

Emergency Medical Services Protocol for Sexual Assault

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

I. Introduction

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

II. Objectives

- A. To provide quality emergency medical services and care to the sexual assault victim

- B. To assist in preservation of forensic material during the prehospital care of the patient

III. Recognition

A. Scene Response

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

B. Patient Evaluation

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

scene, please handle accordingly if patient is medically stable (see VII).

8. Screen for current pregnancy (2, 4, 5, 6).
9. Examine area of injury if the patient permits. In the absence of hemorrhage, there is rarely any need for visualization of genitalia by EMS.

IV. Treatment

A. Unstable patient:

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

B. Stable patient:

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

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

V. Transport

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

VII. Documentation

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

VII. Preservation and Handling of Evidence

- A. If asked to collect pertinent scene items (patient's clothing, used towels, etc.) place each item in its own paper bag and label with patient name. Plastic bags should not be used as moisture degrades important organic materials (2, 4, 6).
- B. Chain of custody must be maintained for each item to be valuable in the process.

- C. If the patient needs to urinate or vomit, the evidence should be preserved in a sterile or clean container (e.g. urine specimen container) if available (2, 4). This is especially important in drug-facilitated sexual assault (DFSA). Again, chain of custody must be maintained if these fluids are collected.
- D. Any on scene containers the patient believes may have been used in drugging should also be collected and custody maintained.
- E. While it is most likely law enforcement that will take any evidence from the scene, if EMS is asked to do any of the above, chain of custody is most easily done by having the patient keep the bagged material in their possession until seen in the emergency department.

RESOURCES

1. Centers for Disease Control and Prevention (CDC) – Injury prevention & Control: Data & Statistics. Web-based Injury Statistics Query and Reporting System (WISQARS), Nonfatal Injury Data. <http://www.cdc.gov/injury/wisqars/index.html>. Accessed June 25, 2012.
2. Norris, P. (2009). Sexual Assault. In Krohmer J.R., Sahni R., Schwartz B, Wang H.E. (Eds.), Clinical Aspects of Prehospital Medicine (pp. 155-160). USA: Mosby-Year Book, Inc., National Association of EMS Physicians.
3. National Center for Victims of Crime. Sexual Assault, <http://www.ncvc.org/ncvc/main.aspx?dbName=DocumentViewer&DocumentID=32369>. Accessed June 25, 2012.
4. Linden J.A. Clinical practice. Care of the adult patient after sexual assault. N Engl J Med. 2011 Sep 1; 365(9):834-41.
5. Ige O, Fawole O.I. Evaluating the medical care of child sexual abuse victims in a general hospital in Idaban, Nigeria. Ghana Med J. 2012 Mar;46(1):22-6.
6. American College of Emergency Physicians (ACEP): Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient. <http://www.acep.org/WorkArea/DownloadAsset.aspx?id=8984>. Accessed June 6, 2012.
7. EMS Response to Sexual Assault. Jimmy Futrelle. <http://theemtspot.com/2009/05/23/ems-response-to-sexual-assault/>. Accessed June 25, 2012.