenders, like their adult counterparts, pose a danger to the public. Research has shown, however, that there are significant differences between adult and juvenile criminal sexual offenders. Juveniles are much more likely to respond favorably to sexual offender treatment. Juvenile offenders have a shorter history of committing sexual offenses. They are less likely to have deviant sexual arousal patterns and are not as practiced in avoiding responsibility for their abusive behavior. Juveniles are dependent upon adults for food and shelter, as well as the emotional and practical support vital to treatment efforts. Earlier intervention increases the opportunity for success in teaching juveniles how to reduce their risk of sexually re-offending. The Legislature finds that juvenile criminal sex offenders should be subject to the Community Notification Act, but that certain precautions should be taken to target the juveniles that pose the more serious threats to the public.

Therefore, the state policy is to assist local law enforcement agencies' efforts to protect their communities by requiring criminal sex offenders to register, record their address of residence, to be photographed, fingerprinted, to authorize the release of necessary and relevant information about criminal sex offenders to the public, to mandate residency and employment restrictions upon criminal sex offenders, and to provide certain discretion to judges for application of these requirements as provided in this article.

The Legislature declares that its intent in imposing certain reporting and monitoring requirements on criminal sex offenders and requiring community

notification of the residence and workplace of criminal sex offenders is to protect the public, especially children, from convicted criminal sex offenders.

15-20-21

For purposes of this article, the following words shall have the following meanings:

(1) ADULT CRIMINAL SEX OFFENDER. A person convicted of a criminal sex offense, including a person who has pleaded nolo contendere to a criminal sex offense, regardless of whether adjudication was withheld.

(2) CHILD CARE FACILITY. A licensed daycare center, a licensed child care facility, or any other child care service that is exempt from licensing pursuant to Section 38-7-3.

(3) COMMUNITY NOTIFICATION FLYER. This notification shall include the following information on the criminal sex offender: Name; actual living address; sex; date of birth; complete physical description, including distinguishing features such as scars, birth marks, or any identifying physical characteristics; and a current photograph. This notification shall also include a statement of the criminal sex offense for which he or she has been convicted, including the age and gender of the victim, the geographic area where the offense occurred, and the date upon which the criminal sex offender will be released. This notification shall also include a statement that the same information is on file at the sheriff's office and police headquarters, if a police department has jurisdiction over the criminal sex offender's residence, and that the information will be available to the general public for inspection and identification purposes during regular business hours.

(4) CRIMINAL SEX OFFENSE. Any of the following offenses:

a. Rape in the first or second degree, as proscribed by Section 13A-6-61 or 13A-6-62; provided that a sentencing court may exempt from this article a juvenile or youthful offender criminal sex offender for a criminal sex offense as defined in Section 13A-6-62(a)(1).

b. Sodomy in the first or second degree, as proscribed by Section 13A-6-63 or 13A-6-64.

c. Sexual torture, as proscribed by Section 13A-6-65.1.

d. Sexual abuse in the first or second degree as proscribed by Section 13A-6-66 or 13A-6-67.

e. Enticing a child to enter a vehicle, room, house, office, or other place for immoral purposes, as proscribed by Section 13A-6-69.

f. Promoting prostitution in the first or second degree, as proscribed by Section 13A-12-111 or 13A-12-112.

g. Violation of the Alabama Child Pornography Act, as proscribed by Section 13A-12-191, 13A-12-192, 13A-12-196, or 13A-12-197.

h. Kidnapping of a minor, except by a parent, in the first or second degree, as proscribed by Section 13A-6-43 or 13A-6-44.

i. Incest, as proscribed by Section 13A-13-3, when the offender is an adult and the victim is a minor.

j. Soliciting a child by computer for the purposes of committing a sexual act and transmitting obscene material to a child by computer, as proscribed by Sections 13A-6-110 and 13A-6-111.

k. Any solicitation, attempt, or conspiracy to commit any of the offenses listed in paragraphs a. to j., inclusive.

l. Any crime committed in any state or a federal, military, Indian, or a foreign country jurisdiction which, if it had been committed in this state under the current provisions of law, would constitute an offense listed in paragraphs a. to k., inclusive.

m. The foregoing notwithstanding, any crime committed in any jurisdiction which, irrespective of the specific description or statutory elements thereof, is in any way characterized or known as rape, sodomy, sexual assault, sexual battery, sexual abuse, sexual torture, solicitation of a child, enticing or luring a child, child pornography, lewd and lascivious conduct, taking indecent liberties with a child, or molestation of a child.

(5) CRIMINAL SEX OFFENSE INVOLVING A CHILD. A conviction for any criminal sex offense in which the victim was a child under the age of 12 and any

offense involving child pornography.

(6) EMPLOYMENT. Includes employment that is full-time or part-time for any period, whether financially compensated, volunteered, or for the purpose of government or educational benefit.

(7) JUVENILE CRIMINAL SEX OFFENDER. An individual adjudicated delinquent of a criminal sex offense.

(8) MENTAL ABNORMALITY. A congenital or acquired condition of a person that affects the emotional or volitional capacity of the person in a manner that predisposes that person to the commission of criminal sex offense to a degree that makes the person a menace to the health and safety of other persons.

(9) PREDATORY. An act directed at a stranger, or a person with whom a relationship has been established, or promoted for the purpose of victimization.

(10) RELEASE. Release from a state prison, county jail, or municipal jail, or release or discharge from the custody of the Department of Youth Services or other juvenile detention, or placement on an appeal bond, probation or parole or aftercare, or placement into any facility or treatment program that allows the offender to have unsupervised access to the public.

(11) RESPONSIBLE AGENCY. The person or government entity whose duty it is to obtain information from a criminal sex offender before release and to transmit that information to police departments or sheriffs responsible for providing community notification. For a criminal sex offender being released from state prison, the responsible agency is the Department of Corrections. For a criminal sex offender being released from a county jail, the responsible agency is the sheriff of that county. For a criminal sex offender being released from a municipal jail, the responsible agency is the police department of that municipality. For a criminal sex offender being placed on probation, including conditional discharge or unconditional discharge, without any sentence of incarceration, the responsible agency is the sentencing court. For a criminal sex offender being released from the Department of Youth Services, the responsible agency is the Department of Youth Services. For a criminal sex offender who is being released from a jurisdiction outside this state and who is to reside in this state, the responsible agency is the Department of Public Safety.

(12) RISK ASSESSMENT. A written report on the assessment of risk for sexually re-offending conducted by a sexual treatment program approved by the Department of Youth Services. The report shall include, but not be limited to, the following regarding the criminal sex offender: Criminal history, mental status, attitude, previous sexual offender treatment and response to treatment, social factors, conditions of release expected to minimize risk of sexual re-offending, and characteristics of the criminal sex offense.

(13) SCHOOL. A licensed or accredited public or private school, or church school, that offers instruction in grades K-12. This definition shall not include private residences in which students are taught by parents or tutors.

(14) SENTENCING COURT. The court of conviction or the court that determines sentence as a result of conviction or adjudication.

(15) SEXUALLY VIOLENT PREDATOR. A person who has been convicted of a criminal sex offense and who suffers from a mental abnormality or personality disorder that makes the person likely to engage in predatory criminal sex offenses.

(16) STUDENT. A person who is enrolled on a full-time or part-time basis, in any public or private educational institution, including any schools as defined in subdivision (13).

(17) YOUTHFUL OFFENDER CRIMINAL SEX OFFENDER. An individual adjudicated a youthful offender for a criminal sex offense.

15-20-22

(a) Forty-five days prior to the release of an adult criminal sex offender, the following shall apply:

(1) The responsible agency shall require the adult criminal sex offender to declare, in writing or by electronic means approved by the Director of the Department of Public Safety, the actual address at which he or she will reside or live upon release and the name and physical address of his or her employer, if any. Any failure to provide timely and accurate declarations shall constitute a Class C felony. Any adult criminal sex offender in violation of this section shall be ineligible for release on probation or parole. Any adult criminal sex offender in violation of this section who is to be released due to the expiration of his or her sentence shall be charged with violating this section and, upon release, shall immediately be remanded to the

custody of the sheriff of the county in which the violation occurred. Any adult criminal sex offender charged with violating this section may only be released on bond on the condition that the offender is in compliance with this section before being released.

(2) If the adult criminal sex offender declares his or her intent to reside or be employed outside of the state, the responsible agency shall, within five business days of the declarations required by this article, notify the Director of the Department of Public Safety, the Attorney General, or the designated state law enforcement agency of the state to which the adult criminal sex offender has declared his or her intent to move or in which he or she intends to be employed, and shall also notify the Alabama Criminal Justice Information Center. The notification shall include all information available to the responsible agency which would be necessary to identify and trace the adult criminal sex offender, including, but not limited to, the offender's declared places of residence and employment, each sex offense history or pre-sentence investigation of the sex offense, fingerprints, and a current photograph of the adult criminal sex offender.

(3) If the adult criminal sex offender declares his or her intent to reside, live, or be employed within this state, the responsible agency shall, within five business days of the written declaration, notify the Attorney General, the Director of the Department of Public Safety, the district attorney and the sheriff of any county in which the adult criminal sex offender intends to reside or be employed, the chief of police of any municipality in which the adult criminal sex offender intends to reside or be employed, and the Alabama Criminal Justice Information Center. The notification shall include all information available to the responsible agency which would be necessary to identify and trace the adult criminal sex offender, including, but not limited to, the offender's declared places of residence and employment, each sex offense history or pre-sentence investigation of the sex offense, fingerprints, and a current photograph of the criminal sex offender.
(4) The Alabama Criminal Justice Information Center shall be responsible for notifying the Federal Bureau of Investigation with sex offender information upon receiving this information from the responsible agency. Measures shall be taken to ensure this information is submitted to and included in the national database of sex offenders established pursuant to
42 U.S.C. § 14072.

(b) If a sentencing court does not impose a sentence of incarceration upon conviction of the adult criminal sex offender for a criminal sex offense, notification shall be provided by the responsible agency in accordance with subsection (a) within 24 hours of release.

(c) Prior to release, every adult criminal sex offender convicted for a criminal sex offense shall submit to the probation officer or sheriff a DNA sample that will be sent to the Department of Forensic Sciences. An adult criminal sex offender who intentionally fails to provide a DNA sample shall be guilty of a Class C felony.

(d) If an adult criminal sex offender is unable to declare a place of employment prior to release because he or she is unemployed, the offender shall declare in writing or by electronic means approved by the Director of the Department of Public Safety the name and physical address of his or her employer to the sheriff of the county and chief of police of the municipality in which the offender is employed by the end of the next business day after he or she obtains employment. Any failure to provide a timely and accurate written declaration as required by this section is a Class C felony.

15-20-23

(a) If an adult criminal sex offender intends to transfer his or her residence to a different location, he or she shall submit a notice of intent to move to the sheriff of the county and the chief of police of the municipality in which he or she resides, and to the sheriff of the county and chief of police of the municipality to which he or she plans to move, if such are different, at least 30 days prior to moving to the new location. The notice of intent to move shall be on a form developed by the Department of Public Safety provided by the sheriff and shall include all the information required by this article for community notification. Failure to provide a timely and accurate written declaration shall constitute a Class C felony.

(b) Notwithstanding other provisions of law regarding establishment of residence, an adult criminal sex offender shall be deemed to have established a new residence in any of the following circumstances:

(1) Whenever that adult criminal sex offender is domiciled for three consecutive days or more.

(2) Whenever that adult criminal sex offender is domiciled following his or her release, regardless of whether that criminal sex offender has been domiciled at the same location prior to the time of conviction.

(3) Whenever an adult criminal sex offender spends 10 or more aggregate days at a location during a calendar month.

15-20-23.1

If an adult criminal sex offender intends to change his or her place of employment, he or she shall submit a notice of intent to do so to the sheriff of the county and the chief of police of the municipality in which he or she is then employed and to the sheriff of the county and chief of police of the municipality in which he or she intends to be employed, if such are different, at least seven days prior to beginning employment at the new location. An intentional failure to provide a timely and accurate written declaration shall constitute a Class C felony.

15-20-24

(a) Sixty days after an adult criminal sex offender's most current release and, except during ensuing periods of incarceration, thereafter on the anniversary date of an adult criminal sex offender's birthday occurring more than 90 days after the release and the date six months after the anniversary date of an adult criminal sex offender's birthday occurring more than 90 days after the release, the Department of Public Safety shall mail a non-forwardable verification form to the address of the adult criminal sex offender. The sheriff, or chief of police where applicable, where the adult criminal sex offender resides shall be notified of the pending verification and whether the verification form was received by the adult criminal sex offender.

(b) Within 10 days of the receipt of the verification form, the adult criminal sex offender shall present in person the completed verification form to the sheriff, or chief of police where applicable, who shall obtain fingerprints and a photograph of the adult criminal sex offender. The verification form shall be signed by the adult criminal sex offender and shall state that the adult criminal sex offender still resides at that address and that the adult criminal sex offender is in compliance with the residence restrictions established in this article. In the event the adult criminal sex offender does not receive a verification form from the Department of Public Safety, the offender must nonetheless report in person to the sheriff, or chief

of police where applicable, to verify his or her place of residence within 90 days of his or her most recent release and thereafter each year within 30 days of the offender's birthday and the date six months after the offender's birthday.

(c) Within 30 days of an adult criminal sex offender's address verification, the Department of Public Safety shall, in accordance with guidelines promulgated by the Department of Public Safety, receive from the appropriate sheriff or chief of police verification of the adult criminal sex offender's address. Such guidelines shall ensure that address verification is accomplished with respect to these individuals and shall require the submission of fingerprints and photographs of the individuals.

(d) An adult criminal sex offender who fails to verify his or her place of residence in accordance with this section, provides a false statement to law enforcement in the verification process, or knowingly fails to permit law enforcement personnel to obtain fingerprints or a photograph shall be guilty of a Class C felony.

15-20-25

(a) Within five business days after the responsible agency provides notice of a release or intent to transfer residence of any adult criminal sex offender, the following procedures shall apply:

(1) In the cities of Birmingham, Mobile, Huntsville, and Montgomery, the chief of police shall notify all persons who have a legal residence within 1,000 feet of the declared residence of the adult criminal sex offender and all schools and child care facilities within three miles of the declared residence of the adult criminal sex offender that the criminal sex offender will be establishing his or her residence.

(2) In all other cities in Alabama with a resident population of 5,000 or more, the chief of police, or if none then the sheriff of the county, shall notify all persons who have a legal residence within 1,500 feet of the declared residence of the adult criminal sex offender and all schools and child care facilities within three miles of the declared residence of the adult criminal sex offender, that the adult criminal sex offender will be establishing his or her residence.

(3) In all other municipalities with a resident population of less than 5,000, and in all unincorporated areas, the sheriff of the county in which the adult criminal sex offender intends to reside shall notify all persons who have a legal residence within 2,000 feet of the declared residence of the adult criminal sex offender, and

all schools and child care facilities within three miles of the declared residence of the adult criminal sex offender, that the adult criminal sex offender will be establishing his or her residence.

(b) A community notification flyer shall be made by regular mail or hand delivered to all legal residences required by this section. In addition, any other method reasonably expected to provide notification may be utilized, including, but not limited to, posting a copy of the notice in a prominent place at the office of the sheriff and at the police station closest to the declared residence of the released criminal sex offender, publicizing the notice in a local newspaper, or posting electronically, including the Internet, or other means available.

(c) Nothing in this article shall be construed as prohibiting the Department of Public Safety, a sheriff, or a chief of police from providing community notification under the provisions of this article electronically or by publication or periodically to persons whose legal residence is more than the applicable distance from the residence of an adult criminal sex offender.

15-20-25.1

(a) Any adult criminal sex offender not a resident of this state shall register with law enforcement whenever the offender comes into this state to accept employment, to carry on a vocation, or to become a student. The offender shall also register any subsequent changes in his or her place of lodging, employment, or school being attended.

(b) Any adult criminal sex offender required to register under this section shall, within five days after entering this state or changing his or her place of lodging, employment, or school being attended, provide a written declaration to the sheriff of the county and chief of police of the municipality in which the offender intends to work or become a student. This written declaration shall contain all of the following:

(1) Information concerning the registrant's place of employment or the school being attended.

(2) The registrant's address in his or her state of residence.

(3) The address of any place of lodging the registrant may have in this state for purposes of employment or attendance as a student.

(4) Other information as would be necessary to complete a community notification flyer as defined in subdivision (3) of Section 15-20-21.

(c) Whenever an adult criminal sex offender registers pursuant to this section, he or she shall be subject to the community notification procedures set forth in Section 15-20-25. The adult criminal sex offender shall be treated as though he or she had transferred his or her place of residence to the place of lodging declared under subdivision (3) of subsection (b). If no place of lodging is declared or exists, the adult criminal sex offender shall be treated as though he or she had transferred his or her place of residence to

the place of employment or the school being attended declared under subdivision (1) of subsection (b).

(d) An intentional failure to provide a timely and accurate written declaration as required by this section shall constitute a Class C felony.

15-20-25.2

(a) In addition to any other requirements of this article, an adult criminal sex offender shall provide written notice to the sheriff of the county and chief of police of the municipality in which the offender resides, of the following:

(1) Each institution of higher education at which the offender is employed, carries on a vocation, or is a student.

(2) Each change in enrollment or employment status of the offender at a an institution of higher education.

(b) An adult criminal sex offender shall provide written notice as required under subdivision (1) of subsection (a) within five days of becoming employed, carrying on a vocation, or becoming a student at an institution of higher education.

(c) A change in status noticed under subdivision (2) of subsection (a) shall be reported by the adult criminal sex offender within five days after the change becomes effective.

(d) Any written notice provided to law enforcement under this section shall be forwarded to the Department of Public Safety and the Alabama Criminal Justice Information Center, both of which shall enter the information contained in the written notice in the appropriate state records or data system.

(e) Any written notice provided to law enforcement under this section shall also be forwarded to campus police and any other security personnel of the school or institution of higher learning where the adult criminal sex offender is employed, carries on a vocation, or is a student.

(f) An intentional failure to provide timely and accurate written notice as required by this section shall constitute a Class C felony.

15-20-25.3

(a) Whenever an individual is convicted of a criminal sex offense in this state, the state, at the time of sentencing, may petition the sentencing court to enter an order adjudging the offender to be a sexually violent predator.

(b) If the state so petitions, it shall present clear and convincing evidence that the offender suffers from a mental abnormality or personality disorder that makes the person likely to engage in predatory criminal sex offenses.

(c) Any offender determined in any other state to be a sexually violent predator shall be considered a sexually violent predator in this state.

(d) Sexually violent predators shall be required, upon release, to provide to the responsible agency, in addition to the information required to complete a community notification flyer as provided in subdivision (3) of Section 15-20- 21:

(1) A full history of criminal offenses committed by the offender.

(2) Documentation of any treatment received for the mental abnormality or personality disorder of the offender.

(e) A sexually violent predator shall be required to verify his or her place of residence on a quarterly basis, rather than an annual basis as is generally provided in Section 15-20-24.

(f) A sexually violent predator, as a condition of the offender's release from incarceration, shall be subject to electronic monitoring and be required to pay the costs of such monitoring, as set forth in Section 15-20-26.1, for a period of no less than 10 years from the date of the sexually violent predator's release. This requirement shall be imposed by the sentencing court as a part of the sexually violent predator's sentence, as provided in Sections 13A-5-6(c) and 15-20-26.1.

(g) An intentional failure to comply with any provision of this section shall constitute a Class C felony.

15-20-26

(a) Unless otherwise exempted by law, no adult criminal sex offender shall establish a residence or any other living accommodation or accept employment within 2,000 feet of the property on which any school or child care facility is located.

(b) Unless otherwise exempted by law, no adult criminal sex offender shall establish a residence or any other living accommodation within 1,000 feet of the property on which any of his or her former victims, or the victims' immediate family members reside.

(c) No adult criminal sex offender shall establish a residence or any other living accommodation where a minor resides. Notwithstanding the foregoing, an adult criminal sex offender may reside with a minor if the adult criminal sex offender is the parent, grandparent, or stepparent of the minor, unless one of the following conditions applies:

(1) The adult criminal sex offender's parental rights have been or are in the process of being terminated as provided by law.

(2) The adult criminal sex offender has been convicted of any criminal sex offense in which any of the offender's minor children, grandchildren, or stepchildren were the victim.

(3) The adult criminal sex offender has been convicted of any criminal sex offense in which a minor was the victim and the minor resided or lived with the offender at the time of the offense.

(4) The adult criminal sex offender has ever been convicted of any criminal sex offense involving a child, regardless of whether the offender was related to or shared a residence with the child victim.

(d) No adult criminal sex offender shall be permitted to willfully or knowingly come within 100 feet of any of his or her former victims, except as elsewhere provided by law, or make any visual or audible sexually suggestive or obscene gesture, sound, or communication at or to a former victim or a member of the victim's immediate family.

(e) Changes to property within 2,000 feet of an adult criminal sex offender's registered address which occur after an adult criminal sex offender establishes residency or accepts employment shall not form the basis for finding that a criminal sex offender is in violation of subsections (a) or (b).

(f) No adult criminal sex offender, after having been convicted of a criminal sex offense involving a child, shall loiter on or within 500 feet of any property on which there is a school, child care facility, playground, park, athletic field or facility, or any other business or facility having a principal purpose of caring for, educating, or entertaining minors. Under this subsection, "loiter" means to enter or remain on property while having no legitimate purpose therefor or, if a legitimate purpose exists, remaining on that property beyond the time necessary to fulfill that purpose. An offender does not violate this subsection unless he or she has first been asked to leave a prohibited location by a person authorized to exclude the offender from the premises. An authorized person includes, but not be limited to, any law enforcement officer, any owner or manager of the premises, a principal or teacher if the premises is a school or child care facility, or a coach if the premises is an athletic field or facility.

(g) No adult criminal sex offender, after having been convicted of a criminal sex offense involving a child, shall accept, maintain, or carry on any employment or vocation at or within 500 feet of a school, child care facility, playground, park, athletic field or facility, or any other business or facility having a principal purpose of caring for, educating, or entertaining minors.

(h) An adult criminal sex offender who knowingly violates the provisions of this section shall be guilty of a Class C felony.

15-20-26.1

(a) The Alabama Criminal Justice Information Center shall implement a system of active and passive electronic monitoring that identifies the location of a monitored person and that can produce upon request reports or records of the person's presence near or within a crime scene or prohibited area, the person's departure from specified geographic limitations, or curfew violations by the offender. The Director of the Alabama Criminal Justice Information Center may promulgate any rules as are necessary to implement and administer this system of active electronic monitoring including establishing policies and procedures to notify the person's probation and parole officer or other court appointed supervising authority when a violation of his or her electronic monitoring restrictions has occurred.

(b) The Board of Pardons and Paroles or a court may require, as a condition of release on parole, probation, community corrections, Court Referral Officer supervision, pre-trial release, or any other community based punishment option, that any person charged or convicted of a criminal sex offense be subject to electronic monitoring as provided in subsection (a).

(c) Any person designated a sexually violent predator pursuant to Section 15-20-25.3 shall, upon release from incarceration, be subject to electronic monitoring supervised by the Board of Pardons and paroles, as provided in subsection (a), for a period of no less than 10 years from the date of the sexually violent predator's release. This requirement shall be imposed by the sentencing court as a part of the sexually violent predator's sentence in accord with Section 13A-5-6(c).

(d) Any person convicted of a Class A felony criminal sex offense involving a child as defined in Section 15-20-21(5), upon release from incarceration, shall be subject to electronic monitoring supervised by the Board of Pardons and Paroles, as provided in subsection (a), for a period of no less than 10 years from the date of the offender's release. This requirement shall be imposed by the sentencing court as a part of the offender's sentence in accord with Section 13A-5-6(c).

(e) Any one subject to electronic monitoring pursuant to this section, unless he or she is indigent, shall be required to reimburse the supervising entity a reasonable fee to defray supervision costs. The Board of Pardons and Paroles, the sentencing court, or other supervising entity shall determine the amount to be paid based on the person's financial means and ability to pay, but such amount shall not exceed fifteen dollars ($15) per day.

(f) The supervising entity shall pay ACJIC a fee, to be determined by ACJIC but not exceeding ten dollars ($10) per day, to defray monitoring equipment and telecommunications costs.

(g) It shall constitute a Class C felony for any person to willfully or knowingly alter, disable, deactivate, tamper with, remove, damage, or destroy any device used to facilitate electronic monitoring under this section.

15-20-26.2

(a) Every adult criminal sex offender who is a resident of this state shall obtain and always have in his or her possession either a valid driver=s license or identification card issued by the Alabama Department of Public Safety. If any offender is ineligible to be issued a driver's license or official identification card, the Department of Public Safety shall provide the offender some other form of identification card or documentation that, if it is kept in the offender's possession, shall satisfy the requirements of this section. If any adult criminal sex offender is determined to be indigent, an identification card or other documentation in lieu thereof shall be issued to the offender at no cost. An adult criminal sex offender who knowingly violates this provision shall be guilty of a Class C felony.

(b) Whenever the Department of Public Safety issues or renews a driver=s license or identification card to an adult criminal sex offender, the driver =s license or identification card shall bear a designation that enables law enforcement officers to identify the licensee as a criminal sex offender.

(c) This section shall become effective September 1, 2006.

15-20-27

Upon adjudication of delinquency for a criminal sex offense, a juvenile criminal sex offender shall be required to receive sex offender treatment by a licensed sex offender treatment program and submit to the probation officer or sheriff a DNA sample that shall be sent to the Department of Forensic Sciences.

15-20-28

(a) Sixty days prior to the projected release of a juvenile criminal sex offender, the treatment provider shall provide a risk assessment of the juvenile to the sentencing court and the juvenile probation officer.

(b) Upon receiving the risk assessment, the juvenile probation officer shall immediately notify the state, and either the parent, guardian, or custodian of the juvenile criminal sex offender, or attorney for the juvenile criminal sex offender, of the pending release and provide them with the risk assessment.

(c) Unless otherwise ordered by the sentencing court, the juvenile criminal sex offender shall not be subject to notification upon release.

(d) Within thirty days of receiving the risk assessment, the state may petition the court to apply notification.

(e) No juvenile criminal sex offender shall be removed from the supervision of the court until such time as the juvenile criminal sex offender has completed treatment, the treatment provider has filed a risk assessment with the court, and the state has had an opportunity to file a petition to apply notification.

(f) Upon receiving a petition to apply notification, the sentencing court shall conduct a hearing on the risk of the juvenile criminal sex offender to the community. The sentencing court may deny the petition or grant the petition based upon, but not limited to, the following factors relevant to the risk of re-offense:

(1) Conditions of release that minimize risk of re-offense, including, but not limited to, whether the offender is under supervision of probation or parole; receiving counseling, therapy, or treatment; or residing in a home situation that provides guidance and supervision.

(2) Physical conditions that minimize risk of re-offense, including, but not limited to, advanced age or debilitating illness.

(3) Criminal history factors indicative of high risk of re-offense, including whether the offender's conduct was found to be characterized by repetitive and compulsive behavior.

(4) Other criminal history factors to be considered in determining risk, including:

a. The relationship between the offender and the victim.

b. Whether the offense involved the use of a weapon, violence, or infliction of serious bodily injury.

c. The number, date, and nature of prior offenses.

(5) Whether psychological or psychiatric profiles indicate a risk of recidivism.

(6) The offender's response to treatment.

(7) Recent behavior, including behavior while confined or while under supervision in the community as well as behavior in the community following service of sentence.

(8) Recent threats against persons or expressions of intent to commit additional crimes.

(g) If the court determines there is a need for notification, the level of notification to be applied shall be as follows:

(1) If the risk of re-offense is low, notification that the juvenile criminal sex offender will be establishing his or her residence shall be provided to the principal of the school where the juvenile criminal sex offender will attend after release. This notification shall include the offender's name, actual living address, date of birth, and a statement of the criminal sex offense for which he or she has been adjudicated delinquent, including the age and gender of the victim. This information shall be considered confidential by the school and be shared only with the teachers and staff with supervision over the juvenile criminal sex offender. Whomever, except as specifically provided herein, directly or indirectly discloses or makes use of or knowingly permits the use of information concerning a child described in these subsections, upon conviction thereof, shall be guilty of a Class A misdemeanor within the jurisdiction of the juvenile court.

(2) If the risk of re-offense is moderate, notification that the criminal sex offender will be establishing his or her residence shall be provided to all schools and child care facilities within three miles of the declared residence of the juvenile criminal sex offender. A community notification flyer shall be made by regular mail or hand delivered to all schools or child care facilities as required by this subsection. A flyer shall also be on file with the sheriff in the county of residence and made available for public inspection. No other method may be used to disseminate this information.

(3) If the risk of re-offense is high, the public shall receive notification as though the juvenile criminal sex offender were an adult in accordance with Section 15-20-25.

(h) The determination of notification by the sentencing court shall not be subject to appeal.

15-20-29

(a) Prior to release of the juvenile criminal sex offender, the following shall apply:

(1) The responsible agency shall require the parent, custodian, or guardian of the juvenile criminal sex offender to declare in writing the actual living address at which the juvenile criminal sex offender will reside upon release. An intentional failure to provide a timely and accurate written declaration shall constitute a Class A misdemeanor.

(2) If the parent, guardian, or custodian of the juvenile criminal sex offender declares an address outside of the state, the responsible agency shall, within five business days of the written declaration required by this article, notify the Director of the Department of Public Safety, the Attorney General, or the designated state law enforcement agency of the state to which the parent, guardian, or custodian of the juvenile criminal sex offender has declared the actual living address. The notification shall include all information available to the responsible agency that would be necessary to identify and trace the juvenile criminal sex offender, including, but not limited to, the risk assessment and a current photograph of the juvenile criminal sex offender.

(3) If the parent, guardian, or custodian of the juvenile criminal sex offender declares an address within this state, the responsible agency shall, within five business days of the written declaration, notify the Attorney General, the Director of the Department of Public Safety, the district attorney and the sheriff of the county in which the parent, guardian, or custodian of the juvenile criminal sex offender has declared the actual living address, and the chief of police of any municipality in which the parent, guardian, or custodian of the juvenile criminal sex offender has declared the actual living address. The notification shall include all information available to the responsible agency that would be necessary to identify and trace the juvenile criminal sex offender, including, but not limited to, the risk assessment and a current photograph of the juvenile criminal sex offender.

(b) If the parent, custodian, or guardian of a juvenile criminal sex offender intends to transfer the residence of the juvenile criminal sex offender, or the custody of the juvenile criminal sex offender is changed to a different parent or guardian resulting in a transfer of residence, the original parent or guardian in custody shall declare in writing the actual living address of the intended new residence for the juvenile criminal sex offender and provide this information to the sheriff for the current residence at least 14 days prior to moving to the new location. The sheriff shall transfer the information to the Department of Public Safety and the sheriff of the county to which the juvenile criminal sex offender intends to move or the chief of police. An intentional failure to provide a timely and accurate written declaration shall constitute a Class A misdemeanor.

(c) When a juvenile criminal sex offender becomes the age of majority, the parent, guardian, or custodian of the juvenile criminal sex offender shall no longer be subject to the requirements under subsections (a) and (b), and the juvenile criminal sex offender shall instead be subject to Section 15-20-22 or Section 15-20-23 as though he or she were an adult criminal sex offender. Community notification, however, shall not be allowed, unless so ordered by the sentencing court.

15-20-30

(a) Sixty days after a juvenile criminal sex offender's most current release and, except during ensuing periods of incarceration, thereafter on the anniversary date of a juvenile criminal sex offender's birthday occurring more than 90 days after the release, the Department of Public Safety shall mail a non-forwardable verification form to the address of the juvenile criminal sex offender addressed to the parent, guardian, or custodian of the juvenile criminal sex offender. The sheriff, or chief of police where applicable, where the juvenile criminal sex offender resides shall be notified of the pending verification and whether the verification form was received by the parent, guardian, or custodian of the juvenile criminal sex offender.

(b) Within 10 days of the receipt of the verification form, the parent, guardian, or custodian of the juvenile criminal sex offender, accompanied by the juvenile criminal sex offender, shall present in person the completed verification form to the sheriff, or chief of police where applicable, who shall obtain fingerprints and a photograph of the juvenile criminal sex offender. The verification form shall be signed by the parent, guardian, or custodian of the juvenile criminal sex offender and shall state that the juvenile criminal sex offender still resides at that address.

(c) Within 30 days of the annual date of the juvenile criminal sex offender's address verification, the Department of Public Safety shall, in accordance with guidelines promulgated by the Department of Public Safety, receive from the appropriate sheriff or chief of police verification of the juvenile criminal sex offender's address. Such guidelines shall ensure that address verification is accomplished with respect to these individuals and shall require the submission of fingerprints and photographs of the individuals.

(d) A parent, guardian, or custodian of a juvenile criminal sex offender who fails to present in person a completed verification form to the sheriff, or chief of police where applicable, within 10 days, or knowingly fails to permit law enforcement personnel to obtain fingerprints or a photograph of the juvenile criminal sex offender shall have committed a Class C felony.

15-20-31

For the purposes of this article, if a youthful offender criminal sex offender has not been previously adjudicated for a criminal sex offense, he or she shall be considered a juvenile criminal sex offender. If a youthful offender criminal sex offender has been previously adjudicated or convicted of a criminal sex offense, he or she shall be treated as an adult criminal sex offender. A youthful offender criminal sex offender who is treated as a juvenile criminal sex offender for purposes of this article may not be released from the jurisdiction of the sentencing court until the offender has undergone sex offender treatment and a risk assessment as required by Sections 15-20-27 and 15-20-28.

15-20-32

In the case in which any criminal sex offender escapes from a state or local correctional facility, juvenile detention facility, or any other facility that would permit unsupervised access to the public, the responsible agency shall, within 24 hours, notify the Department of Public Safety, the sheriff and the chief of police having had jurisdiction at the time of the criminal sex offense conviction or adjudication, informing such of the name and aliases of the criminal sex offender, of time remaining to be served, if any, on the full term for which the criminal sex offender was incarcerated, and the nature of the crime for which he or she was sentenced, transmitting at the same time a copy of such criminal sex offender's fingerprints and current photograph and a summary of his or her criminal record.

15-20-33

(a) Any adult criminal sex offender shall be subject to this article for life.

(b) A juvenile criminal sex offender, whether having been incarcerated or not, who resides within this state, shall be subject to this article for a period of ten years from the last date of release. A juvenile criminal sex offender who is subsequently convicted as an adult criminal sex offender within the ten-year period shall be considered solely an adult criminal sex offender.

(c) Nothing in this article shall preclude any criminal sex offender from registering in accordance with Section 13A-11-200; however, such registration unless otherwise proscribed by this article does not trigger public notification.

15-20-34

(a) Any notice provided to the community pursuant to this article shall not contain the name or any other information identifying the victim.

(b) If the last known address of a victim is in the State of Alabama, the responsible agency shall notify the Attorney General's Office of Victim Assistance and they shall send a notice to the victim that the criminal sex offender will be released and the location at which the criminal sex offender intends to reside.

The Board of Pardons and Paroles shall furnish the Attorney General's Office of Victim Assistance with any victim information for victims whose offenders are subject to this article. The Attorney General's Office of Victim Assistance shall notify the victims who file a written request to be notified of a criminal sex offender's pending release. This request may be made on a form provided by the Attorney General's Office of Victim Assistance. The Attorney General's Office of Victim Assistance shall send a notice to the address provided on the form notifying the victim that the criminal sex offender will be released and the location at which the criminal sex offender will reside. It shall be the responsibility of the victim to inform the Attorney General's Office of Victim Assistance if the victim's address or any other pertinent information on the notice request changes. If the notice sent by the Attorney General's Office of Victim Assistance is returned as undeliverable, no further action shall be required of the Attorney General's Office of Victim Assistance.

15-20-35

(a) The responsible agency shall cooperate with the Director of the Department of Public Safety in a reasonable manner that enables the Department of Public Safety to prepare a criminal sex offender release notification form, designed by the Department of Public Safety.

(b) The information collected or maintained by the Department of Public Safety, sheriff, or police department under this article shall be used to track the locations and movements of criminal sex offenders in this state and shall be disclosed to any of the following:

(1) Federal, state, and local criminal justice agencies for law enforcement purposes and community notification in accordance with Section 15-20-22 or another state's similar provision.

(2) Federal, state, and local governmental agencies responsible for conducting employment-related confidential background checks.

(c) The information in this section may be made available through the Alabama Criminal Justice Information Center information systems and the National Crime Information Center network for criminal justice purposes or any other purpose authorized by law.

(d) No existing state laws, including, but not limited to, statutes that would otherwise make juvenile and youthful offender records confidential, shall preclude the disclosure of any information requested by a responsible agency, a law enforcement officer, a criminal justice agency, the Attorney General's Office, or a district attorney for purposes of administering, implementing, or enforcing this article.

15-20-36

No criminal sex offender shall be allowed to change his or her name unless the change is incident to a change in the marital status of the criminal sex offender or is necessary to effect the exercise of religion of the criminal sex offender. Such a change must be reported to the sheriff of the county in which the criminal sex offender resides within 30 days of the effective date of the change. If the criminal sex offender is subject to the notification provision of this article, the reporting of a name change under this section shall invoke notification.

15-20-37

Nothing in this article shall be construed as creating a cause of action against the state or any of its agencies, officials, employees, or political subdivisions based on the performance of any duty imposed by this article or the failure to perform any duty imposed by this article.

15-20-38

(a) The Director of the Department of Public Safety shall promulgate rules establishing an administrative hearing procedure for individuals who are made subject to this article pursuant to paragraph 1 of subdivision (4) of Section 15-20-21.

(b) The Director of the Department of Public Safety shall promulgate rules setting forth a listing of offenses from other jurisdictions that are to be considered criminal sex offenses under paragraph 1. of subdivision (4) of Section 15-20-21. Thereafter, any individual convicted of any offense set forth in the listing shall immediately be subject to this article and shall not be entitled to an administrative hearing as provided in subsection (a).

(c) The Director of the Department of Public Safety shall have authority to promulgate any rules as are necessary to implement and enforce the provisions of this article.

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