Sexual Assault Response Team

National Guidelines on Referral and Forensic Clinical Examination Following Rape and Sexual Assault (Ireland).

4th Edition 2018

An Garda Síochána

Sexual Assault Treatment Unit SATU

Psychological Support Services

Sexually Transmitted Infections

Forensic Science Ireland

General Practitioner

Legal

Child and Adolescent Forensic Medical Assessments

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

TUSLA
An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

HSE Social Inclusion

AN ROINN DLÍ AGUS CIRT AGUS COMHIONANNAIS
DEPARTMENT OF JUSTICE AND EQUALITY

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Irish Sexual Assault Response Team

Strategic Vision, Working Philosophy and Mission Statement

Strategic Vision

We envisage all agencies **working effectively together** to provide the **optimum response** in a manner which reflects the core values of the mission and working philosophy of the National Sexual Assault Response Team.

The strategic vision will be realised by:

- Each **individual** being **informed** of their **options** and **supported** in **their decisions**.
- Engaging in **preventing** and **reducing** the incidence of sexual violence.
- **Continuous quality improvement** embedded in all national sexual assault response services.
- **Education** and **professional development** of the service providers being core to **enhancement** of service delivery.
- **Accountability** to **each person** availing of sexual assault services and society **as a whole**, with each organisation also **accountable** for their **participation** in an **inter-agency response** to sexual violence.

Working Philosophy

The **multi-agency team** believe that by **understanding** and **appreciating** the particular dynamics and **sensitivities** involved in **responding** to sexual violence, we can provide **individualised, timely, person-centred** services.

An **ongoing commitment** to the strategic vision and mission is demonstrated by **continuous quality improvement** and **services development**, including work on **prevention** and **reduction** of sexual violence.

Mission Statement

Our mission is to provide a **range of specialist multi-agency responses** following rape/sexual assault.

These services are delivered in a **respectful, non-judgemental** and **supportive** manner by **skilled, competent professionals.**

The above were developed, through collaborative inter-agency input from all the different agencies, which together make up the Irish Sexual Assault Response Team.

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Acknowledgement of Contributions
Many different agencies and individuals gave of their time, knowledge and expertise during the formation of this document, and the National SART Guidelines Development Group thank them all for their invaluable collective and individual contributions.

Acknowledgments and Thanks

The Irish SARTs Logo
Following a consultative process with the Staff of the Irish SATUs, Ms. Andrea Mears, developed and donated the Irish SARTs Logo which appears on the front cover of this document. For an explanation of the Logo please see the inside back cover

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Introduction

This is the fourth edition of the **'National Guidelines on Referral and Forensic Clinical Examination Following Rape and Sexual Assault (Ireland).'** As with previous versions of this document, it is designed to facilitate all aspects of a responsive and coordinated service for men and women over the age of 14 years who have been raped or sexually assaulted. We are delighted that this edition is updated with relevant additions to the various sections, as well as a whole new section on care of children and adolescents. This document therefore outlines comprehensive, best practice care for any survivor of sexual crime, regardless of their age, replacing the 3rd edition in its entirety.

The interagency and holistic nature of these guidelines enables consistent provision of high quality care at all stages of the journey, regardless of the person's age, circumstances of the incident or their involvement with criminal justice agencies. This document ensures that clearly defined referral pathways exist, so that men, women, children and adolescents can access appropriate individualised care that is responsive to their needs.

It is important to highlight that people respond to instances of sexual violence in different ways, and while this document provides guidance for compassionate and effective care, it does not represent the only medically or legally acceptable response. There may be circumstances where personal or clinical factors may mandate appropriate deviation from these guidelines.

The last edition of these guidelines introduced for the first time, guidance for collection and preservation of evidentially valuable forensic samples in circumstances where the person has yet to decide to report to An Garda Síochána. This was a really welcome development for Irish SATUs and brought us in line with international best practice. While the majority of those who attend SATUs after an acute incident do so in the context of an immediate report to An Garda Síochána, it is very reassuring that we can now offer an option, to those over the age of 18 years, to securely store forensic evidence which can be released in the event of a subsequent disclosure. This has the potential to increase reporting of sexual crime and indeed has been availed of by a considerable number of people since its introduction. Even though immediate reporting of an incident optimizes the legal and forensic response to a crime, delayed reporting is better than never reporting. The fact that forensic examination has been performed and biological evidence has been stored means that these can form part of a subsequent investigation.

As a service, and group of interagency professionals, we continue to be irrepressibly ambitious for the future. We remain involved with national and international programmes to reduce sexual crime but also continue to focus on provision of the highest standard of responsive care to those who need it. We are active participants in implementation of the COSC Strategy on Domestic, Sexual and Gender-based Violence. Ongoing developments within the SATU services that have occurred in conjunction with revision of these guidelines include development of a web-based, comprehensive, anonymous data collection platform which allows us to closely monitor key service activities as well as to assess and monitor various aspects of service provision, quality of care and interagency cooperation. These metrics are underpinned by the Mission, Vision and Philosophy of the services and also the patient documentation template. These developments are vital components of the interagency service that is provided.

In formulating the fourth edition of these guidelines, an evaluation of the 2014 edition was undertaken. This evaluation, combined with current best practice, provided the roadmap for updating this edition. Ongoing review and appropriate updating of these guidelines will be a continued objective of this group. Please forward any feedback and suggestions for future editions to SATU@rotunda.ie with the subject heading: Guidelines feedback/suggestions.

USING THE GUIDELINES

Operational Definitions/Glossary of Terms/Abbreviation List

In devising this book of guidelines, the diversity of language used by each discipline/agency has been recognised. In order to facilitate the reader, the correct terminology which is used by the different professionals is reflected in the section relevant to that discipline. For further clarity, operational definitions, glossary of terms and an abbreviations list have also been included (p. 229). The first time an abbreviation appears in the document, it follows the full text in brackets e.g. Rape Crisis Centre (RCC).

Quick Reference Pages

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

- Response to a History of Rape/Sexual Assault (p. 15-17).
- Contact Details for SATUs and Psychological Support (p. 18-19).
- Guide to Help Preserve Forensic Evidence Which May Be Available (p. 20-21).

Discipline/Agency Guidelines Colour Coding

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

An Garda Síochána	Sexual Assault Treatment Unit SATU	Psychological Support Services	Sexually Transmitted Infections	Forensic Science Ireland	General Practitioner	Legal	Child and Adolescent Forensic Medical Assessments

Boxes with Key Points

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

References

References used in a guideline are recorded directly after the relevant section of the particular guideline.

RESPONSE TO A HISTORY OF RAPE/SEXUAL ASSAULT

An Garda Síochána: Taking a Complaint of Rape or Sexual Assault

Physical & Psychological needs of the complainant are the priority

Medical Assistance	Scene
Initial Complaint	Identify Suspect(s)
Day/Date/Time/Place	Early Evidence Kit
Name/DOB/Address	Nil by mouth
Demeanour of complainant	Sexual Offences Examination Kit
Injuries/intoxication	Evidence Bags
State of Clothing	Scenes of Crime Examiner/Photographer
Vehicles used/Direction of Travel	

↓

Contact SATU for Forensic Clinical Examination (p. 18)

↓

- Use an unmarked car for transport to SATU (where possible)
- Accompanying Gardaí – plain clothes (where possible)
- Complainant brings change of clothes to SATU if possible

Subject to statutory reporting requirements e.g. Children First Guidance[1] or Withholding Information Act.[2]

GP or Emergency Department Response

Physical & Psychological needs of the patient are the priority

- Discuss contacting An Garda Síochána
- RCC personnel are available 24/7 to support the patient (p. 117)
- Discuss with the patient the relevance of contacting a SATU
- Depending on the circumstances (e.g. patient with serious injury), the Forensic Clinical Examiner can carry out the Forensic Clinical Examination at the referring hospital

If not involving a SATU:

- Examine patient, document findings and treat accordingly

Consider:

- Emergency contraception (p. 91)
- Chlamydia prophylaxis (p. 129)
- Hepatitis B vaccine (p. 129)
- HIV PEP (p. 130)
- Check re: child protection and safety issues – home is safe, support of family/friends
- Consider: Tusla referral and/or Primary Care Team referral, STI follow up

Subject to statutory reporting requirements e.g. Children First Guidance[1] or Withholding Information Act.[2]

Psychological Support Response

Physical & Psychological needs of the victim/survivor are the priority

- Support victims/survivors through each component of the SATU service that they choose.
- Serve as an information resource for victims/survivors.
- Provide victims/survivors with crisis intervention and support.
- Let victims/survivors know their reactions to the assault are normal and dispel misconceptions regarding sexual assault.
- Advocate for victims/survivors' self-articulated needs to be identified and their choices to be respected.
- Assist victims/survivors in planning for their safety and well-being.
- Link victims/survivors with relevant services.
- Help victims'/survivors' families and friends cope with their reactions to the sexual violence by providing information.

Subject to statutory reporting requirements e.g. Children First Guidance[1] or Withholding Information Act.[2]

SATU Response

Physical & Psychological needs of the patient are the priority

Following discussion and explanation the patient may choose from the following options:

Option 1: Forensic Clinical Examination and care (Section 2)

Option 2: Health check and care (Section 2)

Option 3: Collection and Storage of Forensic Evidence without Immediate Reporting to of An Garda Síochána (Section 2:21)

Subject to statutory reporting requirements e.g. Children First Guidance[1] or Withholding Information Act.[2]

Child and Adolescent Services Response

Physical & Psychological needs of the patient are the priority

- Urgent medical needs – local Emergency Department
- Urgent child safety concerns – contact Tusla / An Garda Síochána
- Other forensic opportunities – early evidence kit, clothing, nappies, bedding etc.

For Child and Adolescent Forensic Medical Assessment referral pathways see pages 186-189 for pre-pubertal and pubertal pathways

References

1 Department of Children and Youth Affairs (DCYA) Children First: National Guidance for the Protection and Welfare of Children. Dublin: Government Publications; 2017 www.dcya.ie

2 Government of Ireland. Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012. www.irishstatutebook.ie

Sexual Assault Treatment Units (14 years and above)

Location	Address	Email/Fax address	Tel. No.	Out of Hours
CORK South Infirmary, Victoria University Hospital (SIVUH)	Old Blackrock Rd., Cork.	satu@sivuh.ie	021 4926297	Phone Hospital 0214926100 Nurse Manager on duty for Hospital
DONEGAL Letterkenny University Hospital	Letterkenny University Hospital, Oldtown, Letterkenny, Co. Donegal.	satu.letterkenny@hse.ie	087 0681964 074 9104436	Phone 0870681964
DUBLIN Rotunda Hospital	Parnell Square, Dublin 1.	SATU@rotunda.ie	01 817 1736	Phone Hospital 01 817 1700 ask for SATU
GALWAY Hazelwood House	Parkmore Rd., Galway.	satugalway.hsewest@hse.ie	091 765751 087 6338118	Phone 091757631 Nurse Manager on duty for Merlin Park Hospital
MULLINGAR Midland Regional Hospital	Mullingar, Co. Westmeath.	satu.mrhm@hse.ie	044 9394239 086 0409952	Phone Hospital 044 9340221 Ask for Nursing Admin to be bleeped
WATERFORD University Hospital Waterford	Dunmore Rd., Waterford.	wrh.satu@hse.ie	051 842157	Phone Hospital 051 848000 Nurse Manager on duty for Hospital

Child & Adolescent Forensic Medical Services (under 14 years)

Location	Address	Email/Fax address	Tel. No.	Out of Hours
CAVAN/ MONAGHAN	Paediatric Department Cavan General Hospital Lisdarn, Cavan, Co Cavan.	Fax 049 4376801	049 4376474	No dedicated on call service. Cases can be discussed with Consultant Paediatrician Dr Nick van der Spek, when available, by contacting Cavan General Hospital: 049 4376000.
CORK AND KERRY Family Centre, St Finbarr's Hospital	Family centre, St Finbarr's Hospital, Douglas Road, Cork	Fax referral to Cork 021-4923192	021-4923302 Cork	No out-of-hours service in Cork/ Kerry at present – fax referral and contact 021-4923302 on next working day.
Kerry Community Services	Kerry Community Services, Rathass, Tralee, Co. Kerry	Fax referral to Cork 021-4923192	Contact Cork 021-4923302	If child has urgent medical needs – attend local Emergency Department If urgent child safety concerns – contact Tusla/An Garda Síochána.
DUBLIN Our Lady's Children's Hospital	Laurels Clinic, Our Lady's Children's Hospital, Crumlin, Dublin 12	laurels.clinic@olchc.ie	01 4096200	No out-of-hours service at present - contact 01 4096200 on next working day. If child has urgent medical needs – attend local Emergency Department If urgent child safety concerns – contact Tusla / An Garda Síochána
GALWAY Hazelwood House	CASATS / SATU, Hazelwood House, Parkmore Road, Galway	satugalway.hsewest@hse.ie	091 765751 087 6338118	Phone 091 544000 (Galway University Hospital) and ask for Nurse Manager on duty
WATERFORD University Hospital Waterford	Community Child Centre, University Hospital, Dunmore Road, Waterford		051 842691	No out of hours service – contact 051 842691 on next working day.

Psychological Support Contact Details

Location	Address	Email/Fax address	Tel. No.	Helpline
DUBLIN Rape Crisis Centre (RCC)	McGonnell House, 70 Lower Leeson Street, Dublin 2	info@rcc.ie	01 661 4911	24-Hour Helpline: 1 800 778 888
CARI	110 Lower Drumcondra Road Dublin 9	info@cari.ie	01 830 8529	1890 924 567

Preservation of Forensic Evidence

NB. Medical stability always takes priority

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

For All Types of Rape/Sexual Assault

- The type of seat the person sits on should be plastic, leather or a leatherette type covering.
- The person should not bathe/shower/douche.[1,3]
- If a condom was used, it should be retained.[1,2]
- The person should not consume food or drink, including alcohol after the assault until oral samples have been taken.[4]

Vaginal & Anal Rape/Sexual Assault

The person should not if possible:

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

If possible:

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

Oral Rape/Sexual Assault

The person should not if possible:

- Brush their teeth or use gargle in their mouth.
- Take fluid or food.
- Smoke.

Clothing

The person should if possible:

- Change out of the clothes worn at the time of the rape/sexual assault as soon as possible.
- Place the items of clothing in separate paper bags (not plastic) and label immediately[1] (See section 1:5).
- Underwear, worn after the incident, should also be collected and placed in a separate paper bag.[2]
- Do not handle clothing - if clothing is handled then it should be with gloved hands.

If clothing has to be cut:

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

Wounds and Blood/Saliva/ Semen Stains

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

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

- Do not talk, cough or sneeze over any specimens.[1-3]
- Do not handle specimens, but if specimen must be handled then do so with gloved hands.
- If bullets are handled then use gloved hands – metal forceps should NOT be used.
- Package specimens individually in an appropriate bag and label immediately.[4]

  NB. The continuity of evidence should be maintained

References

1 Giardino AP, Datner EM, Asher JB. Sexual Assault. *Victimisation across the Life Span: A Clinical Guide.* St. Louis: GW Medical Publishing Inc; 2003: p.85- 6.

2 Crowley S. Sexual Assault: *The Medical-Legal Examination.* Stamford, Connecticut: Appleton & Lange; 1999.

3 World Health Organisation (WHO). *Guidelines for Medico-Legal Care for Victims of Sexual Violence.* Geneva: WHO; 2003.

4 An Garda Síochána. *Garda Síochána Policy on the Investigation of Sexual Crime, Crimes against Children, Child Welfare.* 2013 www.garda.ie

SECTION 1:
AN GARDA SÍOCHÁNA

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1:1 Role of An Garda Síochána

An Garda Síochána is the **national police service** of the Republic of Ireland. It was established in 1922. An Garda Síochána is a **community based** service organisation with over 14,000 Gardaí and civilian employees. Garda Headquarters is situated at the Phoenix Park, Dublin with 564 Garda Stations throughout the State. (List of Garda Stations available at **www.garda.ie**)

The mission of An Garda Síochána is to deliver professional policing and security services with the trust, confidence and support of the people we serve. The functions of An Garda Síochána are outlined in section 7 of the Garda Síochána Act, 2005. The Criminal Justice (Victims of Crime) Act 2017 also requires certain procedures to be adopted by members of An Garda Síochána, with particular emphasis on the provision of information, protection and support to victims of crime.

The services provided by An Garda Síochána are determined and delivered in consultation and partnership with the community. They are constantly evolving to satisfy the requirements of the community. The key service concerns include: **preventing** criminal offences, **investigating** and **detecting** criminal offences, **informing, protecting and supporting** victims of crime, safeguarding **human rights** and dignity, guarding the **security** of the State, **preserving** the public peace, **responding** to emergencies, **contributing** to safety on the roads, **improving** the quality of community life and **enforcing** anti-drug legislation.

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

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

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

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

The Garda Youth Diversion Office at the Garda Bureau of Community Engagement is the national office for the management and implementation of the Diversion Programme.

The Diversion Programme offers young people who accept responsibility for their offending behaviour the opportunity of a caution instead of going to Court. A period of supervision by a Juvenile Liaison Officer (JLO) may follow the caution.

In addition, where other needs are identified, the young person will be referred to a Garda Youth Diversion Project (if one is available in their area), other clubs or projects in their community, or where the young person is out of school, arrangements can be made to link them into Youth Reach or other support services that will assist the young person and/or his or her family. The aim being that the young person gets appropriate support and he or she does not continue to get involved in offending behaviour. The intended outcome of the Programme is to divert young people from committing further offences.

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

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

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

See also

The Law in Relation to Sexual Offences in Ireland (Section 7).

1:2 Initial Actions on Receipt of a Complaint

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

- The Garda Síochána Policy on the Investigation of Sexual Crime, Crimes Against Children and Child Welfare.
- Chapter 23 of the Garda Síochána Code.
- The Garda Síochána Crime Investigation Techniques Manual.
- Children First: National Guidance for the Protection and Welfare of Children.
- Joint Working Protocol for An Garda Síochána / Tusla – Child and Family Agency Liaison.
- Other relevant Garda H.Q. Directives.

An Garda Síochána:
Taking a Complaint of Rape or Sexual Assault

Physical & Psychological needs of the complainant are the priority

Medical Assistance	Scene
Initial Complaint	Identify Suspect(s)
Day/Date/Time/Place	Early Evidence Kit
Name/DOB/Address	Nil by mouth
Demeanour of complainant	Sexual Offences Examination Kit
Injuries/intoxication	Evidence Bags
State of Clothing	Scenes of Crime Examiner/Photographer
Vehicles used/Direction of Travel	

↓

Contact SATU for Forensic Clinical Examination

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- Use an unmarked car for transport to SATU (where possible)
- Accompanying Gardaí – plain clothes (where possible)
- Complainant brings change of clothes to SATU if possible

Subject to statutory reporting requirements e.g. Children First Guidance[1] or Withholding Information Act.[2]

Initial Actions

Members should arrange for the immediate provision of medical attention where required and the victim's removal to hospital when deemed necessary and appropriate.

The first Garda member to respond and investigating members should take note of the following:

- Time and date of complaint
- Full particulars of the complaint
- The general state and demeanour of the complainant – signs of mental shock or distress
- Any evidence of injury or marks, intoxication or drugs
- The state of clothing – torn or disarranged; buttons or jewellery missing; stains of mud, earth, blood or semen on clothing
- Detailed description of the scene
- Details of vehicles used and direction of travel

Where refreshments have been requested, members should be mindful of the fact that evidence could be lost from the mouth or surrounding area.

Complainants should be provided with appropriate information including a copy of the Garda Síochána leaflet 'Information for Persons Reporting Sexual Crime & Child Abuse'. Members should guide the complainant to the 'Useful Contacts and Links' section of the leaflet. The leaflet is available on the Garda Portal.

Sensitivity to Complainant

Disclosing a sexual offence is often difficult for a complainant. Gardaí should adopt a caring, sensitive and non-judgemental approach throughout the entire investigative process. Investigating Gardaí should bear in mind the emotional and physical pain the complainant may be suffering (See 3:2), while ensuring that all available evidence regarding the reported offence is obtained. On receipt of a complaint, a member of An Garda Síochána should, where a Forensic Clinical Examination is required, adhere to the following steps:

- Be aware of the needs of the complainant at all times.
- Immediate medical assistance should be sought, if necessary.
- The investigation process must be explained to the complainant.
- It should be established if the complainant consents to a Forensic Clinical Examination.
- Where the complainant is under 18 years of age, the consent of the parents/guardians is also required.
- Contact is made with a Sexual Assault Treatment Unit/Forensic Clinical Examiner to arrange a prompt Forensic Clinical Examination.
- Use an Early Evidence Kit where necessary and appropriate.
- Use an unmarked patrol car, where possible, in taking the complainant to the Sexual Assault Treatment Unit/Forensic Clinical Examiner.
- Gardaí attending the SATU should dress in plain clothes (where possible) to avoid identification of the complainant.
- If possible, avoid using areas of the Hospital where the complainant could be identified.

KEY POINTS

KEY POINTS: Sensitivity to Complainant

- Explain procedures.
- Consent sought for Forensic Clinical Examination.
- Use unmarked patrol car where possible.
- Gardaí should dress in plain clothes if possible.
- Avoid areas where complainant may be identified if possible.
- Use Early Evidence Kit if indicated (See 1:3).
- Change of clothing brought with complainant to SATU.
- Be aware and sensitive to the needs of the complainant.

Preventing Contamination of Evidence

- Separate vehicles should be used to transport each complainant and each suspect to prevent cross-contamination.
- To prevent the cross-contamination, of evidence (See 5:5); ensure any suspect(s) are not brought to any place that a complainant has been.
- If there are two or more complainants, then different vehicles should be used to transport them.
- To prevent cross-contamination the member dealing with the victim should not have physical contact with any suspect(s) (and vice versa) prior to the taking of forensic samples, clothing, etc from the victim and/or suspect(s).
- A change of clothes for the complainant should also be taken to the SATU if possible.

KEY POINTS

KEY POINTS: Preventing Contamination of Evidence (See 5:5)

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

1:3 Early Evidence Kits Oral or Drugs/Alcohol Facilitated Rape/Sexual Assault

With every hour that passes following a report, physical evidence may deteriorate or be lost. An Early Evidence Kit is available to be used by members of An Garda Síochána in cases of rape/ sexual assault.

It is to be used primarily in cases where:

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

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

The early evidence kit contains:

Instructions, disposable gloves, 5 swabs, small universal container, large container for urine sample, sterile water and a tamper evident bag.

Availability and Use of the Early Evidence Kit

- The Early Evidence Kit should be available in all Garda stations so that it can be accessed quickly.
- The Early Evidence Kit is not a replacement for the existing Sexual Offences Examination Kit, or for the Forensic Clinical Examination.

Procedure when using the Early Evidence Kit

- The Garda who is present for the collection of these samples should have no prior contact with the suspect.
- Check the expiry date on the Early Evidence Kit.
- Gloves must be worn.
- Explain the purpose of the Early Evidence Kit to the complainant.
- Obtain from the complainant her/his written consent for the collection of the samples before using the Early Evidence Kit.
- To enable the Forensic Scientist to interpret any results obtained, the Garda must fill out the information form accompanying the Early Evidence Kit.
- If/when a Forensic Clinical Examination is carried out on the complainant, the Forensic Clinical Examiner should be informed that the Early Evidence Kit was used and whether urine and/or oral swabs have been taken.
- The Garda Portal contains further instruction on the use of Early Evidence Kits.

Box: Oral Sex

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

- Gloves must be worn and swabs should be pre-labelled by the Garda with the victim's name and the site that the sample was taken from.
- If the reported sexual assault occurred more than 24 hours prior to presentation, there is no need to take oral swabs, as semen does not persist in the mouth beyond this time (See 5:5, Table 16).

Box: Drug/Alcohol Facilitated Rape/Sexual Assault

- If the complainant wishes to urinate and there is a delay getting a Forensic Clinical Examiner, a urine sample should be collected at this point.
- A large container is available in the Early Evidence Kit for the collection of urine. This can then be decanted into the smaller screw cap container provided.
- A Garda should witness the urine sample being taken and fill in the accompanying information form. Standing outside the cubicle is deemed adequate for witnessing.
- Urine samples collected from complainants of drug facilitated rape/ sexual assault are analysed at Forensic Science Ireland. A urine sample should be collected as soon as possible after the incident and up to 120 hours after the reported assault (See 5:8 on Toxicology).

KEY POINTS

KEY POINTS: Using Early Evidence Kit

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

Swab sites

- Inside the mouth.
- Gums/teeth.
- Lips.
- Inform the Forensic Examiner when an Early Evidence Kit has been used.

1:4 Continuity of Evidence

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

Each item is packaged individually in the appropriate bag and sealed and labelled immediately.

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

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

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

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

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

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

1:5 Collection of Clothing from the Complainant

- To avoid contamination, use gloves and other personal protection equipment (such as disposable coats) as required.
- The Garda who takes possession of the complainant's clothing should have no prior contact with the suspect.
- The Garda should establish whether these clothes have been washed since the reported rape/ sexual assault.
- Possession should be taken of the clothing the complainant was wearing **during** the reported rape/ sexual assault, preferably **before** attending for a Forensic Clinical Examination to preserve evidence.
- Where the change of clothes has taken place prior to the Forensic Clinical Examination, the need to take possession of the new clothing, particularly underwear, may also be considered. Replacement clothing should be brought to the SATU to allow for this eventuality. Exhibit bags should be available for such an occurrence.
- Each garment/item should be placed in a separate exhibits bag.
- The exhibit bags should be sealed and clearly labelled by the Garda. Paper bags should be sealed by folding over the top of the bag twice and securing with staples or sellotape.
- If envelopes are used for smaller exhibits, these **should not** be sealed by licking.
- If the clothing is **dry**, pack items into separate sealed paper bags (Wet clothes - see Box overleaf).
- Sanitary protection should be packed in paper bags supplied in the Sexual Offences Kit and then placed in the appropriate re-sealable plastic bag labelled "Panties/Sanitary Module", if the sanitary protection is still on the underwear, do not remove it.
- Continuity of evidence (See 1:4) should be maintained at all times.

KEY POINTS

KEY POINTS: Colds/Allergy/Hay fever

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

Box: Wet or Heavily Blood Stained Clothing

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

1:6 Attendance at the Sexual Assault Treatment Unit

When a member of An Garda Síochána receives a report of a recent rape or sexual assault an appointment with a Sexual Assault Treatment Unit should be made as a matter of urgency. SATU services are also provided for children under 14 years of age by Children and Adolescents Sexual Assault Treatment Services (CASATS). Sexual Assault Treatment Units provide a wide range of services apart from the forensic examination, which include:

- Medical care of the victim
- Prevention/Treatment of Sexually Transmitted Infections (STIs)
- Emergency contraception
- Psychological support

Critical Time Considerations

Urgent medical care may be required. Following the commission of a sexual crime, evidence of the presence of semen can be lost from the mouth within 6 hours; from the rectum within 24 hours; and from the vagina within 48 hours. Ideally STIs such as Hepatitis B and other infections including HIV need to be treated within 48 hours and 72 hours respectively. To be most effective, emergency contraception should be administered soon as possible, however can be administered up to 120 hours. Alcohol and other substances begin to reduce in the body within 24 to 48 hours. The sooner a victim of sexual crime is provided with psychological support, the more beneficial it can be.

Getting to the Sexual Assault Treatment Unit (SATU)

An appointment should be made as soon as possible by telephoning the appropriate SATU, depending on the location. See page 18 for SATU contact details where the complainant is aged 14 years and over. See page 19 for SATU contact details where the complainant is under 14 years of age.

Garda members should dress in plain clothes and use an unmarked patrol car, where possible, in taking the complainant to the Sexual Assault Treatment Unit/Forensic Clinical Examiner.

If possible, a change of clothes should be arranged for the complainant.

Where there is a complaint of oral penetration or drug/alcohol-facilitated rape/sexual assault, the Early Evidence Kit should be used at the Garda station as soon as possible. The Forensic Clinical Examiner should be informed of the use of the kit. Where it has not been possible to use the Early Evidence Kit members should ensure as far as possible that the complainant take nil by mouth.

When making the appointment at the SATU, members should ensure that there is a Sexual Offences Examination Kit available at the SATU.

A Scenes of Crime Examiner should be requested to attend the SATU to photograph any non-intimate injuries reported by the complainant to have been received in the course of the assault. The photographing of the injuries will be organised in consultation with the Forensic Clinical Examiner.

Members should bring adequate evidence bags to the Forensic Clinical Examination.

Forensic Clinical Examination

The Garda member should inform the Forensic Clinical Examiner if clothing has been collected or the early evidence kit has been used prior to attendance at the SATU. The Forensic Clinical Examiner may collect the clothing (in particular the underwear) of the complainant even when this has been done by the Garda member prior to the examination. Any clothing collected at the SATU should be retained as exhibits.

The Garda member should ensure that each sample has been correctly labelled by the Forensic Clinical Examiner, and that the examiner has signed each sample. The Garda should sign each sample.

Cancellation of Forensic Examination

Where the forensic examination is cancelled for any reason, the investigating Garda must ensure that all relevant persons are immediately informed, such as the SATU providing the Forensic Clinical Examination, Scenes of Crime Unit, Photographic Section, etc.

1:7 Collecting the Complainant's DNA

When the forensic clinical examination is complete, a member of An Garda Síochána must conduct the voluntary collection of the complainant's DNA pursuant to Section 27(4) of the Criminal Justice (Forensic Evidence and DNA Database System) Act 2014. This should not be done before or at the SATU but at a later date to prevent the unintentional collection of a suspect's DNA. Where practicable, the voluntary collection of the complainant's DNA should occur on the next occasion that a Garda member meets with the complainant. The complainant should be consulted as to the gender of the Garda member who takes the sample.

Prior to collecting the complainant's DNA, the Garda member should obtain the complainant's written consent in the prescribed form. Forms are available on the Garda Portal for the following categories of complainant:

- Persons over the age of 18
- Children of 14 years of age and over
- Children under the age of 14
- Protected persons

When the child is 14 years of age and over, the consent of the child and the parent or guardian is required. When the complainant is a protected person or child under the age of 14, only the consent of the parent or guardian of the complainant is required.

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

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

- Keep the medical form separate from the kits; do not put it in the tamper evident bags. The form must be submitted by the Gardaí when submitting the kit/s to Forensic Science Ireland.
- Samples should be packed in the tamper-evident bag provided in the Sexual Offences Examination Kit.
- On completion of the Forensic Clinical Examination, the Garda member packs, seals, dates and signs the tamper-evident bag in the presence of the examiner. The Forensic Clinical Examiner completes, signs and dates the Sexual Offences Examination Form, which is then attached to the outside of the sealed bag.
- Samples for toxicology are kept separate from the Sexual Offences Examination Kit.
- Toxicology samples (i.e. alcohol/drug module), if taken, should be packaged in the new tamper evident bag provided for this purpose in all alcohol/drug modules.
- The Garda should keep a record of the Serial Number on the tamper evident bag(s) containing the Sexual Offences Examination Kit and on the Toxicology Kit.
- The Sexual Offences and Toxicological Kits should be transported to Forensic Science Ireland, as soon as possible, by a member of An Garda Síochána, but in the interim the Kits should be kept in a fridge in a secure location.
- Continuity of evidence should be maintained at all times (See 1:4).

KEY POINTS

KEY POINTS: Transfer and Storage of the Kits

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

1:9 Option 3: Collection and Storage of Forensic Evidence Without Immediate Reporting to An Garda Síochána

This care pathway (Option 3) allows for the collection and preservation of evidentially valuable forensic samples, in circumstances where the person has yet to decide to make a complaint to An Garda Síochána. Women and men over 18 years of age can now choose to undergo an examination and collection of forensic samples, which will then be stored in an appropriate facility within the SATU for up to one year.

If the incident happened in another jurisdiction, Option 3 is still available, but the evidential value of the samples will be subject to the national law of that jurisdiction. As such there may be unforeseen restrictions on their probative value.

When a complaint is made to An Garda Síochána of a rape or sexual assault having occurred at any time within a year prior to the complaint being made, the Garda member taking the complaint should establish whether the complainant has availed of Option 3.

Mechanism for Formally Reporting to An Garda Síochána

- A person may make a formal report either directly to An Garda Síochána or via a Rape Crisis Centre or SATU.
- Contact is made with the Garda Station local to where the incident happened.
- The complainant may inform the member taking the report that forensic evidence is currently being stored in the relevant SATU. The complainant may simply advise the Garda that they have availed of Option 3.

An Garda Síochána: Process

- The complainant is treated as a **first time reporter.** The Garda member follows the procedures as outlined above with the following exceptions:
  - The Forensic Clinical Examination has already been conducted.
  - The investigating Garda must make arrangements for transporting the forensic evidence from the relevant SATU to Forensic Science Ireland.
- The complainant is requested to sign the appropriate consent form for the release of stored forensic evidence and a legal report from the SATU to An Garda Síochána.
- The investigating Garda informs the relevant SATU as soon as possible that a formal report has been made.
- The investigating Garda will ensure that an appointment is made with the SATU, to collect the stored forensic evidence and, when available, the legal report from the Forensic Clinical Examiner.
- The Garda responsible for collecting the forensic evidence brings the completed consent form to the SATU, authorising the release of the stored forensic evidence and issue of a legal report.
- The Garda and SATU staff confirm the integrity of the tamper evident bags prior to signing the stored evidence record. Any irregularity is documented by the Garda.

- The Garda completes the SATU Stored Evidence Record form for continuity of evidence and two photocopies are made.
- The original copy is retained by the SATU.
- The two photocopies are taken by the attending Garda:
  - One photocopy is retained by the Gardaí ('true copy') as a possible future exhibit with regard to continuity of evidence.
  - Second photocopy will be taken by the Gardaí with the forensic evidence to Forensic Science Ireland.
  - The investigating Garda should check with the complainant whether s/he had decided to self-store relevant items of clothing and, where appropriate, arrange for the delivery of such clothing to Forensic Science Ireland.
  - The Garda transports the Sexual Offences Examination Kit and the Toxicology Kit in a cool box and a copy of the completed SATU Stored Evidence Record form to Forensic Science Ireland. Where possible a Scenes of Crime Examiner should arrange to collect the forensic evidence from the SATU and deliver it to Forensic Science Ireland on the same day.

1:10 Interviewing the Complainant

Following a complaint of rape or sexual assault, a member of An Garda Síochána should interview and take a statement in writing from the complainant. Members should first ensure that the investigation process is explained to the complainant. The interview should be conducted as soon as is practicable in a suitable location for the complainant and the Garda, balancing the needs of the investigation with the needs of the complainant. Level 3 Advanced Interviewers should be considered to take these statements unless circumstances indicate that it should be a specialist interviewer. The statement will contain a detailed account of the events leading up to the incident, the incident itself and the events following the incident. It will be the complainant's account of what took place and any other salient information that may assist the investigation. The statement will provide a written record that will allow a decision to be made on the appropriate action to be taken.

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

1:11 Specialist Interviewers and Dedicated Interview Suites

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

- A sexual offence.
- An offence involving violence or threats of violence to a person.

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

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

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

Garda, HSE and Child & Family Agency (Tusla) personnel throughout the State have received extensive training as Specialist Interviewers and must be employed where appropriate in the circumstances outlined above.

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

KEY POINTS

KEY POINTS: Taking a Statement

Specialist Interviewers and Dedicated Interview Suites:

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

Detailed Account Taken of:

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

On Completion of the Statement:

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

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SEXUAL ASSAULT TREATMENT UNIT (SATU)

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2:0 Sexual Assault Treatment Units – Introduction

Sexual Assault Treatment Units (SATUs) in the Republic of Ireland aim to provide **holistic, responsive and patient focused care**[1] for **women and men** who have experienced **sexual crime**. SATUs need to be appropriately staffed and available **around the clock** to allow **prompt** provision of **medical** and **supportive care** and collection of **forensic evidence.** SATUs in Ireland work within the context of a core agreed upon **model of care**, which includes defined **multiagency guidelines** and choice of **care pathways**,[2] close links with the Rape Crisis Network Ireland, Forensic Science Ireland, An Garda Síochána[3] and allied specialties including Social Services, Tusla: The Child and Family Agency and Infectious Disease Clinics. Such a **nationally agreed upon service** is invaluable so that all patients are assured of receiving a **high quality, standardised care package**,[4] regardless of where or to whom they disclose.[5] Delivery of care is against the background of the Irish Sexual Assault Services: Strategic Vision, Working Philosophy and Mission.

In addition, SATUs participate in patient, staff and community **education** and **risk reduction** programmes. SATUs also contribute to development, evaluation and implementation of **national strategies** on domestic, sexual and gender based violence.[2, 4, 5, 6]

2:1 Pre-requisites for All SATU Staff

- Have (or be in the process of undertaking) training in providing services and care for victims of sexual violence (relevant to the role to be undertaken).
- Have (or be in the process of undertaking) a local SATU induction programme, relevant to that particular SATU.
- Have a working knowledge of the current edition of the National SATU Guidelines and local SATU protocols/policies/guidance.
- Be committed to participating in an around-the-clock, on-call rota, as part of a coordinated SATU response.
- Be willing to respond within a defined timeframe i.e. within 3 hours from call to commencing the Forensic Clinical Examination. **(KPI).**[i]

2:1.1 On-going Commitment to SATU:

- Attend relevant local liaison and update meetings etc.
- Participate, if applicable, in local/national Peer Review Meetings on a quarterly basis.
- Engage in supervision and avail of appropriate learning opportunities.
- Address own health and wellness needs, mindful of this challenging area of care.
- Participate, if, applicable in National Study Day.

NB. The above lists are not definitive or exhaustive.

Key Performance Indicator

[i] **KPI:** % of patients seen by a Forensic Clinical Examiner, within 3 hours of a request to SATU for a Forensic Clinical Examination (See Appendix 1: Record of Request for SATU Services).

2:2 Forensic Clinical Examiner Role

The Forensic Clinical Examiner has many roles. **A caring, non-judgemental** approach is of the utmost importance when providing services for a victim of sexual crime. The Examiner should clearly convey that no one deserves to be raped, and the patient is not responsible for the assault. The person should be reassured that she/he made the best choices possible, under the circumstances (See Box 1). It is important to remember, that the person may not recollect the entire incident (See 3:2), or may be unable or unwilling to talk about some aspects of the incident.

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

Consent for all of the procedures undertaken should be obtained after a thorough explanation. Healthcare providers are responsible for **documenting** the pertinent aspects of the **history**, performing a careful **physical examination**, collecting the required **forensic material, treating physical injuries** that have resulted from the assault, **providing care** in terms of prophylaxis against pregnancy and sexually transmitted infections and ensuring that there is appropriate psychological support.[2]

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

An **objective report** of the history and examination findings is prepared, and it may include an interpretation of the findings (See 2:20). The report is best **prepared as soon as possible, (KPIs)**[i,ii] while the details remain fresh in the Forensic Clinical Examiner's mind.

KEY POINTS

KEY POINTS: Forensic Clinical Examiner Role

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

Key Performance Indicator

i KPI: % of patients who had the opportunity to speak with a Psychological Support Worker at the first SATU visit.

ii KPI: % of patients seen by a Forensic Clinical Examiner, within 3 hours of a request to SATU for a Forensic Clinical Examination.

2:3 SATU Support Staff

The SATU Support Staff plays a key role in helping to co-ordinate responsive SATU care. This role is vital in prioritising the patient's need for support and reassurance throughout their SATU attendance.[7] Traditionally this role has been provided by registered nurses and midwives ('assisting nurses'), but Units may choose to train and support other appropriately skilled staff members to provide this care. A local guideline/policy should outline specific responsibilities of the SATU Support Staff to ensure that the patient receives the highest standard of responsive care[1] throughout their SATU attendance. Support Staff may be called upon by the Gardaí to give a statement and may be requested to attend court.

In particular the following points should be considered:

Pre-examination

- Relevant personnel are informed that a case is commencing/ongoing e.g. Nursing/Midwifery Administration, Security Staff.
- Ensure that the Rape Crisis Centre (RCC) Psychological Support Worker has the opportunity to meet with the patient. **(KPI)**[i]
- Follow the local anti-DNA contamination protocol regarding SATU preparation before a case.
- Keep accurate relevant documentation including documenting delays. **(KPI)**[ii]

Arrival of Patient

- Introduce yourself and guide patient to waiting room.
- Ensure patient's wellbeing is treated as a priority.
- Introduce RCC/CARI psychological support worker to the patient.
- Provide patient with information regarding the Forensic Examination and reassure them that you will be with them throughout.
- Record patient's details and contact information.

During the Examination

- Be with the patient, providing support and encouragement in a chaperone capacity.
- Answer questions or queries, if required.
- Assist the Forensic Clinical Examiner, with appropriate care provision within scope of practice. This may include documentation of weight and height, performing a urinary HCG (pregnancy) test, cleaning and dressing of wounds and administering prescribed medications according to professional guidance.[8]
- Prevent contamination of forensic samples (See 5:5).

Key Performance Indicator

i KPI: % of patients who had the opportunity to speak with a Psychological Support Worker at the first SATU visit.

ii KPI: % of patients seen by a Forensic Clinical Examiner, within 3 hours of a request to SATU for a Forensic Clinical Examination.

Post-examination Care

- Offer the patient a shower and change of clothing.
- Facilitate the patient spending time with the Psychological Support Worker prior to discharge.
- Ensure patient is informed of follow up appointment details.
- Ensure patient is provided with contact information for the SATU of attendance, including relevant leaflets and information.

Following Completion of a Case

- Complete the SATU register and any relevant documentation.
- Best practice procedures followed for blood spillages, laundry, used instruments etc.
- Ensure the local anti-DNA contamination protocol re: actions on completion of a case is followed.
- Leave the SATU prepared and ready to receive the next patient.
- Inform appropriate personnel that the case is finished and the SATU is vacated.

All SATU Staff: Some Do and Don'ts

Box 1: Some Do and Don'ts When Receiving the Patient

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

2:4 Evaluation of Patients with Serious Injury

The Forensic Clinical Examiner is sometimes asked to evaluate a patient who has significant physical injury. In this circumstance, life threatening conditions must be dealt with as a priority, and the Forensic Clinical Examination can then be performed after stabilisation of the patient. Depending on the circumstances, the Forensic Clinical Examiner may carry out the Forensic Clinical Examination at the referring Hospital (See Box 2, overleaf). In these situations, it is important to document the extent and reason for any delay (See consent re: unconscious patient: 2:5.3).

Box 2: Forensic Clinical Examination in Locations Other Than a SATU

In certain circumstances (e.g. co-morbidities, security concerns) it may be necessary to conduct an examination outside the confines of a dedicated SATU.

The following points should be noted:

1. A liaison person should be identified by the Hospital or other facility where the Forensic Clinical Examination is to be carried out.
2. Both the Forensic Clinical Examiner and SATU Support Staff should attend such cases.
3. Each SATU should have a defined list of items to be brought to a case. This list should include a set of patient documentation, including patient labels, Sexual Offences Examination Kit, equipment and disposable linen (if available).
4. Medications that may be required should also be brought – e.g. Emergency Contraception, Chlamydia prophylaxis, Hepatitis B immunisation and PEP (HIV).
5. Consideration needs to be given to potential sources of DNA contamination in the location of the Forensic Clinical Examination (e.g. Emergency Department).
6. Appropriate cleaning of the location prior to the examination and minimisation of staff throughput during the examination are important factors.
7. Forensic samples are taken and given directly to An Garda Síochána, to ensure the continuity of evidence from the moment of collection.
8. Patient information and appointment cards should be provided to facilitate ongoing patient care.
9. Appropriate follow up including RCC/CARI is organised.
10. Consent and the unconscious patient (See 2:5.3).

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8 Nursing and Midwifery Board of Ireland. *Guidance to Nurses and Midwives on Medication Management*. July 2007. www.nmbi.ie/

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10 European Union Agency for Fundamental Rights. *Violence against women: an EU-wide survey*. 2014; p. 58. http://europa.eu

11 Dalton, M. Forensic Gynaecology: Towards better care for the female victims of sexual assault. Plymouth: RCOG Press; 2004.

2:5 Consent to Forensic Clinical Examination

The purpose of a Forensic Clinical Examination is explained to the patient in a way that they can understand.[1] The patient should be fully informed throughout the process, allowing them to make informed choices about their care.[1,2] The patient is entitled to be accompanied during any such discussion by an advocate of their choice.[3,4] A patient's consent should be given freely, voluntarily and without coercion providing that s/he is of the legal age and has the mental capacity to consent.[1,2,3]

Box 3: Consent

Consent is obtained when:

- The patient is fully informed, is of legal age and has the mental capacity to provide consent.

Remember

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

Consent is witnessed and signed by:

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

An outline of what should be explained to the patient prior to obtaining consent for Forensic Clinical Examination can be found in the National SATU Patient Documentation. It is vital to ensure that the patient understands that personal details, details of the incident, examination findings as well as a record of forensic samples will be documented and may be disclosed to criminal justice agencies. The patient should be advised that other details recorded in the Patient Documentation, including follow-up STI screening etc may also ultimately be disclosed to criminal justice agencies if requested.

The consent form should be read and explained to the patient. At each section, a tick box is completed to indicate if the patient agrees with each of the elements of the consent. The Forensic Clinical Examiner then obtains written informed consent for the Forensic Clinical Examination from the patient/parent or guardian. The attending member of An Garda Síochána, if appropriate, and the SATU Support Team Member witness and sign the consent.

Consent is also appropriately sought for:

- Any care/treatment given.
- Provision of a report to the GP regarding their attendance at the SATU.
- Future contact with the patient and methods of contact they would prefer.
- Anonymous use of records for inclusion in the national database and potential future research.
- Contact in the future with regard to further research.

2:5.1 Special Considerations Re: Consent

Age

Current and various aspects of legislation should be considered when obtaining consent for someone less than 18 years of age prior to performing a Forensic Clinical Examination (see Table 1). The Childcare Act 1991[5] prescribes that due consideration must be taken of the wishes of the child as the child increases in age and understanding and the Children First Act, 2015, regards the best interests of the child as paramount.[6] If a parent or guardian is signing the consent, the young person, if appropriate, should also be encouraged to co-sign the consent form.

Guidance in obtaining consent for children under 18 years can be obtained from the HSE National Consent Policy.[2]

Table 1: Consent and Age Considerations

NB. Excerpts only – Each Act is available in full at www.irishstatutebook.ie

Age	Legal Consideration	Legal Reference
16 years	"A minor who has attained 16yrs can consent to surgical, medical and dental treatment."	Section 23: Non-Fatal Offences Against the Person Act (1997)[7]
< 18 years	A 'child' means a person under the age of 18 years other than a person who is or has been married." The Child Care Act states that: "in so far as is practicable, give due consideration, having regard to their age and understanding, to the wishes of the child." Amendment to the Constitution of Ireland: "……. in respect of any child who is capable of forming his or her own views, the views of the child shall be ascertained and given due weight having regard to the age and maturity of the child."	Childcare Act (1991).[5] Children First: National Guidance (2017).[8] Thirty-First Amendment of the Constitution (Children) Act 2012.[9]

Table 1: Consent and Age Considerations (Cont)

NB. Excerpts only – Each Act is available in full at www.irishstatutebook.ie

Age	Legal Consideration	Legal Reference
	Withholding of Information Act, "a person shall be guilty of an offence if– (*a*) he or she knows or believes that an offence, that is a Schedule 1 offence, has been committed by another person against a child, and (*b*) he or she has information which he or she knows or believes might be of material assistance in securing the apprehension, prosecution or conviction of that other person for that offence, and fails without reasonable excuse to disclose that information as soon as it is practicable to do so to a member of An Garda Síochána."	Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012.[10] **NB.** This Act also applies to vulnerable adults.
	The Children First Act, 14(1) Mandated Persons states: " …. where a mandated person knows, believes or has reasonable grounds to suspect, on the basis of information that he or she has received, acquired or becomes aware of in the course of his or her employment or profession as such a mandated person, that a child– (*a*) has been harmed (*b*) is being harmed, or (*c*) is at risk of being harmed, He or she shall, as soon as practicable, report that knowledge, belief or suspicion, as the case may be, to the Agency." Part 1 (7) "...The Agency (Child and Family Agency), in performing a function under this Act, regard the best interests of the child as the paramount consideration."	Children First Act (2015).[6]

For a person under the age of 18 years, the statutory reporting requirements of Children First: National Guidance [8,11] and Withholding of Information Act, [10] should be followed.

2:5.2 Capacity

The Assisted Decision-Making (Capacity) Act 2015[12] states that "...a person's capacity shall be assessed based on his or her ability to understand, at the time that a decision is to be made, the nature and consequences of the decision to be made by him or her in the context of the available choices at that time." [12, 13]

Vulnerable Persons

A vulnerable person is an adult who may be restricted in capacity to guard herself/himself from harm or to report such harm. Restriction of capacity may occur because of physical or intellectual disability.[14] Vulnerability to abuse is influenced by both context and individual circumstances.[14]

Assessment of Capacity

There is a presumption of capacity,[2 4,12,13,14] unless proven otherwise,[12,13,14] for every person who has reached the age of majority, which is 18 years of age.[15] All practical steps have to be taken to support a person in terms of decision-making capacity before it can be decided that she or he lacks capacity.[2,4,12,14] Capacity should focus on the specific decision that needs to be made, at the specific time the decision is required.[2,12] It does not matter if the capacity is temporary, or the person retains the capacity to make other decisions, or if the capacity fluctuates. The assessment of capacity is issue or task-specific.[2,4,12,] A person cannot be deemed to lack decision-making capacity simply because there is a risk that she or he might make an unwise decision.[2,4,12,14] It is important to give those who may have difficulty making decisions the time and support they need to maximise their ability to make the decision for themselves[2,4,12,14] (See Box 4).

Box 4: To Demonstrate Capacity the Patient Should Be Able To:

a) Understand in simple language what the Forensic Clinical Examination is, its purpose and nature and why it is being proposed.

b) Understand the principal benefits, risks and alternatives.

c) Understand in broad terms the consequences of not having a Forensic Clinical Examination and appropriate treatment.

d) Retain the information for a sufficient period, to consider it and arrive at a decision.

e) Communicate that decision whether by talking, writing, using sign language, assisted technology or any other means of communication.[2, 12]

Assisted Decision-Making

The underpinning philosophy of the Assisted Decision-Making (Capacity) Act 2015,[12,] is that all persons have equal legal rights. A person, who may be deemed to lack capacity to make her or his own decisions due to a disability, life-long condition or acquired condition, may require assistance and support to exercise his or her individual rights. These rights are protected under the Constitution of Ireland, the European Convention on Human Rights and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).[16]

Support must be given to people who may have difficulty making and communicating decisions. It also requires that the past will and preference of the person, and their beliefs and values, insofar as is practicable and reasonably ascertainable, are considered, even when she or he has been found to lack decision-making capacity. [2, 4, 16]

The Forensic Clinical Examiner should work from a position of enabling the person's decision making rather than purely from a best interests viewpoint. If an adult patient lacks capacity to decide, the Forensic Clinical Examiner must take reasonable steps to find out if anyone else has the legal authority to make decisions

on the patient's behalf.[4] If so, the Forensic Clinical Examiner should seek that person's consent to the proposed treatment. [4]

In situations where there is no one with legal authority to make decisions on the patient's behalf, then the Forensic Clinical Examiner must consider what is in the patient's best interest.[4] Consideration should weigh up a range of factors (including the wishes or preferences, if known, of the person and the views of their families and carers) and decide what is on balance, the best for the person both now and in the future.[2,4,12,16] 'Best interests' encompasses not only medical but also 'emotional and all other welfare best interests'.[17] The aim is to build up a picture of the person's preferences so that the action taken will tally with what the person would have wanted, had she or he been able to say so.[2,4,17]

2:5.3 Patient with Serious Injury/Unconscious Patient

Attendance in an acute care setting to carry out a Forensic Clinical Examination on a seriously ill/unconscious patient should be with the prior knowledge and permission of the consultant in charge of that patient's medical care.[1] Each patient and their condition should be evaluated on an individual basis. Consideration is always given to the constitutional rights [12,18] of the patient namely:

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

Acting on the basis of good professional practice,[2,4] the Forensic Clinical Examination should be undertaken if it is considered to be in the best interests of the patient.[1] The rationale behind any decisions, the factors considered and the judgements made need to stand up to any future scrutiny.[18] All steps taken and decisions made are clearly documented [1] (See Box 5 overleaf).

Patient Regains Capacity

If the patient regains capacity to understand, they are informed as soon as possible, that a Forensic Clinical Examination was performed and why.

Box 5: Patient with Serious Injury / Unconscious Patient

The Forensic Clinical Examiner independently assesses the patient's capacity/lack of capacity to consent and whether they believe any incapacity will persist for a considerable time.

Prior to undertaking the Forensic Clinical Examination:

- The Forensic Clinical Examiner speaks with and informs the patient's family/ significant others.*
- Elicits any beliefs and values the patient may hold prior to this so these can be considered.[1, 2, 4, 16]

***NB:** A family member has no legal right to give or refuse consent on behalf of the adult patient. If someone has the legal authority to make decisions on the patient's behalf, the Forensic Clinical Examiner should seek that person's consent to the proposed Forensic Clinical Examination.[2,4,12,16]

2:5.4 Intoxicated Patients

There may be a temporary loss of capacity in patients who are intoxicated due to alcohol or drugs.[1] A guiding principle is that no action should be taken if the matter is not urgent, or if the person is likely to recover capacity shortly.[16] Forensic Clinical Examination should therefore normally be deferred until the patient's capacity has returned.[1] Always record the clear and precise reasons for deferring a Forensic Clinical Examination. Time is crucial in relation to the collection of forensic evidence and therefore the Forensic Clinical Examination should take place as soon as capacity returns. The Gardaí may wish to use an Early Evidence Kit in the interim period (See 1:3).

2:5.5 Communication Difficulties and Informed Consent

Principles of equity, accessibility and person-centeredness are central to effective and efficient services.[19] Patients attending for a Forensic Clinical Examination may have ethnic, cultural, linguistic and/or literacy challenges.[20, 21] Health literacy has been defined as multi-dimensional and includes both system demands and complexities, as well as the skills and abilities of individuals to process and understand the basic health information and services they need to make appropriate informed decisions.[20,21,22] Services should be flexible to meet individual's specific abilities and needs. Several studies found that repeating information to patients, in various formats and modes, at different times, can strengthen comprehension and recall.[23, 24]

2:5.6 Use of Interpreters

Using interpreters enables staff to provide high quality care and services through effective communication. It is important to use professional interpreters[2] who are neutral, independent and who accept the responsibility of keeping all information confidential.[19, 25, 26] If the patient has reported the incident, then the Gardaí should adhere to current An Garda Síochána policy regarding the use of interpreters. For the patient who is not reporting the incident, comply with the Hospital/local policy on the use of interpreters. Obtaining informed consent and maintaining confidentiality are critical elements of medico-legal responsibility.[19] The use of an interpreter, and the interpreter's name, registration number and contact details should be recorded in the SATU patient documentation.

Using family members or friends as interpreters is not recommended,[2, 19, 25] unless there is no alternative. Good practice guidelines state that friends or relatives do not interpret where there are:

- Child protection issues.
- Vulnerable adult issues.
- Reasons to suspect Domestic Violence.[19]

The use of family members or friends may cause the Forensic Clinical Examination and any evidence to be called into question in any subsequent court proceedings, and the reason for choosing to use such a person must therefore be clearly documented.

Refer to Guidance on good practice in the use of interpreters[21] and Emergency Multilingual Aids[27] for further information.

2:5.7 Patients with Hearing Impairments

People who are deaf or hard of hearing choose to communicate in different ways depending on their level of deafness. People who have a hearing impairment should be allowed to communicate in their preferred mode of communication.[2] The individual should be asked how they would like to communicate. For example, ask if the patient would like an interpreter or if they would prefer to lip-read you. Clinicians should be prepared to take additional time and be patient during the interview process, as communication can be slower when a patient is using lip-reading as a mode to communicate, or if a sign language interpreter is being used.

For the patient to give consent, it may be necessary to use non-traditional methods; for example the use of anatomical pictures/sketches may help the patient identify the nature, details and circumstances of the sexual assault (See Box 6).

Sign Language Interpreting Services

It is not appropriate to ask family members/friends to interpret for patients. Using a sign language interpreter is the only effective communication method with someone whose first language is sign language.[2,19]

Box 6: Communicating With Patients with Hearing Impairments

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

For further information contact
www.deafhear.ie

2:5.8 Patients with Visual Impairments

Over 8,000 people use the services of the National Council for the Blind of Ireland (NCBI) every year and of this figure, 95% have some degree of useful vision. With an ageing population, the number of people needing to access the NCBI is increasing by 12% each year.

If a person is vision impaired, their vision may be blurred, colours can become dulled and they may not see small details.[28] The NCBI provide information on a range of ways in which services for the blind or vision impaired patients can be more accessible (See Box 7).

Box 7: Patients with Visual Impairments

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

These and other services can be accessed at:
http://www.ncbi.ie/

A patient's visual impairment should be supported through effective communication to understand the process and give their informed consent (See Box 8).

Box 8: Supporting the Process of Informed Consent for Patients with Visual impairment

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

2:5.9 Patients with Disabilities

Ireland as a signatory to the United Nations (UN) Convention on the Rights of Persons with Disabilities 2006, [29] ratified the convention in March 2018, protecting the fundamental rights of equal recognition and treatment for all people with disabilities (See 2:5.2).

The Assisted Decision-Making (Capacity) Act 2015[12] has been framed to meet Ireland's obligations under Article 12 of the Convention. The Act 2015, prescribes a model of supported decision-making aimed at enabling all persons to exercise their decision-making capacity.

2:5.10 Patients with Intellectual Disabilities

Rates of sexual violence against persons with disabilities and intellectual disabilities are significantly higher than in the general population.[30, 31] Furthermore, adults with intellectual disability have additional barriers to overcome in accessing equal rights to healthcare and the legal system.[31] Each patient should be assessed on an individual basis regarding their capacity to understand and give their consent (See 2:5.2). If a person

with an intellectual disability lacks the capacity to give consent, the Forensic Clinical Examiner should consult their parents, guardians and/or carers. Many Intellectual Disability Services now have a Designated Person structure, with nominated Organisation Designated Persons and onsite Designated Contact Persons to manage abuse incidents/allegations. The SATU should establish local service level agreements with the Intellectual Disability Services regarding referral processes and activating the Organisation Designated Persons system. The benefits of using Garda Specialist Interviewer's skills should also be considered (See 1:4).

2:5.11 Patients with Mental Health Conditions/Disorders

Consent in relation to a patient with a mental health condition should be obtained in the same manner as all other patients that is - they give their consent freely, following adequate information which is given in the appropriate manner[4] (See 2:5.2). Where an adult patient is deemed to lack capacity to make the decision then steps should be made to find out whether any other person has legal authority to make decisions on the patient's behalf.[4]

In the case of a patient who is an in-patient through an Involuntary Admission Order to a Psychiatric Hospital, the Consultant Psychiatrist responsible for the care and treatment of that patient assesses if the patient is capable of understanding the nature, purpose and likely effects of treatment.[13,30] In cases where the patient has reported a sexual assault/rape it is essential that the Forensic Clinical Examiner discusses proposed care and treatment with the patient and the responsible Consultant Psychiatrist. In these instances it is the responsibility of the Forensic Clinical Examiner to ensure that all practical steps are taken to support a person in terms of decision-making capacity before it can be decided that she or he lacks capacity. The assessment of capacity is issue or task-specific.[2,4,12] Guidance on consent with regard to the Mental Health Act[13,32,33,34] and the Mental Health Commission (MHC) reference guide[33,34] should be accessible from within the SATU.

2:5.12 Ward of Court

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

- The first comprises adults who have been brought into Wardship because of mental incapacity.
- The second is persons under 18 years of age who are taken into Wardship as minors.[34]

Ward of Court and Forensic Clinical Examination: The following approach has been recommended by the Wards of Court Office (May 2014):

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

- Any treatment or procedure that might be considered controversial should not be carried out without the consent of the Court. In that regard, it is always possible to arrange an urgent sitting of the High Court, if the Court's intervention is necessary. The Judge on duty is authorised to exercise the Wardship jurisdiction, and the solicitor dealing with any such application can make arrangements by contacting the Four Courts, even after normal business hours and at weekends.[35]

Office of Wards of Court Contact Details

Office of Wards of Court

Phone: 01 888 6189/6140/6210

Fax: 01 8724063

E-mail: Wards@courts.ie

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

2:5.13 Refusal of a Forensic Clinical Examination

Every adult with capacity is entitled to refuse medical treatment, and their refusal must be respected.[12] A person cannot be deemed to lack decision-making capacity simply because there is a risk that she or he might make an unwise decision.[12] If a patient chooses not to have a Forensic Clinical Examination, then they should do so with a clear understanding of the implications of the choice they are making.[4] If the person does not report the incident to An Garda Síochána and have a Forensic Clinical Examination performed, they must understand that the case will not progress through the criminal justice system. The person can report the incident to An Garda Síochána at a future date if they change their mind; but they must be aware that any delay in reporting the incident may cause forensic evidence to be lost. Other options available e.g. Forensic Clinical Examination without involvement of An Garda Síochána and storage of evidence are fully explained (See 2:21). The Rape Crisis Centre personnel and SATU Staff are available to support the person with her/his decision making (Other possible scenarios: see Box 9).

Box 9: Possible Scenarios

1. Patient Wishes to Seek Advice from An Garda Síochána:

- Without making a formal complaint.
- Without having a Forensic Clinical Examination.

Action:

- Inform An Garda Síochána.
- Arrange psychological available for additional support.
- The patient can have an informal discussion with An Garda Síochána.
- Proceed, following informed consent with a physical/health examination, appropriate care, treatment and follow up, but no forensic evidence is collected.

2. Patient Does Not Wish An Garda Síochána Involvement:

Action:

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

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

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2:6 Forensic Clinical Examination

2:6.1 History Taking

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

- Obtain a medical history that may assist in the management of the patient,[1, 2] or explain subsequent findings.[3]
- Precisely and accurately record a brief account of the events that occurred, as relayed by the patient.
- Guide the clinical examination and forensic evidence collection.[1, 2, 5]
- Assess the risk of possible pregnancy and Sexually Transmitted Infections (STIs).[1, 2, 5]
- Facilitate discharge planning and follow-up care.[2, 6]

By initially obtaining a medical and social history, the examiner aims to put the patient at ease, rather than escalating their distress by immediately obtaining an account of the events that precipitated their referral.[4] The patient should be informed that it will be necessary to ask some personal questions. Questions should be limited to recording relevant medical history. The history should accurately reflect what the patient has told the Forensic Clinical Examiner in relation to the incident, and it does **not** need to be an exhaustive account of every detail of surrounding events. To ensure accuracy, the history as documented may be read back to the patient.[7] It is important that the clinician does not stray into the role of an investigator.[5] The full history of the incident and recording of the statement is the remit of An Garda Síochána,[8] not the Forensic Clinical Examiner.

KEY POINTS

KEY POINTS: History Taking

The purpose is to:

- Obtain a medical history to assist in the management of the patient.
- Record a brief account of the events, as relayed by the patient.
- Guide the clinical examination and forensic evidence collection.
- Assess the risk of possible pregnancy and STIs.
- Facilitate discharge planning and follow-up care.

To ensure accuracy:

- The history may be read back to the patient.

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2:6.2 Medical History

The medical history should include the following information:

- Past relevant medical/surgical/mental health/family history.
- Medications (prescribed, over the counter and/or recreational)
- Allergies.
- Social history: alcohol intake/cigarettes/illicit drug use.
- Home circumstances, with a view to discharge planning.[1, 2, 3, 5, 6, 7]

Gynaecological/Obstetric history including:

- Menstrual cycle.
- Date of last menstrual period.
- Tampon/sanitary pad use.
- Obstetric history.
- The patient is asked if they had sexual intercourse within the last 7 days, or since the incident.

  If yes:

  - Type and frequency of sexual experience.
  - Use of a condom.
- Contraceptive use.
- Possibility of current pregnancy.[1,2,3,4,7]

2:6.3 Forensic History

The forensic history provides a brief account of the incident (See overleaf). The patient must be informed that they may stop the questioning for a time if they wish and then continue, if and when ready. The patient is given the time throughout to find the words to articulate details of the event.[2]

Forensic History Taking should Include:

- Brief description of the incident.
- Number and identity of the alleged perpetrator, if known.
- Date and time of the incident and the time lapse from the incident.
- Location where incident took place.
- Type of sexual acts that the patient reported occurred:
  - For a female: contact with the vagina/anus/mouth/breasts and other locations on the body.
  - For a male: contact with the mouth/anus/genitalia or other parts of the body.

Also noted is the following:

- Consideration as to whether and where ejaculation took place.
- Use of a condom.
- Use of objects to achieve penetration.
- Reported use of weapons or restraints.
- Any bites or other wounds.
- Actual or threatened violent behaviour used in the course of the incident.

Any bleeding:

- Menstrual bleeding.
- Bleeding due to genital/anal injury.
- Tampon/pad in place during incident.
- Tampon/pad worn after incident.
- Bleeding from any other part of the body at the time of the incident.

After the incident, document whether the patient has:

- Eaten/brushed teeth/washed out mouth (If the oral cavity was involved).
- Bathed/showered.
- Changed clothes, including under garments.
- Opened their bowel (If anal involvement).
- Passed urine; if yes, how many times since the incident and the time they last urinated.

2:6.4 Prior to Commencing a Forensic Clinical Examination

Prior to Commencing a Forensic Clinical Examination

Record:

- Consent.
- Date and time (24 hour clock) of the examination.
- Date and time (24 hour clock) of incident.
- Time interval from incident until examination.
- Location of the examination.
- Name of the SATU support person, grade and location.
- Name of any other person present (e.g. interpreter).
- Garda Name, Garda Station and Garda Registration Number.
- Name, grade of Forensic Clinical Examiner

The Sexual Offences Examination Kit

Check and record:

- The expiry date on the outside of the Sexual Offences Examination Kit.
- The Sexual Offences Examination Kit is opened in the presence of the Garda (Storage of evidence: See 2:21).
- The Sexual Offences Examination Kit number.
- The tamper evident bag number.
- Toxicology bag number.

2:6.5 Collection of Clothing

The patient should be asked to remove their clothing, including underwear (if relevant). A disposable gown is provided. If appropriate, the patient may be asked to undress in a private area standing on a clean paper sheet, which will collect any debris that might be used as evidence.[2] The clothing may need to be retained for forensic evidence[1, 2, 3, 4, 5, 6] (See 1:5).

2:6.6 General Physical Examination[1,2,3,4,5,6]

General Physical Examination:

- Appropriate measures are taken to prevent contamination of evidence (See 5:5).
- A thorough physical examination is performed.
- It is best to begin the examination with a non-threatening approach, such as examining the head and neck first.
- A head-to-toe survey is carried out.
- The forensic samples may be collected as the examination progresses (Table 2: p 67). Where body fluids may have been deposited, or if there are marks or injuries on the skin, that the patient attributes to direct contact with the alleged perpetrator, use the double swab technique, and document as to why the swab was taken. (See below).

Double Swab Technique[3, 5, 7, 8]

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

Assessment of Non-Genital Physical Trauma

- Non-genital trauma may include: mouth trauma, lacerations, bruises, abrasions, evidence of bite marks, kicks, hand tie marks, tape marks or marks from attempted strangulation (See 2:12).

Documentation

- The Forensic Clinical Examiner should document all findings in detail as the physical examination proceeds.
- Documentation of general appearance, presentation and behaviour may also be appropriate, bearing in mind that individuals respond to stressful circumstances in different ways (See 3:2).
- Relevant negative findings should also be documented.
- Body maps are helpful and are included in the National Patient Chart and should be used to document injuries.

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Collection of Forensic Samples

2:6.7 Collection of Forensic Samples

Table 2 on the following pages, provides guidance regarding forensic sample collection. It is important to remember that:

If there is an allegation of oral sex

The patient should **not** be given a drink until after oral swabs have been taken either via an Early Evidence Kit (See 1:3) or during the Forensic Clinical Examination (See Table 2 p. 66).

If toxicology is required

- Blood samples for toxicology should be taken **as soon as possible** (See Table 2, p. 67).
- If the patient needs to urinate, collect a urine sample in case it is required for toxicology (See Table 2, p. 67).
- **Packaging of the toxicology specimens** (See 2:13).

Table 2: Collecting Forensic Samples from Different Locations of the Body			
Unused swab	**Control sample** • Submit one **unopened** swab (for every kit used).		
External lip swabs	Detection of body fluids on lips and skin around mouth e.g. semen; blood stain which may not be from the victim. • If stain is moist, recover on a dry swab. • If stain is dry, dampen swab with sterile water and rub lips and skin around the mouth. • Repeat with second swab. • Return swabs immediately to the tubes.		
Mouth swabs	Detection of semen if oral penetration within 1day. • Take 2 sequential samples by rubbing swab around inside of mouth, under tongue and gum margins or over dentures and dental fixtures. • Return swabs immediately to the tubes.		
Skin swabs	Detection of body fluids on skin e.g. semen; saliva on kissed, licked, bitten area; blood stain which may not be from the victim. • If stain is moist, recover on a dry swab. • If stain is dry, dampen swab with sterile water prior to swabbing. • Repeat with second swab. • Return swabs immediately to the tubes.		
Head hair	**Rationale for Collecting**	**Method of Collecting**	**Method of Packaging**
	A. Detection of semen.	**A.** Cut or swab relevant area if applicable.	**A.** Place hair in plastic bag/ return swabs immediately to the tubes.
	B. Detection of fibres, foreign particles, foreign hairs.	**B.** Draw comb with cotton wool through all the hair.	**B.** Place in plastic bag.

Table 2: Collecting Forensic Samples from Different Locations of the Body (Cont.)	
Underwear and sanitary protection	Detection of semen on sanitary protection and underwear worn after incident. **Underwear and sanitary pads** • Take underwear worn at time of examination. • Underwear in paper bag. If wet, put paper bag into a plastic bag. • Leave pad attached to underwear if present. • Pack in the tamper evident bag with the kit. **Tampons** • Take tampon if worn. • Tampon in plastic bag.
Mons pubis area swabs	Take **only if pubic hair is absent.** The detection of body fluids e.g. semen, saliva, blood that may not be from the victim. • If stain is moist, recover on a dry swab. • If stain is dry, dampen swab with sterile water. • Repeat with second swab. • Return swabs immediately to their tubes.
Vulval swabs	Detection of body fluids if vaginal intercourse within 7 days or if anal intercourse within 3 days, or ejaculation onto perineum. **First sample** (Moisten swabs with sterile water if required) • Rub 2 sequential swabs over whole of vulval area. • Return swabs immediately to their tubes.
When using a speculum or proctoscope, take the sample beyond the instrument and avoid contact with its sides to prevent contamination.	
Vaginal swabs – Low	Detection of body fluids if vaginal intercourse within 7 days or if anal intercourse within 3 days. **Second sample** (Moisten swabs with sterile water if necessary) • Take 2 sequential swabs approx 1 cm above hymen, using a speculum. • Return swabs immediately to their tubes.
Vaginal swabs – High	Detection of body fluids if vaginal intercourse within 7 days or if anal intercourse within 3 days. **Third sample** • Take 2 sequential swabs from the posterior fornix via the speculum. • Return swabs immediately to their tubes.

Table 2: Collecting Forensic Samples from Different Locations of the Body (Cont.)

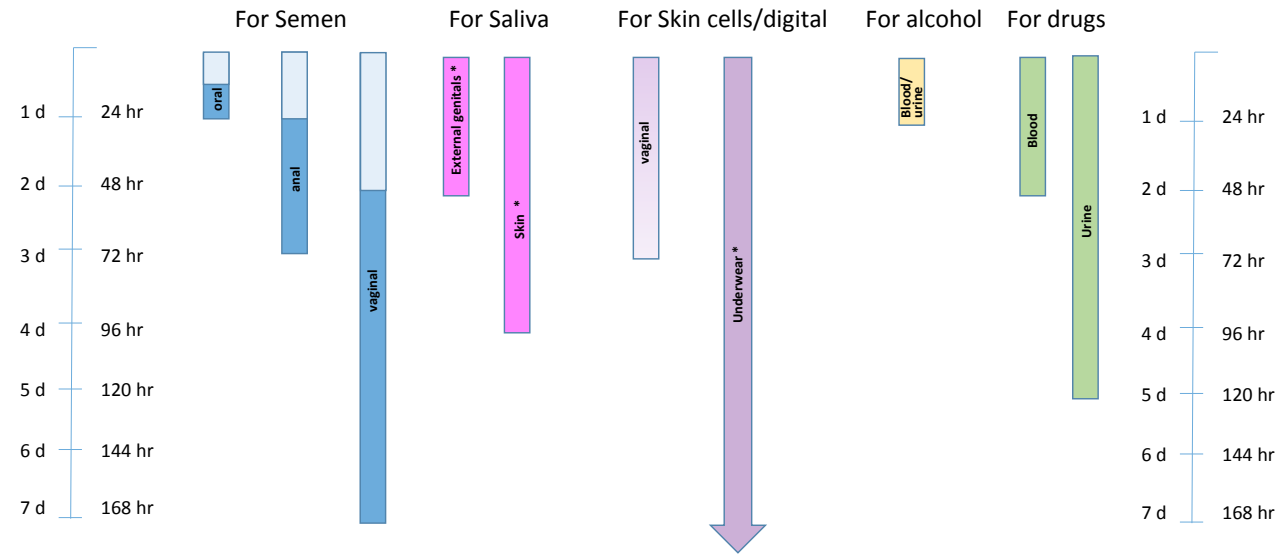
Endocervical swabs	Take **only** if vaginal intercourse **more than 48 hours** previously. **Final sample** • Take 2 swabs via the speculum. • Return swabs immediately to their tubes.		
Pubic Hair **Take only if hair is present**	**Rationale for Collecting**	**Method of Collecting**	**Method of Packaging**
	A. Detection of semen.	**A.** Cut or swab relevant area if applicable.	**A.** Place hair in plastic bag/ return swabs immediately to the tubes.
	B. Identification of foreign hairs.	**B.** Comb pubic hair.	**B.** Place in plastic bag.
Penile swabs	Detection of body fluids if intercourse within 7 days. • Use swabs moistened with sterile water. **A.** 2 sequential swabs from shaft & external foreskin. **B.** 2 sequential swabs from coronal sulcus. **C.** 2 sequential swabs from glans. **D.** 2 sequential swabs from base of penis including pubic hair and scrotal sac. • Return swabs immediately to their tubes.		
Perineum swabs	Detection of body fluids if vaginal or anal intercourse **within 7days.** • Take 2 sequential swabs from the perineum area using swabs moistened with sterile water. • Return swabs immediately to their tubes.		
Perianal swabs	Detection of body fluids if vaginal or anal intercourse **within 3 days.** • Take 2 sequential swabs from the perianal area using swabs moistened with sterile water. • Return swabs immediately to their tube.		

Table 2: Collecting Forensic Samples from Different Locations of the Body (Cont.)	
Rectal swabs	Detection of body fluids if anal intercourse **within 3 days.** • Pass a proctoscope 2-3 cm into the anal canal. (Use lubricant if necessary). • Take 2 swabs from the lower rectum. • Return swabs immediately to their tubes.
Fingernails including false fingernails	Recovery of trace evidence (e.g. body fluid, possible fibres) or connection with fingernail broken at scene (if the circumstances suggest this as a possibility). • Preferably swab nails. • Moisten a swab with sterile water and thoroughly swab the area underneath each fingernail of one hand. • Use a second swab for the fingernails of other hand. • Return swabs immediately to their tubes. • If false nails are worn and some are missing, remove samples of the nail and place in an evidence bag. • Nails may also be cut if required.

Toxicology Samples

Blood	Detection of alcohol and drugs of abuse. Only taken if within **48 hours of incident.** • Approximately 2 x 5ml of blood (no more than ¾ full). • Place blood samples into sealed plastic containers provided and then into tamper evident bag. • **REFRIGERATE OR FREEZE.**
Urine	Detection of alcohol and drugs of abuse. Only taken if **within 120 hours of incident.** • Ask subject to urinate into the wider foil capped container and decant into the 2 smaller glass tubes containing tablet **(no more than ¾ full).** • **Do not discard tablet** (preservative for sample). • Place urine samples into sealed plastic containers provided and then into tamper evident bag. • **REFRIGERATE OR FREEZE.**
Testing cut hair for drugs of abuse is done 1 month after the incident in special circumstances contact FSI. (See 5:8).	

Table 2a: FSI Sampling timeframe guidelines 2018



* If unwashed

2:7 Female External Genitalia

See Table 3 below and Figure 1, p. 72

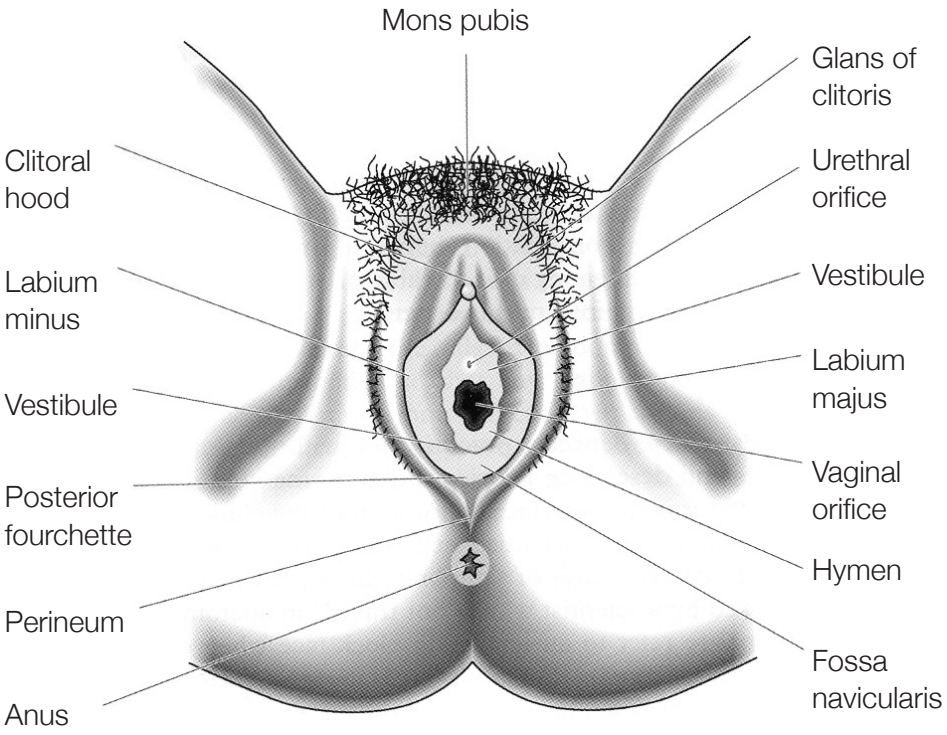
Table 3: Female External Genitalia

NAME	DESCRIPTION
Vulva	The collective term used to describe the external female genitalia. It incorporates the mons pubis, labia majora, labia minora, clitoris, clitoral hood and vestibule.[2,3]
Labia Majora	The two large folds which form the outer boundary of the vulva.
Labia Minora	Two smaller folds of skin between the labia majora. Anteriorly the labia minora meet at the clitoris and posteriorly they fuse to form the fourchette.[2,4]
Clitoris	Erectile tissue situated beneath the mons pubis and above the urethra; the clitoris is covered by the clitoral hood or prepuce.[2,5]
Urethral Orifice	Opening into the urethra.
Hymen	A membranous collar or semi collar inside the vaginal introitus[3] (See Table 4).
Hymenal Remnants	After vaginal delivery.
Fourchette	The posterior margin of the vulva: the site where the labia minora unite posteriorly.[1]
Introitus	An opening or entrance into a canal or cavity as in the vaginal introitus.[3]

Table 3: Female External Genitalia (Cont.)	
NAME	**DESCRIPTION**
Fossa Navicularis	Concavity anterior to the posterior fourchette and posterior to the hymen.[3]
Vestibule	An almond shaped space between the lines of attachment of the labia minora; four structures open into the vestibule-urethral orifice, vaginal orifice, and the two Skene's ducts of the glands of Bartholin.[3]
Perineum	Area between the posterior fourchette and the anus.[10]
Anus	see Table 6
Vagina	see Table 6

Figure 1: Female: Genital Landmarks

Figure 1: Female: Genital Landmarks from Maureen Dalton (Ed.), *Forensic Gynaecology, Towards Better Care for the Female Victim of Sexual Assault* © 2004 The Royal College of Obstetricians and Gynaecologists, published by Cambridge University Press, reproduced with permission.



2:7.1 Hymen: Definition, Anatomical Variations and Terms

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

Hymen: Anatomical Variations

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

Terms relating to the hymen

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

2:7.2 The Vagina: Definition and Descriptive Terms

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

Definition of the vagina: A fibromuscular sheath extending upwards and backwards from the vestibule.[4]

Descriptive terms for the vagina

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

The Fornix: Spaces in which the upper vagina is divided; the spaces are formed by the protrusion of the cervix into the vagina.[3] The spaces are referred to as:

- Anterior/posterior.
- Right/left.

2:7.3 Anal Canal: Definition and Descriptive Terms

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

Definition of the anal canal: The terminal part of the large intestine extending from the rectum to the anal orifice.[5]

Descriptive terms for the anal anatomy

- Anal skin fold: Folding or puckering of the perianal skin radiating from the anal verge.[5]
- Anorectal line: The line where the rectal columns interconnect with the anal papilla: also called the dentate line.[3]
- Anus: The anal orifice; the outlet of the large bowel, opening of the rectum.[3]
- Dentate line: See anorectal line.[3]
- Perianal: Around the anus.

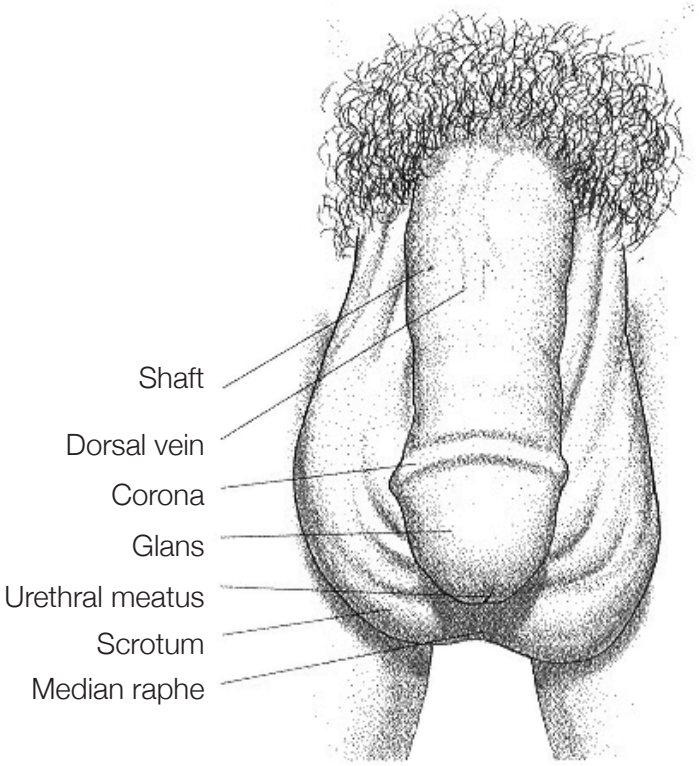
2:8 Male External Genitalia

Table 7: Male External Genitalia (See Figure 2, overleaf)

NAME	DESCRIPTION
Penis	Male organ of reproduction and urination,[6] composed of erectile tissue, through which the urethra passes. It has a shaft and glans (head); the glans may be covered by the foreskin.[7,8]
Shaft of the penis	The shaft of the penis is the area from the body of the male to the glans penis and is composed of three cylindrical masses of erectile tissue.[8] The dorsal surface of the penis is located anteriorly on the non-erect penis, and its ventral surface is in contact with the scrotum.[9]
Glans of the penis	The cone shaped head of the penis,[6] distal to the coronal sulcus.
Foreskin	The movable hood of skin covering the glans of the penis.[6]
Frenulum	The thin fold of tissue that attaches the foreskin to the ventral surface of the glans penis.[9] It attaches immediately behind the external urethral meatus.[10]
Corona	The widest portion around the glans,[10] the ridge that delineates the glans from the shaft of the penis.[8]
Coronal sulcus	The groove at the base of the glans.[9]
Urethral meatus	Situated at the end of the penis the external opening of the urethra which serves as the duct for both urine and ejaculate flow.[6]

Table 7: Male External Genitalia (Cont.)	
NAME	**DESCRIPTION**
Scrotum	The scrotum is a pouch of deeply pigmented skin, fibrous and connective tissue and smooth muscle. It is divided into two compartments each containing one testis, one epididymis and the testicular end of a spermatic cord.[11]
Median Raphe	A ridge or furrow that marks the line of union of the two halves.[10]
Perineum (Male)	The area between the base of the scrotum and the anus.[11]
Anus	**See 2:7.3**

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



Frontal view of the external male genitalia

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2:9 Male Patient

2:9.1 Prevalence and Incidence

Internationally male rape and male sexual assault is still a taboo subject. It is estimated that the occurrence of male on male rapes is approximately 5-10% in the western world. This highlights the belief that male sexual assault is severely under-reported.[1] One of the reasons for this is that victims feel that the authorities will not believe them.[2] This attitude together with feelings of stigma, shame and fear continue to discourage men from reporting and seeking services.[2] In response, the services promote a patient centred approach to service delivery, acknowledging and addressing the patient's fears in a sensitive, non-judgmental and caring environment.

2:9.2 Examination of the Male Patient

The Forensic Clinical Examiner firstly evaluates the patient to determine if:

- There are any acute injuries that need to be medically assessed.
- If the patient is competent to give consent for the Forensic Clinical Examination (see section 2:5.3).

The Sexual Examination Offences Kit is used for both male and female patients.

The history taking involves a general medical history and a history of the events that occurred. A top to toe examination is performed with the patient wearing a disposable hospital gown. Forensic swabs and samples are taken as suggested in the Sexual Offences Examination Kit. A genital examination is performed with care. The penis and scrotum are examined for signs of injuries.

Proctoscopy allows inspection of the rectum for injuries and also for collection of evidence.

If ano-genital injury is present it should be clearly documented using standard accepted descriptive terminology for classifying wounds (See 2:11)

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2:10 Ano-Genital and Pelvic Examination

When relevant, following the general physical examination, patients should be offered a comprehensive assessment of the ano-genital area, during which injuries, scars and medical conditions are noted. This part of the examination may be particularly difficult for the patient because it may remind them of the assault.[1] Prior to commencing, inform the patient of any expected discomfort so that they can stop the examination at any time.[2] Swabs are taken as suggested in the Sexual Offences Examination Kit (See Table

2: p. 66) for forensic evaluation from the external genitalia. A gentle stretch at the posterior fourchette may help reveal abrasions that are otherwise difficult to see.[2]

Vaginal Examination

The speculum examination should be performed after the complete examination of the external genitalia. A transparent plastic speculum, should, if possible, be used for the vaginal examination to inspect the vaginal walls and cervix.[1] Assessment is made for vaginal and/or cervical bleeding, lacerations and/or foreign bodies. Any foreign body e.g. a tampon or hair should be removed and retained for forensic analysis.[3] Swabs are taken as suggested in the Sexual Offences Examination Kit for forensic evaluation (See Table 2: p. 66).

Anal Examination

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

Proctoscopy is usually only performed when anal assault is alleged or in cases of anal bleeding or severe anal pain post-assault. The recommended swabs should be taken from the ano-rectal area (See Table 2: p. 66).

Pelvic Examination

It is important to consider a pelvic bi-manual examination, in order to exclude internal trauma e.g. broad ligament haematoma, [5] which can occur without vaginal bleeding or vaginal discomfort being present, in the early hours after the incident. This is more commonly seen with accompanying physical trauma.

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2:11 Ano-genital Injuries in Adult Patients

The presence and diagnosis of injury in patients who report sexual assault and rape is thought to significantly influence decision making in the criminal justice process, from the decision of a patient to report an incident, the decision to prosecute, and decision making around conviction.[1] It is essential that ano-genital injury, or its absence, be interpreted carefully within the unique context of each individual case. The Forensic Clinical Examiner should explain the relevance of clinical examination findings prudently. Opinion upon the relevance of clinical examination findings should draw upon the clinical experience of the Forensic Clinical Examiner in addition to their knowledge and understanding of research literature.[2] It is important that the implications of ano-genital injury, or its absence, be described in a balanced way, whereby any limitations to the significance of clinical examination findings are made clear. The Forensic Clinical Examiner should state when a particular subject falls outside of their professional expertise.

Ano-genital injury is not an inevitable consequence of sexual assault or rape. Very many patients who undergo forensic examination will be found to have no injuries. It is widely accepted that the absence of injury does not imply that non-consensual sexual contact did not occur. The absence of ano-genital injury does not imply that anal or vaginal penetration did not occur. It is possible for a patient with a history of vaginal penetration to have an entirely normal genital examination. That includes patients who had no prior sexual intercourse experience (i.e. those who were 'virgins') prior to penetration.

Many research studies have explored the frequency with which injury is detected in patients who undergo forensic examination after reporting sexual violence. Those studies have reported a wide range in results, with some citing a very low rate of injury and others a very high rate.[3] The variation in results appears to be, at least in part, related to heterogeneity in research methodologies between the studies.[3] For example, some studies employed colposcopy as part of a standard clinical examination technique. Those studies are not reflective of current Irish clinical practice because colposcopy is not routinely used in the forensic examination of adult patients. It is important that the presence or absence of ano-genital injury be interpreted in the context of research data that are most reflective of clinical practice in each individual case.

Furthermore, ano-genital injury may arise from consensual, as well as non-consensual, sexual contact. Thus, the presence of ano-genital injury should not be automatically considered to reflect a non-consensual act.

Several research papers have described the anatomical locations at which ano-genital injury is most commonly identified in patients who undergo forensic examination.[4,5,6] The posterior fourchette and the fossa navicularis appear to be most frequently injured (See Figure 1).

If ano-genital injury is present it should be clearly documented using standard accepted descriptive terminology for classifying wounds (See Table 8).

Injury, or its absence, should always be interpreted within the broad context of each individual case.[2] Consideration must be afforded to all factors that can influence the presence or absence of injury. In addition to the mechanism of injury and the provided history, other factors include pre-existing skin disease, blood disorders, anti-clotting medications, previous FGM, ano-genital injury or episiotomy injury that pre-dates the incident (e.g. bruising from contact sports), and so forth.

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2:11.1 Role of Colposcopy for Adult Patients in Sexual Assault Forensic Examination

The potential advantages of colposcopic examination include provision of a light source, magnification and the ability to obtain photo documentation.[4] It is known that colposcopy increases the rate of detection of injury after both consensual and non-consensual intercourse, particularly if it is carried out within 48 hours of intercourse. There continues to be discussion on the evidential significance of ano-genital findings at sexual assault forensic examination, and the increased identification of genital injury when colposcopy is used, which does not precisely define the aetiology of that injury.[5, 1,2] Colposcopy is not currently in routine use for examination of adults in Irish SATUs. The use of colposcopy differs in accordance with paediatric patients in sexual assault forensic examinations. Other factors that need to be considered if routine use of colposcopy is to be explored, include acquisition and storage of equipment and images, maintenance and de-contamination of equipment, training of relevant personnel and data protection of acquired images.[6]

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2:12 Classification and Documentation of Wounds and Injuries

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

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

Abrasion	**Defined as*: superficial injuries to the skin caused by the application of blunt force.*** **Produced by a combination of contact pressure and movement applied simultaneously to the skin.** Different types of abrasions subdivided as: • Scratches. • Imprint e.g. pattern of the weapon leaving imprint abrasion on the skin. • Friction e.g. grazes from contact with carpet or concrete.
Bruise	**Defined as: *an area of haemorrhage beneath the skin*** Bruising follows blunt trauma; the discolouration is caused by blood leaking from ruptured vessels. The site of the bruise is not necessarily the site of the trauma and may not necessarily reflect the shape of the weapon/s. Some bruises may bear features that may well assist in their interpretation. • Bite marks: Oval or circular bruises with a pale central area. • Fingertip bruises: Caused by the forceful application of fingertips. Usually appear as 1 – 2 cm round shaped clusters of three to four bruises. There may also be a linear or curved abrasion from contact with fingernails. • Patterned (imprint) bruises: Occurs when a bruise takes on the specific characteristics of the weapon used (e.g. the sole of a shoe). Clothing imprints may also occur. • Petechial bruises: Pinpoint areas of haemorrhage and are caused by the rupture of very small blood vessels. Usually seen on the face, scalp or eyes after neck compression. • Trainline bruises: These are parallel linear bruises with a pale central area produced by forceful contact with a linear object (e.g. stick or a baton) (See also 2:12.1 Bruising).

Table 8: Standard Descriptive Terms for Classifying Wounds[1,2 (adapted)] (Cont.)	
Laceration	**Defined as: *ragged or irregular tears or splits in the skin, subcutaneous tissues or organs resulting from blunt trauma. (e.g. trauma by impact)*** Characteristics of a lacerated wound: • Ragged, irregular or bruised margins, which may be inverted. • Intact nerves, tendons and bands of tissue within the wound. • The presence of foreign material or hair in the wound. The shape of the laceration may reflect the shape of the causative implement.
Incised wounds	**Defined as: *injuries produced by sharp edged objects whose length is greater than their depth.*** May be produced by a knife, razorblade, scalpel, sword or glass fragment. Characteristics of an incised wound: • Borders: sharply defined edges. • Surrounds: minimal damage. • Blood loss: variable, often profuse. • Contents: rarely contaminated.

Stab wounds	**Defined as: *incised wounds whose depth is greater than their length on the skin surface.***
	
	Important points to note:
	• The degree of penetration and depth of resulting stab wounds are affected by a number of factors, including:
	  • the amount of force delivered;
	  • the robustness of protective clothing;
	  • the sharpness of the tip of the blade;
	  • tissue resistance and any movement of the victim.

Scab	**Defined as: *a hard crust of dried blood, serum or pus that develops during the body's wound healing process over a sore, cut or scratch.*[3]**

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

Table 9: Documenting and Describing Features of Physical Injuries and Wounds[1, 2 (adapted)]	
Site	Record the anatomical position of the wound (reference to the nearest bony point can be helpful).[4]
Size	The dimensions of the wound(s) should be measured.
Shape	Describe the shape of the wound(s) (e.g. linear, curved, irregular).
Surrounds	Note the condition of the surrounding or the nearby tissues (e.g. bruised, swollen).
Colour	Observation of colour is relevant when describing wounds e.g. bruises (See Section 2:12.1 Bruising).
Course	Comment on the apparent direction of the force applied (e.g. in abrasions – horizontally; vertically; obliquely).
Contents	Note the presence of any foreign material in the wound (e.g. dirt, glass).
Age	Comment on any evidence of healing. **Note: Accurate ageing** is impossible and great caution is required when commenting on this aspect.[1, 2, 4] **Note: Scars** which predate the incident should be described and noted in the documentation and on the legal report.
Borders	The characteristics of the edges of the wound(s) may provide a clue as to the weapon used.
Classification	Use standard descriptive terminology wherever possible (See Table 8).
Depth	Give an indication of the depth of the wound(s); this may have to be estimated.

Injuries Caused by Teeth: Bite Marks

- Swab the affected area[1, 2, 3] where saliva may be deposited using the double swab technique.[2]
- Measure and record a full description and record also on body maps.
- Liaise with Garda Photographer.[2,3]
- An odontologist's opinion may be considered if appropriate.

Management

A wide range of pathogens may infect bites; the risk of infection increases with puncture wounds, hand injuries, full thickness wounds and those involving bones, tendons and ligaments.[2] Therefore referral to the relevant emergency services may be required. Wound irrigation is recommended and antibiotics may need to be considered. Tetanus (See 2:16.1) and Hepatitis B immunisation status of the patient should be established.[2] (See section 4:3.2)

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2:12.1 Bruising

The colour of a bruise can be red, blue, black, purple, yellow, brown, orange or green.[5, 6] A mixture of different colours can appear in the same bruise at the same time.[5] Furthermore, the colour of individual bruises can change over time. A systematic review with regard to bruising in children, updated in 2013, concluded that it is not possible to accurately age a bruise by examination with the naked eye *in vivo* or by viewing a photograph.[7] Similarly, a study in older adults concluded that it is not possible to reliably predict the age of a bruise by its colour.[8]

Forensic experts are frequently asked to comment on the age of bruising, where interpretation may have significant medico-legal consequences.[9] A recent study assessed whether the number of years of forensic experience affected the accuracy with which 'forensic experts' were able to age bruises. The study concluded that the visual assessment of bruises is unreliable, and the accuracy of ageing was not improved by the degree of forensic experience.[10] Another systematic review that was limited to patients in the age group 0-18 years reported that 'a bruise cannot accurately be aged from clinical assessment *in vivo*, or from a photograph.' The review concluded that ageing of a bruise from its colour has no scientific basis.[11] Bruise-age-estimates from photographs, by forensic experts, have been found to be unreliable[9] and are now considered to be 'highly inaccurate.'[12]

When assessing a bruise, the forensic examiner should document the individual characteristics of each bruise. This may include its size, shape, location, colour(s), distinction of margins, and whether it is indurated or tender.[13] If the patient is able to provide a history in relation to the bruise, then the explanation should be noted verbatim.[14] On occasion, bruising may have a 'patterned imprint,' which may be representative

of characteristics of the weapon or object used e.g. handprint, or a loop or belt print.[12,13] It is also the case that there may be multiple bruises, that when examined as a whole, may demonstrate a 'pattern of injury,' (e. g. a history of being forcibly grasped may be consistent with a finding of finger-tip bruising, which is evident as a group of ovoid bruises, caused by the fingers, with a single 'thumb' mark).[13,15] In all cases, it is important to consider bruising in the context of the history provided and, in particular, whether the bruising is consistent with the history.

Points worth noting:

- It is not possible to accurately age a bruise by visual inspection.[6]
- There are many variables that could potentially affect the ability to estimate the age of a bruise[6] and indeed bruising may be difficult to discern in deeply pigmented skins.[14,16]
- Neither the colour nor the progressive changes in colour are reliable indicators of the age of bruises.[12]
- Different colours can appear in the same bruise at the same time,[5, 14] and all bruises do not go through every colour change.[7,14]
- Some people detect the colour yellow less well than others, with observation limited by the physiology of the human eye.[6,14]

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2:12.2 Female Genital Mutilation (FGM)

Definition: The partial or total removal of the external female genitalia, or any practice that purposely alters or injures the female genital organs for non-medical reasons.[1, 2, 3] The practice is internationally recognised as a human rights violation of women and girls.[2, 3]

Women may not be able to correctly self-identify the specific type of FGM that they have experienced. The following WHO classification[1] is useful in terms of documentation (See Table 10). Alternatively, clinicians may prefer to clearly document anatomical changes identified at examination if classification is difficult.

Table 10: WHO Classification of FGM 2008

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

A specialised clinic offering care and support to women who have experienced FGM is held in Dublin. Information relating to the service can be found at:
http://www.ifpa.ie/Sexual-Health-Services/FGM-Treatment-Service

Further information for clinicians can be found in the World Health Organisation 2018 publication 'Care of Girls and Women living with Female Genital Mutilation – A Clinical Handbook' which can be downloaded here: http://www.who.int/reproductivehealth/publications/health-care-girls-women-living-with-FGM/en/

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2:13 On Completion of the Forensic Evidence Collection

On Completion of the Forensic Evidence Collection:

The Sexual Offences Examination Kit and Form

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

Samples for Toxicology (See 5:8)

- Samples are labelled as above, the date and time of the specimen was taken is recorded on all toxicology samples.
- Keep the toxicology specimens separated from the Sexual Offences Examination Kit i.e. they are not packaged together.
- The Garda seals, completes and signs the tamper evident toxicology bag (Storage of Evidence: See 2:21).
- **Both tamper evident bags and the form for the Sexual Offences Examination Kit are submitted via the Gardaí to Forensic Science Ireland.**

2:14 Photographic Evidence

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

Consent to Photographic Evidence

Prior to photographic evidence being taken, the patient must give written consent and must be fully aware that the photographs may be shown in any subsequent court proceedings; this means the Defence team may have access to any photographs. This is of particular relevance for photographs taken of the genital area.

Who Takes the Photographs?

The person with the most appropriate skill and expertise to take the required photographs is a Garda Photographer. This also supports safe practice with regard to continuity and storage of evidence. The details of the Garda Photographer local to the SATU should be available in that SATU. The request for photography should be recorded in the patient record. If a Garda Photographer attends the SATU, their details are recorded in the patient's documentation.

Where a Garda Photographer is not available or not appropriate, some SATUs may choose to have local arrangements for photographic evidence. In this situation, it is vital that the chain of evidence is maintained and all images are stored in a safe manner.

The Future

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

KEY POINTS

KEY POINTS: Photographic Evidence

Take photographs if:

- They would be relevant to convey the extent and impact of any injuries.

Taken following:

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

Who Takes the Photographs?

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

Record in the Patient Documentation:

- If a Garda Photographer is requested to attend SATU.
- Garda Photographer details if they attend SATU.

2:15 Care of the Patient

- Offer the patient a shower and a change of clothing after the examination.
- Emergency contraception (See 2:17).
- Wound management and Tetanus Immunisation (See 2:16.1).
- STI infection prophylaxis for bacterial infection (See 4:2.1).
- Hepatitis B post-exposure prophylaxis (PEP) (See 4:2.2).
- Assessment for HIV PEP (See 4:3.3).

Referral, Follow-up Care and Discharge Planning

- Referral, follow-up care and discharge planning (See 2:18.1 – 2:18.3).
- STI testing (See 4:4).
- Information regarding counselling re: Rape Crisis Centre (See section: 3:5).

2:16 Wound Management

The wound assessment should be completed by the Forensic Clinical Examiner. If the wound is considered minor, it should be treated according to best practice for wound care[1]

2:16.1 Tetanus Infection

Tetanus is a serious but rare condition caused by bacteria getting into a wound. Tetanus bacteria can survive for a long time outside of the body and are commonly found in soil and the manure of animals, such as horses and cows.

If the bacteria enter the body through a wound, they can multiply and release a toxin that affects the nerves, causing symptoms such as muscle stiffness and spasms.

Tetanus is not spread from person to person.

Tetanus Immunisation

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

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

NB. Occasionally, apparently trivial injuries can result in tetanus.[4] Check the patient's tetanus immunisation status; if appropriate follow the Immunisation Guidelines for Ireland.[4]

NB. Staff giving any immunisations (Tetanus or Hepatitis B) should ensure that they have training in Basic Life Support and anaphylaxis and that retraining is provided in accordance with best practice i.e. every 2 years.[4]

Staff should be familiar with the following documents[5] adapted

A. Immunisation Guidelines for Ireland, 2016. http://www.immunisation.ie/en/HealthcareProfessionals/ImmunisationGuidelines/

B. A Practical Guide to Immunisation, National Immunisation Office, 2008. http://www.immunisation.ie/en/HealthcareProfessionals/ TrainingManual/

C. Immunisation training slides for Health Professionals, National Immunisation Office, 2011. http://www.immunisation.ie/en/HealthcareProfessionals/ TrainingSlides/

D. Summary of Product Characteristics (SmPCs) for each of the vaccines available at www.imb.ie or www.medicines.ie

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2:17 Emergency Contraception (EC)

Sexual assault may place women of reproductive age at risk of unwanted pregnancy.[1] Although little research exists, the pregnancy rate after rape has been estimated at 5% among those of reproductive age, if EC is not used.[1, 2] EC measures should therefore be discussed with all women who attend a SATU for evaluation.[3] **KPI**[i]

The most suitable method of EC will depend on the patient characteristics, the time that has elapsed since the assault and the timing of any unprotected consented intercourse.[4] EC is offered as soon as possible after exposure, to maximise effectiveness.[1, 5] In general EC is effective and well-tolerated, although women should be advised that no contraceptive method is 100% reliable.[1, 4] Oral EC is unlikely to be effective if ovulation has already taken place. If vomiting occurs within three hours of oral EC administration a repeat dose may be required. If available/acceptable, it is recommended that all women are offered a copper-IUD if within the appropriate timeframe, as this is the most effective method of emergency contraception.[21]

2:17.1 Emergency Contraceptive Pill (ECP): Ulipristal Acetate

Ulipristal acetate (UPA) is licensed for use in Ireland as emergency contraception for use within 120hrs (5 days) of unprotected sexual intercourse or contraceptive failure.[9, 10, 11] UPA has been demonstrated to be more effective than Levonorgestrel (LNG) from 0-120 hours after unprotected sexual intercourse (UPSI). There is no significant reduction in the efficacy of UPA as increasing time elapses from the UPSI. In addition UPA can delay ovulation even after the start of the LH surge (a time when LNG is no longer effective). Therefore, UPA should be considered for all female patients who present to the SATU within 120hrs (5 days) of unprotected intercourse[21].

There is evidence that UPA is not effective if it is taken after ovulation has occurred[21]. Furthermore, many women who take UPA will go on to ovulate later in the cycle. It is important that women are made aware of this so they can choose whether they consider longer term reliable contraception to be needed. Local medication protocols for the supply and administration of UPA should be followed and patients should be provided with the appropriate information.

Key Performance Indicator

[i] **KPI:** % of female patients who present within 120 hours and appropriately received emergency (EC) contraception.

Dose of UPA: A single dose of UPA 30mg tablet is given orally.[9]

Contraindications and Precautions associated with UPA

- UPA should not be used in women who have severe asthma that is controlled by oral glucocorticosteroids.
- "Ella One" contains lactose.
- There is an absence of safety data regarding the use of UPA in hepatic impairment.
- Breastfeeding women may wish to consider expressing and discarding milk for seven days following administration of UPA.
- If the BMI is >26 kg/m2 or weight is >70 kg, the efficacy of UPA may be reduced but less so than with 1.5 mg LNG. It is not known whether UPA is more effective than 3 mg LNG for women with a BMI over 30kg/m2.

The following are no longer contraindications to the use of UPA

- A woman who has already taken EC during the cycle can receive UPA if indicated (although she should not receive UPA if she has received LNG in the previous 7 days)
- A women who has had other episodes of UPSI can receive UPA

Drug Interactions relevant to UPA

- Hormonal contraception–
  - **After UPA:** the effectiveness of UPA could be reduced by immediate subsequent use of hormonal contraception or any medication that contains progesterone. Therefore hormonal contraception should be held/should not be commenced for 5 days after the woman has taken UPA. Also, a woman who has another episode of UPSI within 5 days of taking UPA should not be given Levonorgestrel. In this situation an additional dose of UPA or consideration of the copper IUD would be preferable alternatives.
  - **Before UPA:** the effectiveness of UPA could theoretically be reduced by any progesterone-containing medication, such as hormonal contraception or Levonorgestrel, that is taken in the 7 days prior to administration of UPA.
- Liver-enzyme inducing drugs can increase the metabolism of UPA thereby rendering it less effective. A double dose of UPA is NOT recommended.
- Drugs that increase gastric pH – lower doses of UPA have had their pharmacokinetics altered when esomeprazole is used. The clinical significance of this interaction for single administration of UPA for EC is unknown.

2:17.2 ECP Levonorgestrel

Levonorgestrel is not licensed for use after 72 hours, and the evidence suggests that it is ineffective if taken more than 96 hours after unprotected sexual intercourse (UPSI) [21]. Although it is not licensed beyond 72 hours, it may therefore be of value up to 96 hours post UPSI if other methods of EC are contraindicated or unavailable. Local medication protocols for the supply and administration of the ECP LNG should be followed, and patients should be provided with the appropriate information. LNG taken after the LH surge is likely to be ineffective. The evidence suggests that LNG administered after ovulation is not effective.

Dose of LNG: A single dose of one LNG 1.5 mg tablet is given orally. Occasionally an unlicensed dose of 3mg may be considered for some of the considerations outlined below.

Contraindications and Precautions associated with LNG[21]

- LNG is less likely to be effective in women whose BMI>26 and whose weight is >70 kg. Double dose of LNG (3mg) should be considered in these cases.
- The SPC for Levonelle states that it is not recommended for women with severe hepatic dysfunction.
- Many preparations of LNG contain lactose.
- If a woman has received UPA in the previous 5 days, LNG should not be administered.

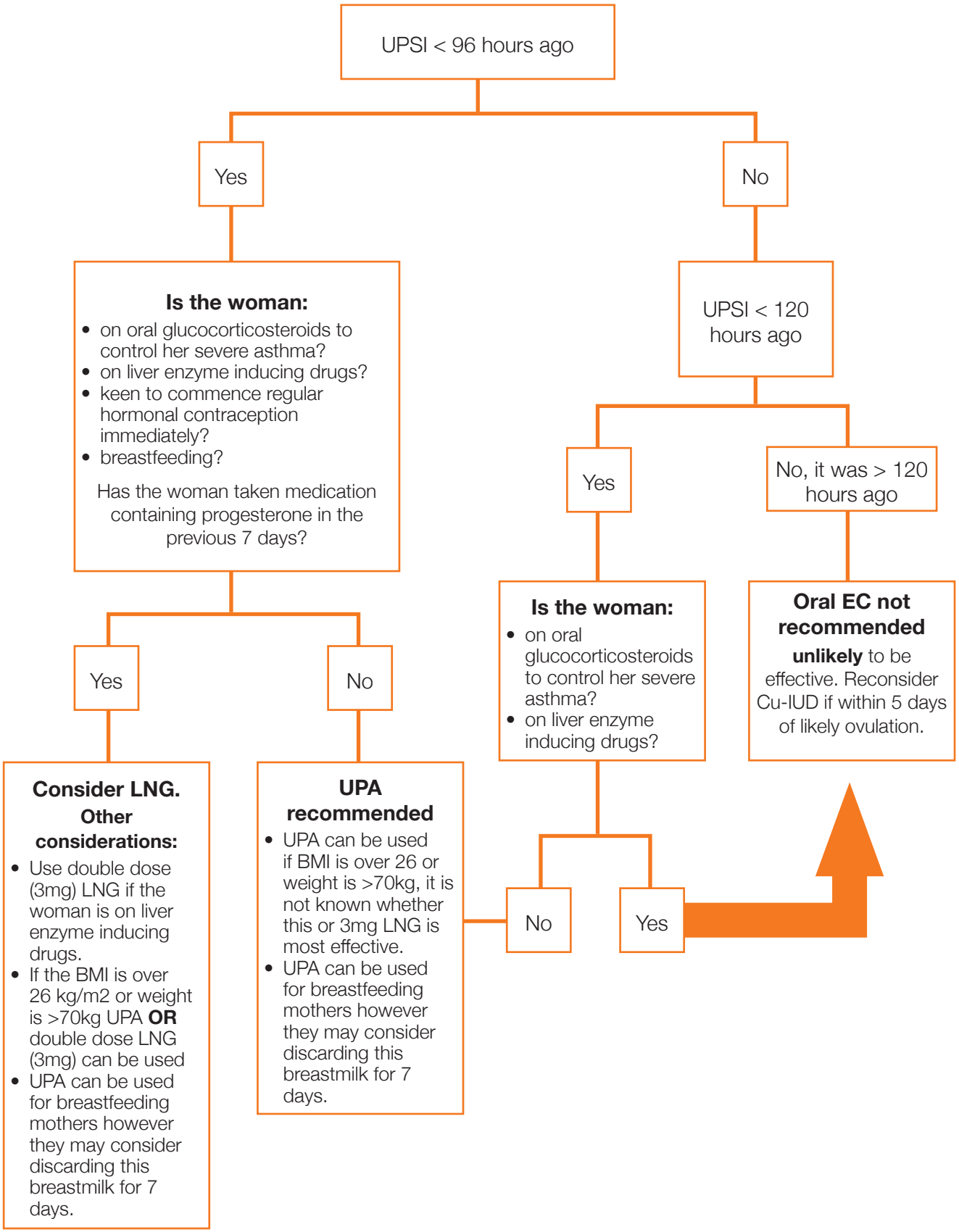
Drug Interactions Relevant to LNG

- Hormonal contraception – suitable hormonal contraception can be commenced immediately after taking LNG. If a woman desires to commence hormonal contraception immediately, and UPSI is unlikely to have occurred during her fertile period, the option of using LNG with immediate commencement of hormonal contraception would be preferable to UPA and delayed commencement of contraception.
- Liver-enzyme inducing drugs can increase the metabolism of LNG thereby rendering it less effective. A double dose of LNG (3mg) can be considered, however women should be advised that the effectiveness of this regimen is unknown. The Cu-IUD would be more effective in this scenario. Examples of enzyme-inducing drugs are outlined below.

2:17.3 Deciding which Oral Emergency Contraception to Prescribe (adapted from FSRH21)

All women should be informed that the Cu-IUD is the most effective form of EC. If this is not available or not acceptable, or an appointment for same is awaited, oral EC should be used.

Figure 3: Emergency Contraception Care Pathway



Key Performance Indicator

[i] **KPI:** % of female patients who present within 120 hours and appropriately received emergency (EC) contraception.

2:17.4 Insertion of Copper Intrauterine Device

Insertion of a copper containing intrauterine contraceptive (Cu-IUD) device is the most effective method of preventing pregnancy,[12, 13, 14, 15, 21] and should be considered for all women who present within 5 days (120 hours) of UPSI or who present later than 120 hours after UPSI but whose earliest likely date of ovulation is 5 days ago or less. The Cu-IUD is the only method of EC that is effective after ovulation has taken place. It also has the advantage of providing effective ongoing contraception. It is not affected by BMI or by other drugs.

Each SATU should develop local pathways to facilitate patient access to Cu-IUD. All women being referred onwards for insertion of Cu-IUD should be given oral EC at the time of referral (unless contraindicated) in case of failed insertion of the Cu-IUD or the woman changes her mind.

Contraindications and Precautions associated with Cu-IUD[21]

- The contraindications to insertion of Cu-IUD for EC are similar to those for routine insertion.
- Breastfeeding – the risk of uterine perforation during insertion of a Cu-IUD is slightly higher when a woman is breastfeeding.
- The Cu-IUD should be inserted after the forensic examination has been performed.
- Antibiotic cover for STI should be considered if a woman opts for Cu-IUD insertion after sexual assault.

Table 11: Time Frames for Emergency Contraception

METHOD	TIME FRAME
Single dose of Levonorgestrel 1.5 mg. (one tablet) orally	As soon as possible within 72 hours.[1, 5] Some evidence suggests value up to 96 hours but the efficacy is uncertain and it is not licensed for use after 72 hours.[1, 7, 8]
Ulipristal acetate 30mg (one tablet) orally	Within 5 days (120 hours) of unprotected intercourse.[10, 11]
A copper containing intra-uterine device	Within 5 days (120 hours) of unprotected intercourse or whose UPSI was over 120 hours ago but the earliest likely day of ovulation is 5 days ago or less.[13,14,15]

2:17.5 Liver Enzyme-inducing Drugs[12]

Women taking liver enzyme-inducing drugs (or who have stopped within the last 28 days) should be advised that a Cu-IUD is the only method of EC not affected by these drugs.

Women taking liver enzyme-inducing drugs (or who have stopped within the last 28 days), and who decline or are not eligible for a Cu-IUD (or indeed if it is not possible to access a Cu-IUD), should be advised to take a dose of 3 mg LNG (e.g two Levonelle tablets) as soon as possible within 120 hours of exposure (outside the product licence).

Examples of liver enzyme inducing drugs include:

- Anti-epileptics such as carbamazepine, phenytoin, topiramate
- Anti-depressants such as St. John's Wort
- Antibiotics such as rifampicin and rifabutin
- Antiretrovirals – use www.hiv-druginteractions.org to check for interactions. Of note the drugs currently used for PEPSE, Truvada® and Raltegravir are NOT enzyme inducers.

Women taking liver enzyme-inducing drugs should be advised not to use UPA during or within 28 days of stopping treatment.

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2:18 Referrals, Follow-up Care and Discharge Planning

2:18.1 Referrals

All SATUs should have a system in place whereby patients have access to a broad range of services/ expertise which is immediately available, if the need arises e.g. Emergency Departments, gynaecology and Mental Health services[1] (See Box 10). Some of these needs are identified at the time of the Forensic Clinical Examination, whereas others may become apparent during the follow-up examinations. The examiner will use professional judgement and in consultation with the patient and/or parent/guardian, make the decision regarding appropriate referrals for support and care. This may include wound care, vaccinations (Tetanus, Hepatitis B vaccine) (See 2:16.1, 4:2.2) prevention and/or treatment of short and long term health problems. Referral is discussed with the patient and clearly documented in the SATU chart.

Box 10: Possible Follow-up Referrals

- Services / expertise from other services e.g. Emergency Department, Gynaecology, Mental Health Services and/or specialist services e.g. Spirasi, Irish Family Planning Association FGM Treatment Service.
- Follow up appointment or referral for STI screening (See 4:2).
- Psychological support services (See 3:4).
- For a patient under the age of 18 years, Children First [2] referral procedures must be followed.
- Social worker referral of vulnerable persons if appropriate (See 2:18:2).
- GP and/or other Primary Health Care Professionals (See 6:2).

2:18:2 Tusla Referrals

A Social Services referral is made for any person who may benefit from Social Services support and intervention. Each SATU should have local referral arrangements in place in conjunction with the local Child and Family Agency. The key aim of the Child and Family Agency (Tusla) and Children First Guidance is to promote the safety and wellbeing of children. For a person under the age of 18 years who attends SATU, Children First referral procedures[2] must be followed. **(KPI)**[i]. All mandated persons have a legal obligation to:

- Report harm of children to Tusla.
- To assist Tusla if requested in dealing with a concern.

If the child is in imminent risk of harm, An Garda Síochána should be contacted and an emergency or Out-of-hours Social Services should be contacted.

This may be facilitated via local arrangements between the SATU and local emergency Social Work services and/or An Garda Síochána.[2]

Referrals should also be sent for children who may be indirectly affected by an adult's attendance in SATU e.g. where a child has witnessed a sexual assault, alcohol and drug use in the home, children of patients with mental health concerns, or any child identified as being at risk by a perpetrator of sexual violence. Particular patients e.g. vulnerable adults, patients in a vulnerable situation, or belonging to a marginalised group, such as people who are homeless, should be referred to the appropriate Social Services Department, where indicated.[4] If the patient has previously been attending Social Services, then with the patient's permission the referral is made through their allocated Social Worker, to facilitate continuity of care.

If concerns exist regarding domestic violence/interpersonal violence[5, 8] it is vital that as well as being provided with a place of safety if required, the patient should also be given information about their local

Key Performance Indicator

[i] **KPI:** % of patients less than 18 years of age who had a referral made to the Child and Family Agency (Tusla), at the first SATU visit.

support services.[6, 7, 8] A full list of national and local services available in Ireland can be accessed from the *Cosc* website www.cosc.ie. In the situation where children may be at risk Children First Guidance [2] must be adhered to. It is also recommended that the contact telephone number of the Garda Station proximate to the SATU, as well as the telephone number of the patient's local Garda Station be made available. A full list of Garda Stations is available at www.garda.ie

Where there are concerns of elder abuse, the HSE Elder Abuse guidelines[5] www.hse.ie should be consulted and followed. If the alleged perpetrator of the abuse is a member of the Health Services Executive staff, the document 'Trust in Care'[9] www.hse.ie gives policy guidance for the procedures to be followed.

2:18.3 Follow-up Care

Appropriate follow-up care is arranged depending on individual patient needs and local services. For Sexually Transmitted Infection follow-up see 4:4. **(KPIs)**[i]

2:19 Discharge

On completion of care in SATU, the patient should be discharged to a safe environment, **(KPI)**[ii] ideally accompanied by a family member, guardian, friend or support person.[1, 3,10] Consent to contact the patient to remind them of future appointments etc. should be confirmed and documented prior to discharge.

(See Box 11 for discharge information which is given to the patient.[11, 12])

When the Forensic Clinical Examiner has completed all the documentation, if the patient wishes, they can return to the waiting area to spend additional time with the Psychological Support Worker and/or family/ friends. Tea/coffee is offered. When the patient and Garda (if present) are ready, they leave SATU prior to SATU staff leaving.

2:19.1 Patient Feedback Mechanism

An anonymous patient feedback mechanism exists, whereby the patient is given a feedback form (usually at the follow-up visit). If the patient wishes to participate in giving feedback regarding the care they received, they may deposit the completed feedback form in a designated collection box, or give their feedback on-line at www/hse/satu.ie/feedback

Key Performance Indicator

[i] **KPI:** % of patients who attended the SATU who were given an STI review appointment.

[ii] **KPI:** % of patient SATU documentation completed, with regard to safety of home environment, after the first SATU visit.

Box 11: Discharge information given to the patient:

1. Patient Information Leaflet which should include:
    - Date of attendance
    - Tests/procedures performed
    - Medications given
    - Follow-up appointment date and time, and what will take place at that appointment
    - Contact details for SATU, Gardaí and psychological as relevant
2. Instruction on the care of any injuries.
3. Medication instructions, if applicable.
4. Referral letter, if applicable.
5. Information re: TUSLA referral as per Children First Guidance[2]
6. If the patient consents, a letter is provided for the G.P.
7. Letter for work, college, school, if required.
8. Phone number and printed information leaflet from psychological support.
9. Relevant information leaflets specific to the individual patient's needs, e.g:
    - Domestic Violence.[6, 7, 8]
    - Interpersonal Violence.
    - Drug and Alcohol programmes.[11]
    - Personal Safety Awareness programmes.[12]

References

1 White, C. *Sexual Assault: A Forensic Clinician's Practice Guide*. St. Mary's Centre, Manchester. 2010.

2 Department of Children and Youth Affairs (2017) *Children First – National Guidance for the Protection and Welfare of Children*. Department of Children and Youth Affairs, Dublin

3 Government of Ireland. *Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons)* Act 2012. www.irsihstatutebook.ie

4 Health Service Executive *HSE Policy on Domestic, Sexual and Gender Based Violence*. Stationery Office, Dublin. 2010. www.lenus.ie

5 Health Service Executive. *Open Your Eyes: there's no excuse for elder abuse*. HSE Elder Abuse Services, Dublin. 2012. www.hse.ie

6 World Health Organisation (WHO). *Responding to intimate partner violence and sexual violence against women. WHO clinical and policy guidelines*. 2013 Geneva: WHO www.who.int

7 World Health Organisation (WHO). *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*. WHO: Geneva. 2013; www.who.int

8 ní Riain, A. and Daly, M. *Domestic Violence: A Guide for General Practice*. Irish College of General Practitioners (ICGP) Update, 2014. www.icgp.ie

9 Health Service Executive. *Trust In Care: Policy for Health Service Employers on Upholding the Dignity and Welfare of Patient/Clients and the Procedure for Managing Allegations of Abuse against Staff Members*. Stationery Office, Dublin. 2005. www.lenus.ie

10 Eogan, M., McHugh, A. and Holohan, M. The role of the sexual assault centre. Best Practice and Research Clinical Obstetrics and Gynaecology, 2013; 27, 47- 58.

11 Department of Health *Steering Group Report on a National Substance Misuse Strategy*. Stationery Office, Dublin. 2012. www.dohc.ie/publications

12 Department of Children and Youth Affairs *Child Protection Policy and Code of Behaviour for working with children/young people*. Department of Children and Youth Affairs, Dublin. 2011. www.dcya.ie

2:20 Legal Report Writing

The Forensic Clinical Examination report should be dictated/typed as soon as possible after the Forensic Clinical Examination. A legal report template, covering all the salient points may be useful (See Appendix 2: SATU Legal Report Template).

2:20.1 Responding to an Additional or Alternative Opinion

In circumstances where an additional or alternative opinion is sought by the defence, or occasionally, the prosecution, the Forensic Clinical Examiner, who carried out the original examination and produced the medico-legal report:

- Will be furnished with a copy of the additional or alternative opinion.
- May be asked for their opinion on the additional or alternative opinion.
- The original Forensic Clinical Examiner's further opinion may then become particularly important; sometimes explaining or indeed changing the opinion they gave in their original report .
- The Forensic Clinical Examiner responds with their comment on the findings and the academic content in the additional or alternative report, focusing always on the relevance to the particular case.
- No new or undisclosed material should be brought by the Forensic Clinical Examiner into court. Any such material e.g. literature etc. that is used in response to the additional or alternative opinion should be disclosed in advance (See 7:4).

Option 3: Collection and Storage of Forensic Evidence Without Immediate Reporting to An Garda Síochána

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Option 3: Collection and Storage of Forensic Evidence Without Immediate Reporting to An Garda Síochána

2:21 Introduction to Option 3

This care pathway (Option 3) allows for the collection and preservation of evidentially valuable forensic samples, in circumstances where the person has yet to decide to report to An Garda Síochána. Women and men 18 years and older can now choose to attend a SATU, where they will receive the full package of care, including examination and collection of forensic samples (See 2:6). These samples will then be stored in an appropriate facility within the SATU for up to one year with checks in place to ensure continuity of evidence. Over that time, the person can come to an informed decision, regarding whether or not they wish to report the incident to An Garda Síochána. As the evidence will be in secure storage, this can subsequently be released to An Garda Síochána to facilitate detection of the reported crime.

Provision of this reporting option is underpinned by the knowledge that sexual violence, is unfortunately, common in our society.[1] Both the high prevalence, but also the high rates of non-disclosure or delayed disclosure are areas of concern. Any improvements in service delivery that might redress non- disclosure or delayed disclosure is vital, primarily for affected individuals, but also for society as a whole. National strategies from Cosc[2] and the Health Service Executive (HSE)[3] have highlighted the importance of frameworks not only to prevent, but also to appropriately respond to sexual violence.

Reporting to An Garda Síochána is however encouraged. For a possible prosecution to proceed, a complaint must be made to An Garda Síochána. Involvement of An Garda Síochána from the outset provides the greatest potential for gathering the best possible evidence for a successful prosecution. However, the traumatic nature of such incidents can result in the person requiring some time to consider whether or not to make a formal complaint to An Garda Síochána. With a view to gathering the best possible evidence in these circumstances, Option 3 is offered.

Before Option 3 was available, forensic evidence would have been lost if the person chose not to report promptly.[4] Option 3 allows retention of some forensic samples but delayed reporting to An Garda Síochána may mean that other forensic evidence is lost e.g.

- CCTV may no longer be available.
- Potential witnesses may not be identifiable/available.
- Forensic evidence will be lost from the scene(s) of the incident.

Should a prosecution proceed following the Option 3 pathway, the reason for any delay in reporting the incident to An Garda Síochána will need to be explained by the complainant.

If the incident happened in another jurisdiction Option 3 is still available, but the evidential value of the samples will be subject to the national law of that jurisdiction. As such there may be unforeseen restrictions on their probative value.

It is hoped that the provision of Option 3 will increase the rates of reporting of sexual crime; as people who are uncertain about their reporting intentions[4] will not make a rapid decision not to report the incident, which they may subsequently regret. In the United States Military Model, in 2007, 14% of *victims* who had initially chosen to restrict their reports later reported to allow a criminal investigation to ensue.[5] Similarly in Ireland between July 2016 and December 2017, 11% patients chose Option 3. Within this cohort, 15% have gone on to report the incident to An Garda Síochána allowing a criminal investigation to proceed. Whilst there

is no 'statute of limitation' in respect of serious offences and delayed reporting should therefore not be considered an impediment to prosecution per se or indeed to affect the credibility of a complainant, there are legal consequences to delayed reporting (See 7:6).

References

1 Magee, *et al*. *The SAVI Report: Sexual Abuse and Violence in Ireland*. Dublin: The Liffey Press in association with Dublin Rape Crisis Centre. 2002.

2 Cosc. The National Office for the Prevention of Domestic, Sexual and Gender- based Violence; Dept. of Justice, Equality and Law Reform (DJELR). *National Strategy on Domestic, Sexual and Gender-Based Violence 2016-2021*. Dublin: Stationary Office. 2010. www.lenus.ie

3 Health Service Executive (HSE) *HSE Policy on Domestic, Sexual and Gender Based Violence*. Dublin. 2010. www.lenus.ie

4 Wolitzky-Taylor, K.B., Resnick, H.S., McCauley, J.L., Amstadter, A.B., Kilpatrick, D.G. and Rugiero, K.L. Is Reporting of Rape on the Rise? A Comparison of Women with Reported versus Unreported Rape Experiences in the National Women's Study Replication. *Journal of Interpersonal Violence*. 2011; 26 (4) pp. 807-832.

5 US Department of Defence. *Report on Sexual Assault in the Military* (No FY07). 2008.

Option 3: Collection and Storage of Forensic Evidence Without Immediate Reporting to An Garda Síochána

- Not reporting to An Garda Síochána* at the initial SATU visit but having:
  - A Forensic Clinical Examination **without** Garda involvement.
  - Storage of the Sexual Offences Examination Kit/Toxicology Kit for the defined duration of 1 year (unless a further year is requested in writing by the patient, samples are destroyed).
  - Contemporaneous medico-legal report to be written and filed confidentially in the SATU (i.e. not issued to An Garda Síochána at this juncture).
- The person has a choice at a later date to make a formal report to An Garda Síochána:
  - The Sexual Offences Examination Kit/Toxicology Kit and the medico-legal report will then be released to An Garda Síochána (ensuring the continuity of evidence).

*Subject to statutory reporting requirements e.g. Children First Guidance[1] or Withholding Information Act.[2]

1. Department of Children and Youth Affairs (2017) Children First – National Guidance for the Protection and Welfare of Children. Department of Children and Youth Affairs, Dublin.

2. Government of Ireland. *Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act*, 2012. www.irishstatutebook.ie

2:22 Aim/Objectives/Scope/Service Provision

2:22.1 Aim

The aim of this section of the document is to define best practice for SATUs who offer patients Option 3: Forensic Clinical Examination with collection and storage of evidence without the immediate involvement of An Garda Síochána.

2:22.2 Objectives

To define:

- Best practice criteria for SATUs who offer Option 3.
- Safeguards to protect the patient's confidentiality.
- A framework for quality assurance and quality control.

2:22.3 Scope

The scope of this section of the SATU guidelines covers: Forensic Clinical Examination without An Garda Síochána Involvement. The guideline covers all disciplines involved when offering Option 3 including the following key elements:

- Facilitating the choice of option(s).
- Maintaining confidentiality.
- Safe, secure storage of forensic evidence.
- Maintaining continuity of evidence.
- Release of stored evidence and medico-legal report following a formal complaint to An Garda Síochána.
- Destruction of stored evidence when the time frame for storage has lapsed, or on the patient's explicit instructions.
- Outlining specific staff roles and responsibilities.

2:23 Who Can Avail of Option 3?

- Any person aged 18 years of age or over who has the capacity to make these decisions and who presents within 7 days of the incident.

2:24 Who Cannot Avail of Option 3?

- Persons less than 18 years of age.[1, 2]
- A person lacking the capacity to consent (See 2:5.2).
- If the incident happened more than 7 days ago (See 5:7).

2:25 Option 3: SATU Process

NB. The person may firstly contact another agency e.g. RCC/CARI, An Garda Síochána or Healthcare Personnel and subsequently be referred on to a SATU.

2:25.1 SATU Process: Setting up an Appointment

- Give the person information regarding their options.
- Schedule an appropriate appointment.
- Link with appropriate supports.
- Option 3 cases should only take place in SATU.

2:26 When the Person Presents to the SATU

- The person is introduced to the SATU Team and is offered the services of the Psychological Support Worker.
- The Sexual Offences Examination Kit is opened:
  - By the Forensic Clinical Examiner in the presence of the SATU support staff.
  - Identifying details of the Kit and personnel are documented in the SATU chart.
- Consent:
  - Consent is obtained and **PART A** of the relevant consent form (SATU National Patient Documentation) is completed.

2:27 Forensic Clinical Examination and Care

The history, examination and associated care follow the National Guidelines format (See 2:6) and the SATU National Patient Documentation is used.

2:28 What can be stored?

- Sexual Offences Examination Kit.
- Underwear packed within the Kit.
- Sanitary protection packed within the Kit.
- Toxicology Kit.

2:29 What cannot be stored?

- Clothes other than underwear (See Box 12)

Box 12: Patient may decide to store relevant items of their clothing

If appropriate, the patient may decide to self store relevant items of their clothing. The patient should be aware of possible future difficulties with regard to self storage (e.g. questions regarding continuity of evidence). If the patient wishes to proceed with self storage of relevant items of their clothing paper bag/s may be given to the patient, for individual items of clothing that will be stored.

2:30 Packaging the Sexual Offences Examination and Toxicology Kits

Pack the tamper evident bags with the specimens signed by the Forensic Clinical Examiner. Ensure all components are stored together in the freezer.

Sexual Offences Examination Kit

- The medical form is completed and attached to the outside of the Sexual Offences Examination Kit tamper evident bag.
- The Sexual Offences Examination Kit tamper evident bag is sealed and signed by the Forensic Clinical Examiner.

Toxicology Kit

- The Toxicology Kit tamper evident bag is sealed and signed by the Forensic Clinical Examiner.

2:31 Legal Report

- The Forensic Clinical Examination legal report[i] should be prepared as soon as possible after the Forensic Clinical Examination.
- If a formal report of the incident is made to An Garda Síochána, an addendum is made to the legal report[ii] prior to its release, outlining that the forensic samples had been stored and details of their release to An Garda Síochána.

i Appendix 2: SATU Legal report template: Sample.

ii Appendix 3: Addendum to legal report: Sample.

2:32 Storage Facilities and Storage of Forensic Evidence

- A locked freezer is located in a password or swipe card protected secure area.[iii]
- The freezer temperature is kept between minus 10° to minus 30° centigrade.[iii, iv, v]
- Only key personnel have access to the password protected secure area.[vi]
- The Forensic Clinical Examiner places the tamper evident bags containing the Sexual Offences Examination Kit with the relevant form attached and the Toxicology Kit in the freezer.
- The Forensic Clinical Examiner completes **Section A of the stored evidence record**[vii] (Incorporated into the SATU National Patient Documentation, p.25).
- Freezer temperature monitoring[iii, viii] and maintenance requirements are observed.[viii, ix] as per guidelines.

2:33 Pre-Discharge Care is Provided as per Section 2

The patient is reminded of their options with regard to subsequent reporting to An Garda Síochána and given relevant written information.

References

1 Department of Children and Youth Affairs (2017) Children First – National Guidance for the Protection and Welfare of Children. Department of Children and Youth Affairs, Dublin.

2 Government of Ireland. *Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act*, 2012. www.irsihstatutebook.ie

iii Appendix 4: Information regarding freezers.

iv Forensic Science Laboratory: Calibrating of Temperature Monitored Equipment. FSLBTS007.

v Forensic Science Laboratory: Temperature Monitoring DNA. FSLBTS0071

vi Appendix 5: Form for list of key personnel with access to the password protected secure area.

vii Appendix 6: Stored Evidence Record for Continuity of Evidence.

viii Appendix 7: Form for Recording Freezer Temperature Monitoring: Sample.

ix Appendix 8: Form for Recording freezer maintenance / Service / Repair / Calibration record.

An Garda Síochána

2:34 Person Subsequently Reports the Incident to An Garda Síochána

(See also Flowchart: Figure 4: p. 113).

2:34.1 Mechanism of Formally Reporting to An Garda Síochána

- A person may make a formal report either directly to An Garda Síochána or via a RCC or SATU.
- Contact is made with the Garda Station local to where the incident happened. The full list of Garda Stations and District Headquarters is available at www.garda.ie
- An Garda Síochána is informed of the nature of the complaint and that forensic evidence is currently being stored in the relevant SATU.

2:34.2 An Garda Síochána: Process

- The complainant is treated as a **first time reporter.** The Garda follows the procedures as outlined (See 1:9) with the following exceptions:
  - The Forensic Clinical Examination has already been conducted.
  - The investigating Garda must make arrangements for transporting the forensic evidence from the relevant SATU to the Forensic Science Ireland.
- The complainant is requested to sign the appropriate consent form[i] for the release of stored forensic evidence and a legal report from the SATU to An Garda Síochána.
- The investigating Garda informs the relevant SATU as soon as possible that a formal report has been made.
- The investigating Garda will ensure that an appointment is made with the SATU, to collect the stored forensic evidence and, when available, the legal report from the Forensic Clinical Examiner.
- The Garda responsible for collecting the forensic evidence brings the completed consent form to the SATU, authorising the release of the stored forensic evidence and issue of a legal report.
- The Garda and SATU staff confirm the integrity of the tamper evident bags and toxicology bags, prior to signing the stored evidence record. Any irregularity is documented by the Garda.
- The Garda completes the SATU Stored Evidence Record form for continuity of evidence[i] and two photocopies are made
  - The original copy is retained by the SATU.
  - The two photocopies are taken by the attending Garda:
- One photocopy is retained by the Gardaí ('true copy') as a possible future exhibit with regard to continuity of evidence.

ii Appendix 9: Consent authorising release of stored forensic evidence and a legal report to An Garda Síochána: Sample.

- Second photocopy will be taken by the Gardaí with the forensic evidence to Forensic Science Ireland.
- The investigating Garda should check with the complainant whether s/he had decided to self-store relevant items of clothing and, where appropriate, arrange for the delivery of such clothing to Forensic Science Ireland.
- The Garda transports the:

  1) Sexual Offences Examination Kit

  2) Toxicology Kit in a cool box

  3) A completed SATU Stored Evidence Record form to the Forensic Science Ireland.

SATU

2:34.3 SATU Releasing Stored Evidence to An Garda Síochána: Process

- Any communication from An Garda Síochána that the person has made a formal complaint is clearly recorded in the patient's SATU documentation.
- The completed consent form[ii] is brought by the Gardaí to SATU, authorising the release of the stored forensic evidence and a legal report to An Garda Síochána.
  - A copy of the consent form is kept by SATU to be filed in the patient's SATU documentation.
- The patient's SATU documentation is located and the consent form is checked against the:
  - Patient's name, date of birth, date of examination.
- The patient's SATU documentation is then used to locate the correct stored tamper evident bag/s, cross-checking the following:
  - Patient's name, date of birth, SATU reference number, date of examination and the tamper evident bag numbers toxicology bag.
- The integrity of the tamper evident bag/s is confirmed in the presence of the Garda.
- **Section B of the Stored Evidence Record**[i] is completed in the SATU by a Forensic Clinical Examiner or Registered Nurse/Midwife and the Garda receiving the forensic evidence (same incorporated into the SATU National Patient Documentation, p. 25). Two photocopies are made:
  - The original Stored Evidence Record form is filed in the patient's documentation.

    This original record must be retained by the SATU, in the event that it is required by the court.
  - The two photocopies are given to the Garda,

i Appendix 6: Stored Evidence Record form for Continuity of Evidence.

ii Appendix 9: Consent authorising release of stored forensic evidence and a legal report to An Garda Síochána: Sample.

- One photocopy is retained by the Gardaí ('true copy') as a possible future exhibit with regard to continuity of evidence.
- Second photocopy will be taken by the Gardaí with the forensic evidence to Forensic Science Ireland.
- The Forensic Clinical Examiner who carried out the forensic examination is notified to complete the legal report addendum,[ii] prior to the release of the legal report to the Gardaí.
- The SATU database is updated at the appropriate section to reflect the fact that the case has converted from Option 3: Forensic Clinical Examination with storage of the forensic evidence, to the person making a formal report to An Garda Síochána.

Forensic Science Ireland

2:34.4 Forensic Science Ireland: Process

Processing Forensic Evidence Previously Stored in a SATU

- The Garda delivers the forensic evidence , the Sexual Offences Examination form, and a photocopy of the Stored Evidence Record form[i] to Forensic Science Ireland.
- A record is made in Forensic Science Ireland that the evidence had been stored for a given period in a SATU.

i Appendix 6: Stored Evidence Record form for Continuity of Evidence.

ii Appendix 3: Addendum to legal report: Sample.

Figure 4: Flowchart - Formally Reporting the Incident to An Garda Síochána when the Forensic Evidence has been Stored in a SATU

RCC/Other
RCC facilitates person contacting An Garda Síochána.

Record made.

An Garda Síochána
Person makes contact with An Garda Síochána, having previously been to a SATU and had a Forensic Clinical Examination.
Record made.

SATU
SATU Staff facilitates patient contacting An Garda Síochána.

Record made in patient's documentation.

Contact made with the Garda Station local to the incident.
Details of all Garda Stations/Divisions at www.garda.ie

Request made to speak to a **Garda Sergeant, where possible**.

Garda Sergeant is informed of the nature of the complaint and of the previous SATU visit and that evidence is being stored in the SATU.

An Garda Síochána

- Treated as a first time reporter by An Garda Síochána.
- Person is requested to sign the consent form, authorising the release of the stored forensic evidence and the issuing of a legal report from the SATU to An Garda Síochána.[1]
- Garda informs the relevant SATU that a formal report has been made (To prevent possible destruction of stored evidence e.g. if 1 year time frame due to expire).
- Member of An Garda Síochána makes an appointment with the relevant SATU to collect the forensic evidence.
- Garda brings the completed consent form, authorising the release of stored evidence and a legal report to SATU. A copy of the consent form is retained in SATU as part of the SATU documentation.
- The Garda and SATU staff, confirm the integrity of the tamper evident bags, prior to completing and signing Section B of the SATU stored evidence record.[2] Any irregularity is documented by the Garda.
- 2 photocopies are made of the completed stored evidence record in SATU:
  - The original copy is filed in the documentation in the SATU.
  - One photocopy is retained by the Gardaí ('true copy') as an exhibit for continuity of evidence.
  - The second photocopy, the Gardaí will take with the forensic evidence to Forensic Science Ireland.
- The Garda transports the Sexual Offences Examination Kit and the Toxicology Kit in a cool box and a copy of the completed SATU Stored Evidence Record form[2] to Forensic Science Ireland.

1 Appendix 9: Consent authorising release of stored evidence and a legal report to An Garda Síochána.
2 Appendix 6: Stored Evidence Record form for Continuity of Evidence.

SATU releasing stored evidence to An Garda Síochána[1]

- SATU receives the completed consent form from the Gardaí,[2] authorising the release of the stored forensic evidence and a legal report to them. Copy of same kept by SATU, filed in patient's documentation.
- The SATU staff and Garda confirm the integrity of the tamper evident bags, prior to completing and signing **Section B** of the SATU stored evidence record[3] (Incorporated in SATU National Patient Documentation, p. 25).
- The original completed stored evidence record must be retained for potential court purposes by SATU.
- The medico-legal report addendum is completed prior to release of the legal report to the Gardaí.[4]

1 Appendix 10: Checklist re: Releasing stored evidence and legal report.
2 Appendix 9: Consent authorising release of stored evidence and a legal report to An Garda Síochána.
3 Appendix 6: Stored Evidence Record form for Continuity of Evidence.
4 Appendix 3: Addendum to the legal report.

Forensic Science Ireland

- Garda delivers the forensic evidence and the copy of the stored evidence record[1] to Forensic Science Ireland
- Forensic Science Ireland makes a record that this evidence had been stored for a given period in a SATU

1 Appendix 6: Stored Evidence Record form for Continuity of Evidence.

2:35 Destruction and Disposal of Forensic Evidence

2:35.1 Reasons the Forensic Samples May be Destroyed and Disposed Of:

- Agreed time frame of 1 year storage has lapsed and there is no request to extend the period of storage **or**
- At the patient's signed request. (**PART B of the consent form** - Storage of Evidence Section, SATU National Patient Documentation, p . 24).

NB. The stored forensic samples cannot be released to the patient; they must be destroyed and disposed of by the SATU Staff.

2:35.2 Principles to be followed:

- Safe disposal of clinical healthcare risk waste.
- Destruction and disposal of confidential forensic evidence.

2:35.3 Destruction and Disposal of the Sexual Offences Examination and Toxicology Kits

- The checklist for destruction and disposal of forensic samples should be used.[i]
- The specimens are disposed of by a Forensic Clinical Examiner or Registered Nurse/Midwife and the process is witnessed by a second person.
- Universal precautions are followed.[1]
- The Sexual Offences Examination and Toxicology Kits are removed from the freezer.
- The patient's name, date of birth, date of examination and tamper evident bag numbers are cross checked against the patient's SATU notes.
- **The stored evidence record is completed at Section B**[ii] by both persons.
- The tamper evident bags are opened.
- Separate the samples (which contain blood and body fluids)[1] from the opened tamper evident bags and the attached Kit forms.
- Place both the samples and the now empty opened tamper evident bags in a clinical waste container.
- The container is sealed, tagged and signed by both witnesses.
- The forms accompanying the Kits are destroyed appropriately.
- The sealed clinical waste container is delivered by both the person disposing of the Kits and the witness, to the designated collection point as per local and national policy.[1]

i Appendix 11: Checklist for destruction/disposal of forensic samples. Sample.

ii Appendix 6: Stored Evidence Record form for Continuity of Evidence.

- The destruction and disposal tag number, the date and the signature of both the person destroying the Kits and the witness are entered in the patient's SATU documentation.
- Local protocol is followed when recording the date and tag number for future audit purposes.
- The completed checklist is filed appropriately in the patient's SATU documentation.

References

1 Department of Health and Children. *Segregation Packaging and Storage Guidelines for Healthcare Risk Waste*, 3rd edition, 2004. Dublin: Department of Health and Children. www.lenus.ie

SECTION 3: PSYCHOLOGICAL SUPPORT

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PSYCHOLOGICAL SUPPORT

Active SATU Multi-Agency Steering Group with RCC member

Current RCC Liaison Person to the SATU

Contact & Referral Protocols between RCCs and SATUs

Information Leaflets for Victims

Victim contacts

- An Garda Síochána
- SATU
- RCC
- A&E or GP

Chooses to Attend a SATU

At SATU

Psychological Support Worker provides:

- Crisis Intervention
- Advocacy
- Psychological Support
- Information for Family/Friends

Leaving SATU

Psychological Support Worker ensures:

- Information
- Links to appropriate services
- Any advocacy/counselling appointments if scheduled

3:1 Psychological Trauma and Sexual Violence

Psychological trauma is an emotional response to a terrible event such as rape, physical attack, a plane crash or a natural disaster. It occurs when both internal and external resources are inadequate to cope with an external threat. The event or events lead to a response involving intense fear, helplessness or horror. In terms of sexual violence: *"The essential element of rape is the physical, psychological, and moral violation of the person. . . . Thus rape, by its nature, is intentionally designed to produce psychological trauma*."[1] Physical injury is not a necessary component. It is not unusual for experiences of sexual violence to be devoid of severe physical injury or threat to the victim's life and yet be extremely traumatic. ". . . . *there is something rather unique about the nature of rape that differentiates it in some important respects from other types of trauma. Evidently, the experience of being treated as less than a human being, being denied one's subjectivity, crushes the rape victim's sense of self and protective capacities in an unmatched manner."*[2]

3:2 Possible Victim/Survivor Reactions

There is no one 'normal' way to react after experiencing sexual violence. A victim/survivor may present as expressive and tearful, quiet and controlled, distressed, in shock, in denial and/or experiencing physical revulsion.[3] The most common immediate emotional reactions reported following sexual and/or physical attacks were shock, anger and fear, followed by annoyance, embarrassment, shame, guilt and aggressiveness.[4] Other common short-term and longer-term emotional reactions include fear, helplessness, panic, despair, anger, frustration, numbness, hyper-alertness, grief, disorientation, uncertainty, and/or a sense of being overwhelmed.[5] In the midst of all of this, a victim/survivor has a variety of needs - varying from immediate physical and emotional safety to overcoming shame, arriving at a fair assessment of their conduct, rebuilding trust, and recreating a positive sense of self.[1] When a victim/survivor discloses sexual violence it is important, and one determinant of a victim/survivor's future well-being, that the response to the disclosure is informed by an understanding of the potential psychological reactions to sexual violence.[3] Anyone subjected to sexual violence must make many, often overwhelming, decisions. These include how the experience is named, whether and how to tell family or friends, whether to report the crime and whether to allow for the collection of forensic evidence from their own bodies.

References

1 Herman, J. L. *Trauma and Recovery: From Domestic Abuse to Political Terror*. London: Rivers Oram Press/Pandora List. 2001, pp. 57-58.

2 Moors, A. et al. Rape: A Trauma of Paralyzing Dehumanization. J*ournal of Aggression, Maltreatment & Trauma*; 2013. Vol. 22, pp. 1051–1069 p. 1063.

3 Mason, F. & Lodrick, Z. Psychological Consequences of Sexual Assault. *Best Practice & Research Clinical Obstetrics & Gynaecology*; 2013. Vol 27, pp. 27-37.

4 FRA European Agency for Fundamental Rights. *Violence against women: an EU-wide survey - Main results*. 2014. Available at http://fra.europa.eu/en/vaw-survey-results.

5 Fanflik, P. *Victim Responses to Sexual Assault: Counterintuitive or Simply Adaptive?* American Prosecutors Research Institute, National District Attorney's Association, 2007. Available at http://www.ndaa.org/pdf/pub_victim_responses_sexual_assault.pdf

Psychological Support Response

Physical & Psychological needs of the victim/survivor are the priority

- Support victims/survivors through each component of the SATU service that they choose.
- Serve as an information resource for victims/survivors.
- Provide victims/survivors with crisis intervention and support.
- Let victims/survivors know their reactions to the assault are normal and dispel misconceptions regarding sexual assault.
- Advocate for victims/survivors' self-articulated needs to be identified and their choices to be respected.
- Assist victims/survivors in planning for their safety and well-being.
- Link victims/survivors with relevant services.
- Help victims'/survivors' families and friends cope with their reactions to the sexual violence by providing information.

Subject to statutory reporting requirements e.g. Children First Guidance[1] or Withholding Information Act.[2]

References

1. Department of Children and Youth Affairs (DCYA) *Children First: National Guidance for the Protection and Welfare of Children*. Dublin: Stationery Office; 2011. www.dcya.ie

2. Government of Ireland. *Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act*, 2012. www.irsihstatutebook.ie

3:3 The Place of Psychological Support within a Multi-Agency SATU Service

Psychological support encompasses a variety of activities that go some way towards meeting both immediate emotional safety and longer term healing needs. This support can potentially come from a number of different sources including friends, family, rape crisis personnel, health care staff, members of An Garda Síochána, work colleagues and religious personnel. Official state personnel with whom victims/survivors come in contact are focused on objective tasks. The role of the Gardaí is to gather information and collect evidence to facilitate their investigation. Evidence indicates that role is best accomplished by treating the victim/survivor respectfully and providing information about the on-going legal process.[1] While health care staff can provide crucial psychological support in terms of treating victims/survivors respectfully, providing information in a way that they can understand, and allowing them to make their own choices, in order for a Forensic Clinical Examiner's report and testimony to be credible, the Forensic Clinical Examination needs to be conducted in an objective manner.

The focus of Rape Crisis Psychological Support Workers is on immediate crisis intervention and advocacy, as well as providing a tangible and personal connection to longer-term sources of advocacy, support and counselling. When Psychological Support Workers support victims/survivors, Forensic Clinical Examiners can more easily maintain an objective stance. The provision of psychological support from rape crisis

personnel is vital in terms of victim/survivors ability to access needed services, and if they choose to report the crime, their willingness to continue with a prosecution.[1]

The International Association of Forensic Nurses (IAFN) recognises the importance of the Psychological Support Worker role including: "*. . . . the benefits to victims of violence when there is timely interaction with Victim Advocates. Furthermore, IAFN recognizes and supports the role of the Victim Advocate as part of a patient centered team approach to providing services to victims. IAFN encourages the creation of strong collaborative relationships between forensic nurses, advocates and other team members in order to provide rapid, compassionate, comprehensive, patient centered and evidence-based care to victims.*"[2] The IAFN is based in the United States and in the U.S.A. Rape Crisis Psychological Support Workers are commonly referred to as Victim Advocates. The Council of Europe considers psychological support and advocacy for those experiencing sexual violence and intimate partner violence important enough to have developed minimum standards for the services.[3] International research indicates that sexual violence survivors receive more and better legal and medical services when accompanied by rape crisis support.[4]

3:3.1 Structures to Support a Multi-Agency SATU Service

In order for a SATU to be in a position to provide the collaborative multi-agency services which are required by victims/survivors five elements are required. Having these elements in place provides the framework for Psychological Support Workers to provide advocacy, crisis intervention and support to individual victims/survivors. These elements are:

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

- The steering group is responsible for the on-going operation and governance of the SATU. This group provides for and fosters the integrated and collaborative inter-agency response necessary for appropriate service provision. This complies with the recommendations contained in *Sexual Assault Treatment Services: A National Review*.[5] In addition, the reflection of the interdisciplinary and multi-sectoral service in the St. Mary's SARC (Manchester, England) steering group is a component of why St. Mary's is considered a best practice service in research commissioned by the European Parliament.[6]

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

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

3. A protocol to ensure that the RCC Psychological Support Worker is contacted

- This protocol needs to encompass contacting the Psychological Support Worker when the SATU is aware that a victim/survivor is on the way, or if the SATU has not had any advance notice, when a victim/survivor arrives in the SATU. This enables the victim/survivor to make a real choice

about whether they want to speak with a Psychological Support Worker. Best practice is that a Psychological Support Worker from the RCC is immediately available to speak with victims/survivors if they choose. **(KPI)**[i]

4. **A protocol to ensure that the RCC has a mechanism to quickly contact the SATU if a victim/survivor contacts the RCC and then chooses to attend the SATU**
   - This protocol needs to be designed to expedite the victim/survivor's access to the SATU.
5. **Information leaflets provided by the RCC/RCNI should be available in the SATU for anyone to take away with them.**
   - It is the responsibility of the RCC SATU liaison person to ensure that the leaflets are available.
   - Leaflets need to be written in simple language.
   - Leaflets should be available in as many languages as possible.

3:4 Psychological Support Worker Role

The role of the Psychological Support Worker is to be available at the SATU at any time, 24 hours a day, when a victim/survivor arrives at the unit or is on the way to the unit. The Psychological Support Worker is trained to and able to provide advocacy, psychological support and crisis intervention throughout the time that a victim/survivor is at the SATU. This includes supporting the victim/survivor in making choices about who is to be told about the violence and any other sources of psychological support that they may access in the longer-term.

The Psychological Support Worker needs to ensure that the victim/survivor has as much information as possible before making choices. An individual victim/survivor may need or want to have someone else with them while they make choices about whether to make a formal statement to the Gardaí and whether to undergo a Forensic Clinical Examination. The accompanying person may be the Psychological Support Worker or a person the victim/survivor chooses or needs e.g. a friend or a family member. If the victim/survivor needs or wants to be accompanied while undergoing a Forensic Clinical Examination, it is important that the potential forensic and legal implications are discussed with the Forensic Clinical Examiner.

The Psychological Support Worker is also available to provide support and information to anyone else who comes to the Unit with the victim/survivor. Many victims/survivors may prefer to use rape crisis personnel for useful support, even when family or friends are present. Some victims/survivors may not be sure what their family or friends will think or how they will react. Other victims/survivors are sure that their family or friends will react badly. If the Psychological Support Worker arrives at the SATU and, at that point, the victim/survivor chooses not to speak with the Psychological Support Worker that choice will be respected. For the specific services provided by Psychological Support Workers[7] (See Box 13).

Key Performance Indicator

[i] **KPI:** % of patients who had the opportunity to speak with a Psychological Support Worker at the first SATU visit.

Box 13: Specific Services provided by Psychological Support Workers include:[7]

- **Supporting victims/survivors through each component of the SATU service** that they choose. This includes deciding whether to have a Forensic Clinical Examination or a Health Check, going through an Examination or Health Check and speaking with An Garda Síochána.
- **Serving as an information resource for victims/survivors.**
- **Providing victims/survivors with crisis intervention and support** to help cope with the trauma of the assault and begin the healing process.
- **Actively listening to victims/survivors to assist in sorting through and identifying their feelings.**
- **Letting victims/survivors know their reactions to the assault are normal** and dispelling misconceptions regarding sexual assault.
- **Advocating for victims/survivors' self-articulated needs to be identified and their choices to be respected,** as well as advocating for appropriate and coordinated response by all involved professionals.
- **Assisting victims/survivors in planning for their safety and well-being.**
- **Aiding victims/survivors in identifying individuals who could support them as they heal.**
- **Linking victims/survivors with relevant services.**
- **Responding in a culturally and linguistically sensitive and appropriate manner** to victims/survivors from different backgrounds and circumstances and advocating for the elimination of barriers to communication.

3:5 When a Victim/Survivor Leaves the SATU

When a victim/survivor leaves the SATU they are entitled to the following in a language in which they are comfortable and can understand:

- **Referrals to or contact information for relevant support agencies**.
  This information needs to be specifically tailored to the victim/survivor – e.g. gender, age, sexual orientation, ethnicity, ability/disability, geographical location, etc.
- **Information about any appointments that the victim/survivor has with a local RCC or any other local support agency**.
- **Information about sexual violence and potential after-effects**.
  This can be in the form of a leaflet.

If a victim/survivor has chosen to speak with a Psychological Support Worker, the Psychological Support Worker is responsible for ensuring that all of this is provided to the victim/survivor. (**KPI**)[ii] If the victim/survivor has chosen not to speak with a Psychological Support Worker, other SATU personnel are responsible for making sure that all of this is provided.

Key Performance Indicator

[ii] **KPI:** % of victims/survivors attending a SATU for the first time who were given the appropriate contact information by the RCC Psychological Support Worker.

References

1 Hanly C, Healy D. & Scriver S. *Rape & Justice in Ireland: A National Study of Survivor, Prosecutor and Court Responses to Rape*. Dublin: The Liffey Press© Rape Crisis Network Ireland; 2009.

2 International Association of Forensic Nurses. (IAFN) *Position Statement: Collaboration with Victim Advocates*. 2008. Available at http://iafn.org/associations/8556/files/IAFN%20Position%20Statement-Advocates%20Approved.pdf

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4 Campbell R. Rape Survivors' Experiences with the Legal and Medical Systems: Do Rape Victim Advocates Make a Difference? *Violence Against Women*; 2006. Vol. 12, No. 1, pp. 1-16.

5 O'Shea, A. On behalf of the Sexual Assault Review Committee. *Sexual Assault Treatment Services: A National Review*. Department of Justice Equality & Law Reform, Department of Health & Children; 2006.

6 Walby, S. *et al. Overview of the worldwide best practices for rape prevention and for assisting women victims of rape*. European Parliament Directorate General for Internal Policies Policy Department C Citizen's Rights and Constitutional Affairs. 2013. Available at http://www.europarl.europa.eu/RegData/etudes/etudes/join/2013/493025/IPOL-FEMM_ET(2013)493025_EN.pdf

7 U.S. Department of Justice, Office on Violence Against Women. *A National Protocol for Sexual Assault Medical Forensic Examinations Adults/Adolescents*, 2nd edition. April 2013. Available at: https://www.ncjrs.gov/pdffiles1/ovw/241903.pdf

SECTION 4:
SEXUALLY TRANSMITTED INFECTIONS

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4:2 STI Testing at Sexual Assault Treatment Units 126

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4:1 Introduction, Epidemiology and Demography

The focus of this section of the guidelines is the testing, prevention and treatment of Sexually Transmitted Infections (STIs) in SATU. Patients may opt to be tested at SATU, their GP or local STI Clinic.

Rates of STIs, following sexual assault are difficult to determine and depend on several factors including the population studied. Prior history of sexual activity is clearly an important factor[1]. In the general Irish population, the most frequently identified STIs are chlamydia, genital warts and herpes[2]. Others include gonorrhoea, trichomoniasis, syphilis, Hepatitis B, Hepatitis C and Human Immunodeficiency Virus (HIV). Chlamydial and gonococcal infections in women are of concern because of the possibility of ascending infection and potential tubal infertility[3].

Prophylaxis is available for some STI, and, in line with international best practice, prophylaxis for chlamydia, hepatitis B and HIV is now available at SATU for at-risk patients[4].

In Ireland, between 2009 and 2016, 5,263 patients were seen at SATUs nationwide of whom 2,507 (48%) had STI screening. Follow-up attendance rates vary geographically (22%-95%) and over time. Use of azithromycin chlamydia prophylaxis has increased from 23.4% of those attending in 2009 to 63% in 2016. Infections detected at follow up visits are as follows: 69 cases (2.75%) *Chlamydia trachomatis*, 26 (1%) Hepatitis C Virus, 8% genital warts, 2% syphilis, 3% *Neisseria gonorrhoea*, 3% HIV, 3% Hepatitis B virus, 2% Herpes Simplex Virus, 1% *Trichomonas vaginalis*. Cases of chlamydia have fallen from 23 (9.7% of those screened) in 2009 to 6 (1.8%) in 2016 in line with increasing use of prophylaxis.[5]

The forensic significance of positive STI results in previously sexually active adults is unclear. It has been suggested that the identification of an STI in the immediate period after sexual assault is seldom useful in court, and there are concerns it could be used to denigrate the patient's character[6]. In individuals who have not previously been sexually active and children, identification of an STI is potentially forensically significant. Maintenance of chain of evidence is important in the handling of these samples and advice should be taken from local laboratories as to whether this can be achieved.

4:2 STI Testing at Sexual Assault Treatment Units

The identification of an STI immediately after an assault is usually more important for the medical and psychological management of the patient than for legal purposes, as an infection diagnosed in the immediate aftermath of an assault is likely to pre-date that assault. It is widely accepted that the optimum time for screening for infection is two or more weeks after potential exposure. Prophylactic treatment may be offered to patients attending SATU at the time of their first presentation, often soon after the assault. Screening for STIs prior to prophylactic treatment is appropriate if the patient presents for the first time two or more weeks after the alleged assault. **(KPIs)**[i, ii].

All patients should be offered STI screening at SATU, some patients may prefer to attend their GP or local STI Clinic. If patients choose to have follow-up elsewhere, a brief letter to the GP or STI clinic recommending testing and outlining prophylactic measures taken should be provided with the patient's permission.

Patients should be advised to use barrier contraception until STI screening has been completed (up to 3 months post assault).

Key Performance Indicators

[i] **KPI:** % of patients who attended the SATU who were given an STI review appointment.

[ii] **KPI:** % of patients who attended a scheduled first STI review appointment following first SATU attendance.

4:2.1 Asymptomatic STI Screening

For most patients, STI screening can be scheduled for 2-4 weeks after the assault. Asymptomatic female patients may prefer to test for chlamydia and gonorrhoea with self- or healthcare provider-taken vulvovaginal swabs rather than have a speculum exam. Asymptomatic male patients will provide a first void urine sample. Rectal swabs can be taken by the patient or healthcare provider. Pharyngeal swabs should be taken by a healthcare provider.

Standard STI screening is outlined in Table 12

Table 12: Standard STI Screening Tests

Infection	Test	Site
Gonorrhoea	Nucleic Acid Amplification Test (NAAT)*	Swabs from sites of penetration or attempted penetration • Vagina • Rectum • Pharynx • First void (bladder not emptied for 1 or more hours) urine (FVU) from males
	Culture and Sensitivity if NAAT positive **prior** to treatment	Use charcoal swab from site of contact or plate directly on NYC agar and place in CO_2 rich environment
Chlamydia	Nucleic Acid Amplification Test (NAAT)*	Swabs from sites of penetration or attempted penetration • Vagina • Rectum • Pharynx • FVU from males
Syphilis *(Treponema pallidum)*	Serology	Venous blood
Hepatitis B	Serology (HBsAg)	Venous blood
Hepatitis C	Serology (HCV Ab)	Venous blood
HIV	Serology	Venous blood

*Combined gonorrheoa and Chlamydia swab (CTNG)

4:2.2 Symptomatic STI screening

Symptomatic patients should be examined by a healthcare provider. See Table 13 for additional STI testing depending on examination findings.

Table 13: Additional STI Tests

Infection	Test	Site
Herpes Simplex Consider if genital ulceration*	Viral culture (swab) and PCR	Any genital ulcer
Trichomoniasis vaginalis Consider if frothy discharge	Charcoal swab Wet prep if available NAAT if available	Vagina
Lymphogranuloma venereum *(chlamydia trachomatis serovars* L1, L2, L3*)* Suspect if proctocolitis, inguinal lymphadenopathy, genital ulcer, particularly in MSM.	NAAT Inform your lab that you suspect lymphogranuloma (LGV)	Rectal, Inguinal or femoral bubo, Vaginal ulcer

*In men who have sex with men (MSM), syphilis should be suspected in cases of genital ulcertion

4:3 STI Prevention at SATU

Prevention of STI at SATU involves use of prophylactic medications and vaccines after possible exposure to an infectious agent. Comprehensive guidance on emergency management of injuries (including sexual exposure) where there is a risk of transmission of blood borne viruses and other infectious diseases is available at www.emitoolkit.ie[7]

Prophylaxis is available for chlamydia trachomatis (azithromycin), Hepatitis B (vaccination and immunoglobulin) and HIV (antiretroviral). Routine prophylaxis for gonorrhoea is no longer used because of rising resistance rates in this infection. The decision to prescribe prophylaxis depends on factors specific to the assault and assailant as well as local disease prevalence. Prophylaxis for C. trachomatis should be considered in patients who have had pharyngeal, vaginal or rectal penetration. Hepatitis B immunisation is offered to all SATU patients not previously vaccinated. Risk assessment and consideration of HIV post-exposure prophylaxis (PEP) should also be made[7, 8]

Key Performance Indicators

[i] **KPI:** % of patients who attended the SATU who were given an STI review appointment.

[ii] **KPI:** % of patients who attended a scheduled first STI review appointment following first SATU attendance.

4:3.1 Antibiotic Prophylaxis for Bacterial STIs

At present all Irish SATUs are offering routine prophylactic treatment for C. trachomatis (KPI)[i]. Routine use of prophylaxis for gonorrhoea is not recommended. There is increasing antibiotic resistance in gonorrhoea worldwide.[2] Prevalence of *N. gonorrhoeae* in the general population is low but higher in men who have sex with men (MSM)[2]. Sensitivities of these organisms to antibiotics, particularly *N. gonorrhoeae*, may change and treatment recommendations must reflect the likely sensitivities in the population. At present, appropriate prophylaxis against C. trachomatis is Azithromycin 1g PO stat.

Symptomatic patients at high risk for gonorrhoea should be tested at time of presentation and treated empirically with ceftriaxone 500mg IM plus azithromycin 1g PO. Nucleic acid amplification tests (NAAT) for gonorrhoea and chlamydia and culture for gonorrhoea is advised so that sensitivity patterns can be established.

Readers are advised to keep up to date with changes in recommendations for testing and treatment for STIs at www.bashhguidelines.org[8].

4:3.2 Hepatitis B Post-Exposure Prophylaxis (PEP)

British and US guidelines recommend that all patients be offered vaccination against Hepatitis B following sexual assault.[3,4] (KPI)[ii] There is evidence that where there is a risk of Hepatitis B acquisition, administration of Hepatitis B vaccine may prevent Hepatitis B infection.[9,10] This is a course of 3 intramuscular injections over 6 months and is administered in the SATU when the patient initially presents, and then 1 month and 6 months following the incident. Accelerated vaccination courses may also be considered in high risk individuals[7].

When the perceived risk of Hepatitis B is high (for example where the alleged assailant is known to be Hepatitis B surface antigen positive) Hepatitis B immunoglobulin should be considered within 48 hours and no later than 7 days. In most SATUs this will mean referral to the Emergency Department. In patients who have previously been vaccinated, or in whom natural immunity is likely, urgent Hepatitis B full markers (specimen sent to the National Virus Reference Laboratory at UCD or your local lab) can be checked to assess the need for vaccination. Administration of Hepatitis B vaccine to a patient who is already immune is not harmful.

Combined vaccination for Hepatitis A and B should be considered in MSM.

Adequate Hepatitis B immunity following completion of the vaccine course should be confirmed by checking titres of antibody to Hepatitis B surface antigen (anti- HBsAg) 8 weeks after the final vaccine dose (See Table 14).

Key Performance Indicators

[i] **KPI:** % of patients offered prophylactic treatment against Chlamydia Trachomatis, at the first SATU visit.

[ii] **KPI:** % of patients aged 14 years and over, who were appropriately given prophylactic Hepatitis B vaccination, at the first SATU visit.

Table 14: Actions Required Following Post-HB Vaccination Testing (Except for Patients with Renal Failure)[7,9,10]	
Anti-HBsAg level (Hepatitis B antibodies)	**Action Required**
0 or <10 mIU/ml Non-responder	Test for anti-HB core antigen. If this is negative, repeat full course of Hepatitis B vaccine using a different brand of vaccine. Double dosing vaccine may also be considered. Recheck anti-HBsAg at 8 weeks post completion. If anti-HBsAg remains <10mIU/ml, person is susceptible to HBV.
10-99 mIU/ml Low response	If low level anti-HBsAg confirmed by 2 different assays, administer one booster dose of vaccine. There is no need to retest for anti-HBsAg.
100 mIU/ml or greater Good response	No need for further vaccination or anti-HBsAg levels.

4:3.3 HIV PEP

Pathogenesis studies indicate that there may be a window of opportunity to abort HIV infection by inhibiting viral replication following an exposure. Animal studies show benefit if antiretroviral medication is administered within 72 hours and continued for 28 days[11]. Retrospective studies in the context of occupational exposure show health care workers who received PEP with zidovudine after needle stick injury were 81% less likely to become seropositive for HIV[12,] although there are instances where PEP has failed to protect[13]. With regard to sexual exposure, prospective observational studies suggest benefit[14].

The decision to proceed with HIV PEP must be made on a case-by-case basis, depending on factors specific to the nature of the assault and the assailant (see Figure 1, HIV PEP Tool). The risks and benefits must be discussed with the patient in the knowledge that the drugs can have side effects (gastrointestinal disturbance, rash, renal impairment) and their effectiveness remains unproven. The British Association for Sexual Health and HIV (BASHH) guideline for PEP following Sexual Exposure (PEPSE)[15] and Health Service Executive and Health Protection Surveillance Centre Guidelines for the Emergency Management of Injuries[7] can be consulted for comprehensive advice. Each unit should have close links with Infectious Disease or Genitourinary Medicine specialists for additional advice and follow-up.

Patients who receive HIV PEP should be advised to avoid unprotected sexual intercourse until they have completed testing (3 months after exposure).

4:3.4 PEP Assessment Tool

SATU RISK ASSESSMENT TOOL FOR HIV AND PEP

Do not prescribe PEP if more than 72 hours since exposure

Patient Name _____

SATU No _____ **Date** _____ **Hrs since assault** _____

HIV – PEP (Table adapted [1-5])

CIRCLE AS APPROPRIATE → ↓ EXPOSURE TYPE	Known HIV positive Assailant		HIV Status of assailant unknown	
	Viral load detectable or unknown	Viral load undetectable <200c/ml for >6months	Assailant from high prevalence group/area*	Assailant from low prevalence group/area
Receptive anal sex	RECOMMEND	NOT RECOMMENDED	RECOMMEND	NOT RECOMMENDED
Insertive anal sex	RECOMMEND	NOT RECOMMENDED	CONSIDER	NOT RECOMMENDED
Receptive vaginal sex	RECOMMEND	NOT RECOMMENDED	CONSIDER	NOT RECOMMENDED
Insertive vaginal sex	RECOMMEND	NOT RECOMMENDED	CONSIDER	NOT RECOMMENDED
Fellatio with ejaculation	CONSIDER	NOT RECOMMENDED	NOT RECOMMENDED	NOT RECOMMENDED
Fellatio without ejaculation	NOT RECOMMENDED	NOT RECOMMENDED	NOT RECOMMENDED	NOT RECOMMENDED
Splash of semen to eye	NOT RECOMMENDED	NOT RECOMMENDED	NOT RECOMMENDED	NOT RECOMMENDED
Cunnilingus	NOT RECOMMENDED	NOT RECOMMENDED	NOT RECOMMENDED	NOT RECOMMENDED
Digital/Object penetration	NOT RECOMMENDED	NOT RECOMMENDED	NOT RECOMMENDED	NOT RECOMMENDED
Unsure if assault occurred	NOT RECOMMENDED	NOT RECOMMENDED	NOT RECOMMENDED	NOT RECOMMENDED

*High prevalence group/area: Intra-venous drug users / Men that have sex with men (MSM) / Commercial sex worker (CSW) / Endemic country

OUTCOME (please tick)	
PEP recommended and prescribed	
PEP recommended NOT prescribed	
Reason:	
PEP considered and prescribed	
PEP considered NOT prescribed	
PEP not recommended	

CONSIDER[1-3,5]

- ☐ Breaches in the mucosal barrier such as: genital injury, first intercourse, mouth/genital disease, menstruation/other bleeding
- ☐ 'Stranger' or 'recent acquaintance'[2]
- ☐ Multiple assailants
- ☐ Known presence, signs or symptoms of STI in source or the victim
- ☐ Multiple risk factors or cumulative risk
- ☐ Other _____

RECOMMEND PEP? Y/N:

SHARED DECISION MAKING: DISCUSS WITH PATIENT[1-5] ☑

- ☐ Efficacy uncertain
- ☐ 28 days treatment - take daily
- ☐ HIV Testing in 6 weeks
- ☐ Side effects: GI, Rash, Renal
- ☐ Symptoms of seroconversion
- ☐ Drug interactions including OCP
- ☐ Window period – safe sex

IF APPROPRIATE PROCEED[6]

CHECKLIST if PRESCRIBING PEP

- ☐ Pregnancy test obtained
- ☐ FBC, U&E, LFTs, Baseline serologies
- ☐ Information leaflet given[4]
- ☐ Appointment for ID/GUM clinic within 3-5 days
- ☐ Appointment SATU 1 month

Commence 3-5 day starter pack.
Give first dose ASAP

Forensic Clinical Examiner signature _____

Examiner's printed name _____

May 2018 / SATU Risk Assessment Tool for HIV and PEP

A starter pack for HIV PEP should be kept in all units, and staff should be familiar with its prescription, possible drug interactions and local follow-up arrangements. It is important to note that when deemed appropriate, HIV PEP should be administered as soon as possible after the assault up to 72 hours. Individual units should develop a referral pathway with local Infectious Disease or Genitourinary Medicine services to ensure availability within 5 days.

EMI guidelines recommend that patients are given combined Tenofovir and Emtricitabine plus Raltegravir or Dolutegravir as PEPSE for HIV[7]. Prescribers should note that Dolutegravir should not be used in women who are or may become pregnant. Most SATUs have 5 day starter packs, and an appointment is given to attend the local Infectious Diseases/Genitourinary Medicine services for follow-up within those five days to discuss completion of a 28 day treatment course.

NB. CONFIDENTIALITY

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

4:4 STI Treatment at SATU

- Each SATU should liaise with their laboratory to discuss the best means of collecting and processing specimens.
- Window period for syphilis and Hepatitis C remains 90 days, although new combined antigen/antibody tests have shortened window period for HIV to 4 weeks after the exposure.
- Repeat screening for HIV, Hepatitis B and C and syphilis 3 months after the incident (to reflect the window period for seroconversion).
- Each SATU will have local arrangements and protocols for follow-up of patients including STI treatment, test of cure where appropriate, contact tracing, vaccination and infectious disease notification.
- The following patients should be referred to STI services: patients with syphilis, patients with penicillin allergy requiring syphilis or gonorrhea treatment, complex contact tracing requirements, LGV.
- Partner notification and contact tracing should be handled sensitively.
- Refer to BASHH guidelines for treatment of pregnant women www.bashhguidelines.org
- SATU healthcare providers are advised to keep up to date with changes in STI guidelines at www.bashhguidelines.org

Table 15: STI Testing Timelines and Treatment

Time	Treatment/Test	Rationale
0	1g Azithromycin po 1st Hepatitis B Vaccine	Prophylaxis *C. trachomatis* Immunisation against Hepatitis B
2- 4 weeks **(Depending on vaccination schedule)**	Combined gonorrhoea/ chlamydia NAAT from appropriate site(s) Serology 2nd Hepatitis B Vaccine	Screening for *C. trachomatis* and *N. gonorrhoeae* HIV, Hepatitis B, Hepatitis C, Treponema pallidum (Syphilis) Immunisation against Hepatitis B
If positive results treat ASAP	Gonorrhoea Culture and sensitivity for gonorrhoea then Ceftriaxone 500 mg IM plus Azithromycin 1g PO stat	If screening NAAT is positive for gonorrheoa, recall patient for culture and treatment. Check Test of Cure (NAAT) two weeks later.
	Chlamydia Doxycycline 100mg bd for seven days***	Treatment for chlamydia. If prophylaxis was given in the previous two weeks consider possibility of re-infection or persistence of DNA*. Re-test in 2 weeks if no new risks. Re-treat if risk of acquisition from new risk.
	Lymphgranuloma venereum Doxycycline 100 mg bd po x 21 days	LGV should be referred to an STI clinic.
	Trichomonas Metronidazole 500 mg bd po x 5/7 (avoid alcohol)	
	Herpes Simplex Virus Vacyclovir 500mg bd po x 5/7	
3 months	Serology	HIV/Hepatitis B & C/Syphilis.
6 months (depending on vaccination schedule)	3rd Hepatitis B Vaccine	Immunisation against Hepatitis B
8 months**	Serology	Anti-HBsAg to ensure Hepatitis B immunity (see Table 14)

NB:

* Using NAAT testing the time to clearance of *C. trachomatis* following 1g Azithromycin is up to 17 days.[16]

** Can also be checked by GP/local services.

*** Doxycycline should not be used in pregnancy.

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SECTION 5:
FORENSIC SCIENCE IRELAND

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5:1 History and Role of Forensic Science Ireland

Vision Statement

Forensic Science Ireland delivers, to best international standards, independent expert opinion, advice, training and research to support the Irish Criminal Justice system.

History

The Irish Forensic Science Laboratory was established in 1975. The Laboratory offers a full service, from crime scene to courtroom and is part of the criminal justice sector. In 2014, the name of the Forensic Science Laboratory was changed to Forensic Science Ireland. Throughout this section of the document, Forensic Science Ireland (FSI) is in places referred to as the Laboratory.

Forensic Science Ireland is divided into nine functional teams. One of these teams is the Sexual Assault Team, which consists of a Scientific Team Manager, Scientists and Analysts. The workload of Forensic Science Ireland has steadily increased throughout the years as An Garda Síochána and the courts realised the value of forensic scientific evidence. In 2018, there are over 105 staff members, including administrative staff.

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

Each year, the Laboratory receives more than 400 cases of alleged sexual assault/rape (throughout this section all sexual crime cases are referred to as sexual assault).

DNA Service

The initiation of a DNA service in 1994 was a quantum leap in Forensic Science Ireland's ability to compare biological samples. DNA profiling is the technique used to identify areas of high variability in the DNA of individuals. DNA (Deoxyribonucleic Acid) is present in all body tissues, except for red blood cells. Those most commonly encountered in criminal cases for forensic analysis are stains or deposits such as blood, semen, vaginal fluid and saliva. Also cellular material (epithelial cells such as skin cells) can be profiled where there has been skin to skin contact (e.g. gripping the arm). Advances such as YSTR profiling (specific for male DNA) have greatly helped touching cases and those that have little or no semen detected. The DNA from crime stains is compared with the control DNA from suspects and complainants. This control DNA (called a reference sample) is extracted from FTA mouth swabs (or blood samples). Forensic Science Ireland has been the custodian of the National DNA database since the 20th of November 2015 following the commencement of the Criminal Justice (Forensic Evidence and DNA Database System) Act 2014. The Database contains DNA profiles from unsolved cases. Separate indices contain profiles of persons defined by legislation. Permitted searching of the sets of profiles is subject to legislation.

5:2 Key Objectives of Forensic Science Ireland

The objective of Forensic Science Ireland is to have the best possible samples collected from the complainant, in a way that minimises the risk of contamination and to elicit the information that aids in the interpretation of the results obtained. Forensic Science Ireland is very dependent on the selection and quality of the samples received. Therefore the laboratory views education as a very important part of their role. Training is provided by the laboratory to An Garda Síochána on collection of samples at crime scenes. Forensic Science Ireland also works closely with the SATUs across the country and provides training and speakers for various SATU conferences and forensic examiner training programmes. This increased communication has been very beneficial, and Forensic Science Ireland welcomes any channel which allows them to further improve the quality of the samples they receive. Forensic Science Ireland views the National Guidelines as a vehicle for the achievement of all of these outlined key objectives.

KEY POINTS

KEY POINTS: Requirements for Forensic Science Ireland in Cases of Alleged Sexual Assault:

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

5:3 Forensic Samples

(See 2:6.7 Table 2 Re: Collecting Forensic Samples)

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

Sexual Offences Examination Kit

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

It includes a form to be completed by the Forensic Clinical Examiner, which elicits information necessary for the scientific interpretation of results. The form also has a complete list of possible samples, where the Forensic Clinical Examiner can itemise the samples taken. These may depend on the allegation and the subject being examined, but include swabs used to collect samples from the vagina, anus, mouth and

also blood samples,hair samples, nail scrapings and other samples considered relevant by the Forensic Clinical Examiner. The medical form should **not** be put in with the samples taken for the Sexual Offences Examination Kit. It should be kept separate and submitted to Forensic Science Ireland at the same time as the Kit.

Supply of Sexual Offences Examination Kits

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

KEY POINTS

KEY POINTS:

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

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

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

5:4 Risk of Contamination

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

Contamination is most likely to be from epithelial (skin) cells from hands, saliva, hair and dandruff. This is known as primary transfer. Contamination between different cases is also a concern. This is known as secondary transfer.

Contamination of trace evidence can also occur (See Table 16). With increased sensitivity in DNA techniques, it has become very important that practitioners take all possible steps to ensure that their own cellular material does not contaminate the samples they obtain.

DNA Reference Elimination Swabs from Healthcare Personnel

Due to the sensitivity of current DNA profiling technology, contamination of casework samples is a constant danger. Since June 1st 2009, anyone entering the Laboratory areas of Forensic Science Ireland is asked to provide a DNA sample (FTA Buccal Swabs) for elimination purposes. This is in line with international practice, in an attempt to ensure that profiles generated in the laboratory are relevant to a particular investigation. Since the enactment of the DNA Database 2014 Act, the provisions for taking elimination samples from SATU personnel have yet to be clarified.

Personnel in SATUs and General Practitioners, who take forensic samples, will be asked to provide buccal swabs for elimination purposes. The DNA profiles generated from the above personnel will not be used for any purpose other than for elimination.

Environmental Monitoring of SATUs

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

These swabs are submitted to Forensic Science Ireland.

5:5 Prevention of DNA Contamination

The following guidelines for the prevention of contamination should be considered during the Forensic Clinical Examination of the complainant in cases of alleged rape/sexual assault.

- The examination couch should be cleaned with bleach or a recommended cleaning agent before and after examinations (e.g Vircon, Actichlor, Klorkleen, or any 10% bleach products).
- Fresh paper roll should be used under each complainant.
- Chairs on which the complainant or anyone involved in the case including Forensic Examiner, Gardai may have sat before or after the Forensic Clinical Examination should also be cleaned with bleach or a recommended cleaning agent.
- The practitioner should wear disposable apron/coat and gloves and face mask .
- Gloves (double gloving is highly recommended) must be worn when handling specimens and clothing. Change gloves frequently as required.
- Ensure that the gloves reach/cover the cuffs and that the wrists are not exposed.
- If coats have shrunk or the wristbands have become loose, the coats should be replaced.
- A chronological log or record should be kept of cases examined on each examination couch.
- All swabs should be placed into their vials immediately after taking the sample.

KEY POINTS

KEY POINTS: Prevention of Contamination

- Clean with bleach or the recommended cleaning agent
  - o Examination couch, trolley and any other equipment (eg colposcope).
  - o Chairs on which complainant sat before or after exam.
- Fresh paper roll for the couch after each case.
- A log or record should be kept of cases examined on each examination couch.

When handling specimens and clothing:

- Use disposable gloves and aprons.
- Ideally gloves should reach the cuffs – wrists should not be exposed and an outer second pair of gloves can be changed regularly
- Masks should be worn at all times during medical examination

Table 16: Contamination of Evidence

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

Contamination of Trace Evidence

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

Contamination is probably the greatest problem that exists in the area of trace evidence (See tables 16 & 17). The possibility of accidental contamination exists from the first moment of contact between the Gardaí and the scene, suspect or complainant.

5:6 Analysing Samples for Semen

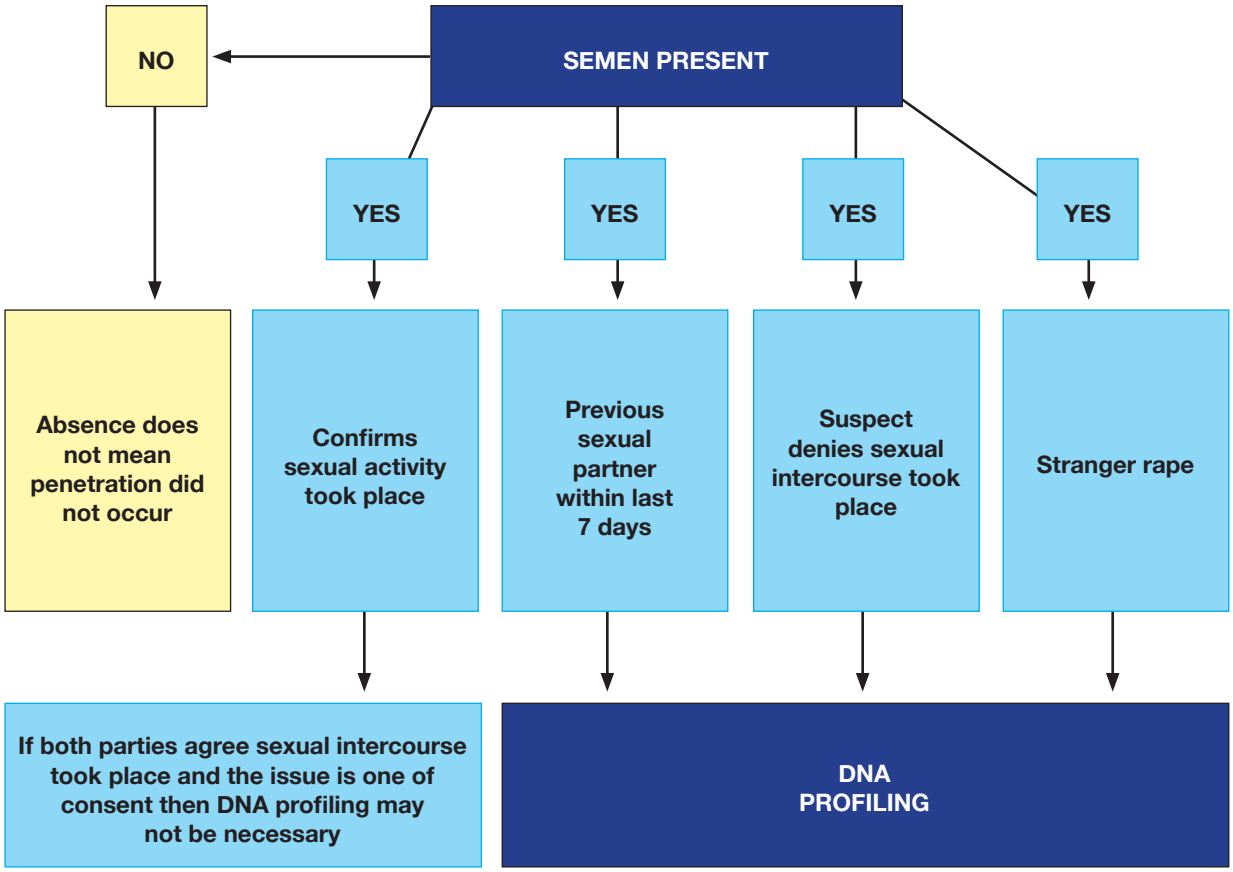
Forensic Science Ireland analyses swabs for the presence of semen. The presence of semen confirms that sexual activity has taken place. The evidence alone does not indicate whether or not a rape/sexual assault has taken place. **Also, the absence of semen on the swabs does not mean that penetration did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

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

When the suspect denies that intercourse took place, or when the complainant has had a previous sexual partner, DNA profiling will be carried out on seminal staining on the swabs or on the clothes. In cases of

"stranger rape", where the victim does not know the assailant, DNA profiling will always be carried out on any seminal staining recovered, and this profile is uploaded to the DNA Database System (See Figure 5).

Figure 5: Outline of When DNA Profiling May Be Carried Out



5:7 Time Frames For Detecting Semen

The persistence of semen varies between individuals and is influenced by the activity of the individual after the alleged offence.[1] In the experience of Forensic Science Ireland, semen may be detected on vaginal swabs taken up to approximately three days after intercourse. In the majority of cases, however, it will not be detected on swabs taken more than 48 hours after intercourse.[2] There are reports in the literature of traces of seminal staining being recovered up to 7 days afterwards,[3] so this is the outer limit after which Forensic Science Ireland will not analyse kits.

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

Semen will persist in dead bodies for a much longer period of time and, in Forensic Science Ireland, it has been recovered on vaginal swabs taken 6 weeks after death. Once the swabs are taken from the person, the semen, if present, will persist indefinitely on dry swabs. Dried seminal staining on clothes will persist

until the clothes are washed; this can be useful in cases which are not reported for some time after the incident (See Table 17).

Table 17: Sites and Time Limits for Examination for Presence of Semen

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

Other Samples

As well as analysing the Sexual Offences Examination Kit for the presence of semen, it may be necessary to carry out other analyses in cases of alleged rape/sexual assault. In cases where kissing, sucking/licking or biting of breasts or the penis is alleged, swabs should be taken from these areas. These swabs will be examined for the presence of saliva. Fingernail swabs should be taken in cases where the complainant may have scratched the offender or from the suspect if the allegation is digital penetration.

The clothes of the complainant will be tested for seminal staining or saliva depending on the circumstances of the case. The clothing will also be checked for damage (See 5:11) and blood staining. In some cases, the Forensic Scientist will look for hairs (See 5:10) and fibres (see section on fibres), which may have transferred between the two parties. If necessary, samples of urine and blood will be sent for toxicology (See 5:8). Depending on the circumstances of the case, items from the scene may also be analysed for the presence of blood, semen, touch DNA and fibres. DNA profiling can be attempted on both swabs and clothing and a technique called YSTR profiling (male specific DNA profiling) is very useful in certain cases.

Role of the Forensic Clinical Examiner as an Investigator

While the samples to be taken are listed and instructions on how they are to be taken are set out clearly in the Sexual Offences Examination Kit, it cannot cover every eventuality. The Laboratory views the Forensic Clinical Examiner as having an investigative role in the procedure of evidence collection, just as the Gardaí do in collecting evidence at the scene of a crime. It is important that they have as complete an account from the complainant as possible, in order to guide them in the direction of potential forensic evidence. Any opportunity that the alleged assailant had to deposit DNA on the victim, or vice versa, should be considered and areas of contact should be swabbed (See 2:6.7). Stains, which are at odds with the account of what happened, should also be swabbed for further examination in Forensic Science Ireland.

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5:8 Samples for Toxicology

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

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

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

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

Urine samples can be collected by non-medical staff and should be collected as soon as possible, after the incident is reported (See 1:6 and 5:9). The most important factor in cases of suspected drug facilitated sexual assault is speed of response. The sooner the samples are collected, the more likely that a useful forensic toxicological examination can be carried out. If there is any doubt as to whether or not a particular sample should be taken, it should be collected and submitted to the laboratory for evaluation, to establish what analysis is appropriate.

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

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

Hair samples may also be considered (See 5:10, trace evidence).

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

	BLOOD	URINE
Alcohol	24 hours	24 hours
Drugs of Abuse	48 hours	120 hours

Sending Samples for Toxicology Screening

- The expiry date on blood bottles should be checked before use.
- Write the date and time of sampling on the blood and urine vials.
- Submit the tamper evident bag with the toxicology samples to Forensic Science Ireland.
- Keep the toxicology samples separate from the Sexual Offences Examination Kit i.e. not packaged together.

Detection of Ingested Drugs from Hair

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

As a rough guide, hair grows approximately 1cm per month; thus the longer the hair, the greater the time frame covered. Drug concentrations in hair cannot be correlated with dose or time of administration. Forensic Science Ireland do not carry out hair testing for drugs and should be contacted in cases where testing hair for drugs of abuse is required. Interpretation of hair toxicology results is not straightforward so hair toxicology should only be considered in exceptional circumstances.

5:9 Early Evidence Kits

In 2004, Forensic Science Ireland introduced an Early Evidence Kit. Sometimes, it may not be possible for the victim of an alleged rape/sexual assault to see a Forensic Clinical Examiner immediately after reporting the crime. Some complainants have to travel long distances in order to be examined at the nearest SATU, or a Forensic Clinical Examiner may not be immediately available. With every hour that passes, physical evidence may be lost or deteriorate. Because of this, an Early Evidence Kit is available to be used by An Garda Síochána in cases of rape/sexual assault. For details relating to the use of the Early Evidence Kit see under An Garda Síochána guidelines (See 1:3).

5:10 Trace Evidence

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

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

Transfer of Fabric Traces on Contact

Textile fabrics are composed of mainly woven or knitted yarns and fibres. Tiny fragments of the fibres are broken off the surface of the fabric and may transfer to a second surface on contact. These fibres are generally invisible to the naked eye and have the potential to provide evidence of contact.

The size of the fibres and the ability to transfer means that great care must be taken at all times to avoid contamination.

Work in Forensic Science Ireland involves searching for transferred foreign fibres and comparing these to suspect sources e.g. fibres from the suspect's jumper, on the clothing of the complainant and vice versa.

Although fabrics are generally mass-produced, the finding of large numbers of transferred fibres, especially if these involve more than one type, is a strong indicator of recent contact.[2]

In addition some fabrics are not suitable as a source of fibres for various reasons. Contamination of trace evidence is a concern for forensic science, and measures should be implemented to avoid possible contamination (See 5:5, Table 17).

Hair

Microscopic comparison of hairs alone is considered to be weak evidence, therefore is not used for identification purposes at FSI. Microscopic examination will allow determination of whether a hair is of human origin, identification is achieved by DNA profiling any root material that is present. DNA profiling would be carried out on selected hair roots (if present).

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

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5:11 Damage to Clothing

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

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

References

1. Taupin, J, Adolf FP, and Robertson J. Examination of damage to textiles in Forensic Clinical Examination of Fibres, 2nd ed. Eds. Grieve MC. and Robertson J. London: Taylor and Francis; 1999.

2. Boland, C.A., McDermott, S.D and Ryan, J. Clothing damage analysis in alleged sexual assault - The need for a systematic approach. Forensic Science International, 2007, 167, pp 110-115.

5:12 Collection and Storage of Forensic Evidence Without Immediate Reporting to An Garda Síochána

Option 3 samples are analysed in FSI in the same manner as other Sexual Offences Examination Kit samples.

See 2:34.4

5:13 DNA Reference Samples

DNA reference samples from complainants of sexual assaults are required for forensic testing. The reference sample is taken by An Garda Síochána (See 1:7) as an FTA sample (mouth swab). The sample may be taken at a date after the forensic medical examination. The DNA profile generated from a complainant does not get uploaded to the DNA Database system and is only used for this particular case.

SECTION 6:
GENERAL PRACTITIONERS (GPs)

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

This section will provide concise guidance for General Practitioners (GPs) when an adult patient makes a disclosure of recent sexual violence.

First steps:

1. The medical stability of the patient always takes priority over the collection of evidence. It is important to evaluate the general condition of the patient and consider if emergency medical treatment is needed. If so, immediate care at an Emergency Department may be appropriate. It is also appropriate to contact a SATU in such cases, provided the patient gives their informed consent, as it may be possible for a Forensic Clinical Examiner to carry out a forensic clinical examination at the Emergency Department. Contact details for SATUs are provided on p. 18.

2. It is important to establish the time frame from the incident. Forensic evidence, including both physical injuries and trace (DNA/semen/etc.) evidence, decays rapidly with time. Thus, if the patient is agreeable, forensic clinical examination at a SATU should take place as soon as possible. Generally forensic samples are not taken if more than seven days have elapsed since the incident; however, it remains very important for a patient to be examined in a timely manner as there may still be evidence of physical injury. SATU response options are outlined on p. 15-16.

If the patient is willing to attend the SATU for a forensic clinical examination, the patient should be advised with regard to the preservation of forensic evidence. This involves provision of information on actions that can be taken/avoided by the patient in order to mitigate against loss of trace forensic evidence during the time period that the patient is awaiting SATU assessment. For example, the likelihood of obtaining trace forensic evidence can be increased if patients do not shower, change their clothes (especially underwear), clean their ano-genital area or throw away sanitary towels or tampons. In cases of oral assault within the preceding 24 hours, patients should be advised to avoid brushing their teeth and eating and drinking where possible. Further details are provided in the section on preservation of forensic evidence. (See p.20-21: Preservation of Forensic Evidence).

If the patient does not want to report the incident to An Garda Síochána, it is possible for the patient to attend a SATU without Garda involvement. The GP can contact their local SATU to arrange an appointment. Where a patient is undecided as to whether or not to report the incident to An Garda Síochána, it is possible for forensic evidence to be obtained and stored for use in later criminal investigations.

Patient Declines SATU Attendance

If the patient is not willing to attend a SATU, the GP will need to address the forensic and health needs of the patient in so far as possible. The following issues should be considered:

- Carefully document the history of sexual violence that has been disclosed. Where possible, use the patient's own words in quotation marks. This may form the basis of a medico-legal report at a later date.
- If the patient is not well known to you, take a complete medical history.
- Consider the need for a chaperone prior to performing an examination.
- Perform a head-to-toe survey, looking for evidence of injury, and a systems examination. Carefully record the findings of the examination, with particular regard to documentation of physical injury

(See 2:12). Ideally, a genital examination is performed so that genital injury can be identified and, if necessary, treated. However, if the patient is unwilling to allow genital examination and if the risk of significant life-threatening genital injury is low, then it is appropriate not to examine the genital area. It is important that the patient knows that potential evidence (i.e. evidence of genital injury) will not then be available for use in any future Garda investigation. Identify and treat any acute medical needs or injuries.

- Assess the need for appropriate Emergency Contraception. This is most commonly provided in the form of a single oral dose of Levonorgestrel 1500mcg or Ulipristal Acetate 30mg. Intra-uterine contraceptive devices are occasionally used. (See 2:17).
- Consider the need for antibiotic prophylaxis against Chlamydia. If not contra-indicated, a single oral dose of 1g of Azithromicin can be prescribed (See 4:3.1).
- Consider the need for HIV/Hepatitis Post-Exposure Prophylaxis following Sexual Exposure (PEPSE). This decision is largely based upon the known or suspected risk of the alleged perpetrator being HIV or Hepatitis B positive and the type of sexual exposure that may have occurred (See 4:3.3, HIV PEPSE decision-making flow chart). Try to establish if the alleged perpetrator is known to be HIV or Hepatitis B positive or if (s)he is from a high risk group (e.g. intravenous drug abusers; men who have sex with men; from a high prevalence country). If uncertain, consider seeking an urgent opinion from a Consultant in Infectious Disease.
- Assess and manage the risk of self-harm. If high risk, consider the need for urgent psychiatric review.
- Ensure adequate psychological support is in place. The National Rape Crisis Centre (RCC) 24 hour helpline number is 1800 778888. Provide the patient with the contact details of the local or a preferred RCC. (RCC details available at www.rapecrisishelp.ie or www.drcc.ie). Consider the need to offer a GP follow-up consultation for psychological support.
- Arrange follow-up Sexually Transmitted Infection (STI) screening in accordance with the patient's preference to attend a GP, Genito-Urinary Medicine clinic or other setting (See 4:4).
- If the patient is under 18 years of age, then Children's First reporting procedures apply.[2,3] Complete and send the appropriate Social Services referral. In all cases of sexual violence, particularly those that involve domestic violence, it is important to consider the patient's safety in the home environment. Consideration must also be afforded to the safety of any children in the household. A Social Services referral should be considered. The welfare of the child is of paramount importance.[2] Relevant guidance from the Medical Council includes the following statement: *"If you believe or have reasonable grounds for suspecting that a child is being harmed, has been harmed, or is at risk of harm through sexual, physical, emotional abuse or neglect, you must report this to the appropriate authorities and/or the relevant agency without delay."*[4]

Finally, it may be helpful for GPs to know that most SATUs have a doctor or nurse on-call at all times. GPs may contact the on-call clinician for advice if they so wish.

KEY POINTS

KEY POINTS: Care of an Adult Patient who Discloses Rape/Sexual Assault

Medical stability of the patient always takes priority over collection of evidence

- If indicated ED referral – SATU Staff can carry out forensic medical examination in ED

If patient is stable

- Discuss with patient and gain their consent re: contacting a SATU.

If not involving SATU:

- Examine patient, document findings and treat accordingly (See 2:6).

Consider and assess re:

- Emergency contraception (See 2:17).
- Chlamydia prophylaxis (See 4:3.1).
- Hepatitis B vaccine (See 4:3.2).
- HIV PEPSE (See 4:3.3).
- STI follow up (See 4:4).
- Risk of self harm, if risk high consider urgent Psychiatric review if appropriate
- Ensure adequate psychological support is in place. The National RCC 24 hour helpline number is 1800 778888. Provide contact details of the local or a preferred RCC. (RCCs details available at www.rapecrisishelp.ie or www.drcc.ie).
- If under 18 years: Children First reporting procedures apply*[2, 3]
- Safety in the home environment, (e.g. domestic violence) for patient and consider children*
- Support of family, friends
- If appropriate social work referral and/or wider Primary Care Team referral.

*Subject to statutory reporting requirements: Children First Guidance. Withholding Information Act.

6:2 Follow-up Care of an Adult Patient Who Has Attended a SATU

This section will provide concise guidance for General Practitioners (GPs) to refer to when an adult patient attends their practice having previously attended a SATU.

The health needs of each patient that reports sexual violence must be considered on an individual basis, as health needs vary considerably from one patient to another. Thus, it is only possible for this guideline to suggest a number of core issues that usually need to be addressed in most patients.

- Emergency Contraception (EC): In many cases, the patient will have been provided with emergency contraception at the SATU. Follow-up pregnancy testing may be considered. In the event that EC was not used, then the GP should consider if it is indicated (See 2:17).
- Sexually Transmitted Infection (STI) screening: Some patients will choose not to return to SATU for follow-up STI screening. If the GP can provide or arrange STI screening allow a 2-4 week interval between the alleged incident and initial STI screening. (See 4:4).

- Hepatitis B vaccination: Patients who have not previously been vaccinated against Hepatitis B are frequently offered the first dose of the vaccine schedule at SATU. It may be necessary for the GP to provide subsequent doses to complete the schedule or to initiate immunisation if required (See 4:3.2).
- Assess and manage the risk of self-harm. If high risk, consider the need for urgent psychiatric review.
- Ensure adequate psychological support is in place. Check if the patient met with RCC personnel in SATU and that they were given the RCC details. If not, provide the patient with the contact details of the local or a preferred RCC. (RCCs details available at www.rapecrisishelp.ie or www.drcc.ie). Consider the need to offer a GP follow-up consultation for psychological support.
- If the patient is under 18 years of age, then Children's First reporting procedures apply.[2]
- In all cases of sexual violence, particularly those that involve domestic violence, it is important to consider the patient's safety in the home environment. Consideration must also be afforded to the safety of any children in the household. A Social Services referral should be considered. The welfare of the child is of paramount importance.[2] Relevant guidance from the Medical Council includes the following statement: *"If you believe or have reasonable grounds for suspecting that a child is being harmed, has been harmed, or is at risk of harm through sexual, physical, emotional abuse or neglect, you must report this to the appropriate authorities and/or the relevant agency without delay."*[4]
- Most adult patients who attend a SATU will be provided with a brief letter that succinctly indicates the treatment they received at SATU. Patients may choose to bring that letter to a GP. It is intended to act as one means of facilitating communication so as to enhance continuity of care. However, should a GP require additional information, in order to provide care to the patient, they can contact the SATU and speak directly to a clinician, provided the patient provides consent.

Finally, it may be helpful for GPs to know that most SATUs have a doctor or nurse on-call at all times. GPs may contact the on-call clinician for advice if they so wish.

KEY POINTS

KEY POINTS: Follow-up Care of an Adult Patient Who Has Attended a SATU

Core issues that usually need to be addressed:

- EC: Question if given: Follow-up pregnancy testing considered.
- STI screening: Between 2-4 weeks post the alleged incident (See 4:4).
- Hepatitis B vaccination: First dose of schedule may or may not have commenced at SATU. GP may initiate or complete the schedule (See 4:3.2).[1]
- Risk of self-harm: if risk high, refer for urgent psychiatric review if appropriate.
- Check if the patient met with RCC or was given the RCC details. If not, contact details available for RCC at www.rapecrisishelp.ie or www.drcc.ie. Consider the need to offer a GP follow-up consultation for psychological support.
- If under 18 years, Children's First reporting procedures apply.[2,3]
- Safety in the home environment, (e.g. domestic violence) for patient and children.*[2,3]
- Support of family, friends.
- Social Services referral and/or wider Primary Care Team referral, if appropriate.

*Subject to statutory reporting requirements: Children First Guidance.[2] Withholding Information Act.[3]

6:3 Child and Adolescent Patients: Useful Information for GPs

This edition of the National Guidelines is the first to include a dedicated section on responding to child and adolescent patients (See Section 8). General Practitioners (GPs) involved in the care of a child or adolescent who has experienced sexual abuse, or is suspected of having experienced sexual abuse, are directed to that section for guidance. The following bullet points provide very brief, practically applicable information, but are not intended to be a substitute for GPs reading appropriate guidance in detail:

1. The complete National Guidelines on Referral and Forensic Clinical Examination Following Rape and Sexual Assault (Ireland) 4th Edition 2018[1] are available at www.hse.ie/satu. Detailed information is available in the child and adolescent section.

2. Further information is available in the *Children Frist National Guidance for the Protection and Welfare of Children*[2]. It is essential for GPs to be aware of their obligations under this Guidance. An e-learning module is available at www.tusla.ie.

- GPs are Mandated Persons under Children First Act 2015. As such, GPs are obliged to assess concerns in relation to children and report to Tusla those that meet a defined threshold. In accordance with Guidance from the Medical Council, GPs *"must be aware of and comply with the national guidelines and legislation for the protection of children"*[4]. In addition to being obliged to report concerns, GPs are also obliged to assist Tusla in their assessment of a concern which has been the subject of a mandated report.

- Reports should be made to the duty social work team in the area where the child lives. Contact details are available from www.tusla.ie.

- It is imperative to always explore and ensure the immediate safety of a child. If a GP considers urgent intervention to be required in order to ensure a child's safety, telephone contact can be made with the local duty social worker. In such cases, where a GP has concern in relation to the immediate safety of a child, consideration can also be afforded to informing An Garda Síochána. GPs should always also consider the safety of other children, such as siblings.

- It is considered best practice for a GP to inform a family/parents that a report is being made to Tusla. However, a GP is not obliged to do so and, in exceptional circumstances, may decide not to if concerned that to do so could place a child at further risk, could impact upon Tusla's ability to carry out an assessment or could place the GP at risk of harm from the family. See www.tusla.ie.

- GPs can refer a child/adolescent for a forensic assessment. Contact details for Child and Adolescent Sexual Assault Services are provided (See p. 19). Referral Pathways for Child and Adolescent Forensic Medical Assessments are provided (See Section 8:4). The urgency of a forensic assessment should always be considered (i.e. timing of the assessment in relation to the abuse/concern) (see Section 8) discuss with Forensic Examiner on call.

- If GPs are in doubt in relation to referral or a concern, it may be helpful for GPs to know that they can contact the Forensic Examiner on call for advice.

- GPs should consider the provision of Emergency Contraception if indicated.

- GPs may find it helpful to inform patients/families of available crisis support services. For example, CARI (www.cari.ie) provide an accompaniment service for children and families attending CASATS, Galway and Rotunda SATU.

References

1 National Guidelines on Referral and Forensic Clinical Examination Following Rape and Sexual Assault (Ireland). 4th Edition 2018. www.hse.ie/satu

2 Department of Children and Youth Affairs (DCYA) Children First: National Guidance for the Protection and Welfare of Children. Dublin: Stationery Office; 2017. www.dcya.ie

3 Government of Ireland. Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act, 2012. www.irishstatutebook.ie

4 Medical Council. Guide to Professional Conduct and Ethics for Registered Medical Practitioners. 8th Edition, 2016. Available from www.medicalcouncil.ie. Accessed 09.10.2017

Additional reading

Kennedy Kieran M, White C, What can GPs do for adult patients disclosing recent sexual violence? British Journal of General Practice, 2015. 65(630):42-44

SECTION 7: LEGAL

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Legal Section

7:1 Purpose of Legal Section

This section is intended to provide a broad overview of the criminal justice process as it relates to sexual offences. It does not provide legal advice[1] but attempts to answer some of the questions commonly asked about the legal process in the aftermath of a sexual assault.

References

1 If you need legal advice on any aspect of the SART National Guidelines, or on any issues arising from their operation and implementation, you should talk to a lawyer or someone in the legal department of the relevant authority, agency, body, institution or organisation to which you belong.

7:2 When Do Sexual Acts Become Sexual Offences?

Depending on the circumstances, there are a wide range of sexual acts that have the potential to be sexual offences. In broad terms, this may be because the victim[1] did not consent to the sexual act, or, because the victim could not consent due to an absence of capacity, perhaps by virtue of age or disability.

References

1 A **'victim'** is defined in section 2 of the Criminal Justice (Victims of Crime) Act 2017 as 'a natural person who has suffered harm, including physical, mental or emotional harm or economic loss, which was directly caused by an offence'.

7:3 The Role of Consent in Sexual Offences

The absence or presence of consent is often the key legal issue for consideration. The law states that a person consents to a sexual act if he or she freely and voluntarily agrees to engage in that act.[1]

If the victim does not offer resistance to an act, that does not of itself constitute consent.[2]

The law sets out a non-exhaustive list of circumstances[3] which are considered non-consensual, such as where a victim is incapable of consenting because of the effect of alcohol or some other drug.

Consent can be withdrawn at any time before the act begins, or whilst it is taking place, in the case of a continuing act.[4]

References

1 Criminal Law (Rape) (Amendment) Act 1990 ('the 1990 Act'), section 9 (1) as substituted by section 48 of the Criminal Law (Sexual Offences) Act 2017 with effect from 27 March 2017.

2 The 1990 Act, section 9 (5) as substituted.

3 The 1990 Act, section 9 (2) as substituted.

4 The 1990 Act, section 9 (4) as substituted.

7:3.1 When Must Absence of Consent be Proven?

Where consent is in issue, the prosecutor must prove beyond a reasonable doubt that the victim did not consent.

Examples include:

- **rape, and**
- **sexual assault,**

A man commits rape[1] if:

(a) he has sexual intercourse with a woman who at the time of the intercourse does not consent to it, and

(b) at that time he knows that she does not consent to the intercourse or he is reckless as to whether she does or does not consent to it.

The old offence of 'indecent assault' was re-named as 'sexual assault'.[2] The consent requirement in those offences appears to arise from the 'assault' element. For example, Lord Lane C.J. in *Faulkner v Talbot* [1981] 3 All ER 468 at 471 stated that: "An assault is any intentional touching of another person without the consent of that person and without lawful excuse."

References

1 Defined in section 2 (1) of the Criminal Law (Rape) Act 1981, as amended by section 21 and the Schedule to the Criminal Law (Rape) (Amendment) Act 1990 with effect from 18 January 1991.

2 Offence established by section 2 of the Criminal Law (Rape) (Amendment) Act 1990, as amended by section 37 of the Sex Offenders Act 2001 with effect from 27 September 2001.

7:3.2 When Is Consent Not In Issue?

The law does not allow an accused to put forward a defence of consent in relation to certain vulnerable victims such as children, or 'protected' or 'relevant' persons.

Child victims aged 16 years or younger cannot consent in law[1] to a 'sexual act' which is defined[2] as:

- **sexual intercourse**[3] between persons not married to each other, or

- **buggery** between persons not married to each other, or
- **aggravated sexual assault,**[4] or
- **'rape under section 4',**[5] meaning **a *sexual assault* that includes:-**
  - penetration (however slight) of the anus or mouth by the penis, or
  - penetration (however slight) of the vagina by any object held or manipulated by another person.

It may be a defence for a person who engages in any of the above **sexual acts with a child victim aged 15 or 16 years**, that the child victim consented, provided that the person is younger or less than two years older than the child victim, and was not a person in authority in respect of the child victim, or in an intimidatory or exploitative relationship with the child victim.[6]

Child victims aged 14 years or younger cannot consent in law[7] to any of the aforementioned sexual acts and, in addition, cannot consent to acts amounting to **sexual assault** or **indecent assault.**[8]

It is an offence for a **'person in authority'** to engage, or attempt to engage, in sexual intercourse, buggery, aggravated sexual assault, or section 4 rape with a **child victim who is aged 17**.[9] The law prevents an accused from putting forward a defence of 'consent' in such cases.[10] A 'person in authority' includes: a parent, grandparent, uncle, aunt, guardian, foster parent, step-parent, partner of a parent of the child, a person in loco parentis, or a person responsible for the education, supervision, training, care or welfare of the child.[11]

It is an offence[12] to engage in a sexual act with a **'protected person'** who is deemed to lack the capacity to consent to such an act.

A **'protected person'** is defined[13] as someone who 'lacks the capacity to consent to a sexual act' by reason of 'a mental or intellectual disability or a mental illness' the effect of which makes that person incapable of:

- understanding the nature, or the reasonably foreseeable consequences of the sexual act, or
- evaluating relevant information for the purposes of deciding whether or not to engage in that act, or
- communicating his or her consent to that act by speech, sign language or otherwise

The sexual acts prohibited in relation to a protected person are: sexual intercourse, buggery, aggravated sexual assault, section 4 rape and 'acts which if done without consent would constitute a sexual assault'.[14]

It is an offence for a **'person in authority'** to engage in a sexual act with a **'relevant person'**.[15]

A **'relevant person'** is defined as 'a person who has a mental or intellectual disability or a mental illness which is of such a nature or degree as to severely restrict the ability of the person to guard himself or herself against serious exploitation'.[16] This definition may capture victims who are less incapacitated than those defined as 'protected persons'.

A **'person in authority'** means anyone who is responsible for the victim's education, supervision, training, treatment, care or welfare in a professional capacity.[17]

The sexual acts prohibited in relation to 'relevant persons' are the same as those set out above for 'protected persons'.[18] A 'person in authority' cannot put forward the defence of 'consent' in such cases.[19]

References

1 Section 3 of the Criminal Law (Sexual Offences) Act 2006, as substituted by section 17 of the Criminal Law (Sexual Offences) Act 2017 with effect from 27 March 2017, makes it an offence to engage, or attempt to engage, in a sexual act with a child who is under the age of 17 years.

2 Defined in section 1 of the Criminal Law (Sexual Offences) Act 2006.

3 Defined in section 1 (2) of the Criminal Law (Rape) Act 1981 by reference to section 63 of the Offences against the Person Act 1861.

4 'Aggravated sexual assault' is defined in section 3 (1) of the Criminal Law (Rape) (Amendment) Act 1990 as 'a sexual assault that involves serious violence or the threat of serious violence or is such as to cause injury, humiliation or degradation of a grave nature to the person assaulted'.

5 Defined in section 4 (1) of the Criminal Law (Rape) (Amendment) Act 1990.

6 Section 3 (8) of the Criminal Law (Sexual Offences) Act 2006, as substituted by section 17 of the Criminal Law (Sexual Offences) Act 2017.

7 Section 2 of the Criminal Law (Sexual Offences) Act 2006, as substituted by section 16 of the Criminal Law (Sexual Offences) Act 2017, makes it an offence to engage, or attempt to engage, in a sexual act with a child who is under the age of 15 years.

8 Section 14 of the Criminal Law Amendment Act 1935 prohibits an accused from putting forward a defence of 'consent' to a charge of indecent assault or sexual assault on a child victim under the age of 15 years.

9 Section 3A of the Criminal Law (Sexual Offences) Act 2006, as inserted by section 18 of the Criminal Law (Sexual Offences) Act 2017.

10 Section 3A (7) of the Criminal Law (Sexual Offences) Act 2006 as inserted.

11 Defined in section 1 of the Criminal Law (Sexual Offences) Act 2006, as substituted by section 15 (a) of the Criminal Law (Sexual Offences) Act 2017.

12 The Criminal Law (Sexual Offences) Act 2017, section 21 (1).

13 The Criminal Law (Sexual Offences) Act 2017, section 21 (7).

14 The Criminal Law (Sexual Offences) Act 2017, section 20.

15 The Criminal Law (Sexual Offences) Act 2017, section 22 (1).

16 The Criminal Law (Sexual Offences) Act 2017, section 22 (8).

17 The Criminal Law (Sexual Offences) Act 2017, section 22 (8).

18 The Criminal Law (Sexual Offences) Act 2017, section 20.

19 The Criminal Law (Sexual Offences) Act 2017, section 22 (4).

7:4 Effects of Delayed Reporting by Victims of Sexual Offences

It is widely understood and acknowledged that the decision to report a sexual offence is often difficult for a victim. However, early reporting to the Gardaí is encouraged and is extremely important in terms of ensuring the best possible outcomes during the investigation and prosecution stages.

Delayed reporting means that forensic evidence may no longer be available. Forensic evidence may assist a case, particularly where sexual contact with the victim is denied by the suspect(s). Forensic evidence of sexual contact can have particular significance when the circumstances are such that the victim lacks the capacity in law to consent.

Delay can be seen, in certain circumstances, to affect the credibility of a victim. However, developments in the criminal justice system reflect a growing awareness of the sensitivities involved in reporting such personal crimes, including: "A greater awareness of the reasons why a complainant may not have made a complaint of a sexual offence at the first reasonable opportunity."[1] (See 3:2)

It is important to note that if the victim does not make an immediate complaint, but goes on to do so at a later date, she or he will almost certainly be asked to explain the reason(s) for the delay in reporting.

References

1 *Access to Justice for People with Disabilities as Victims of Crime in Ireland,* Claire Edwards, Gillian Harold, Shane Kilcommins, UCC, February 2012, page 26.

7:5 Do Others Have a Duty to Report?

If any issue arises in relation to reporting a disclosure made by anyone who may be a victim of crime, you should refer to the applicable legal provisions and the guidance available from your employer or professional body. What is discussed below is a brief summary of some important measures in this area.

Legislation protects persons from civil liability who make a report of assault, ill-treatment, neglect, or sexual abuse of a child to designated officers of the Child and Family Agency (Tusla), the Health Service Executive (HSE), or to members of the Gardaí. That protection applies only where a person acts reasonably and in good faith in forming their opinion and in communicating it to the appropriate person.[1] There is a definition of 'child' in the legislation.[2]

Certain persons have a legal duty to report child protection concerns to the Child and Family Agency (Tusla).[3] Those 'mandated persons' who are listed[4] in the legislation must report any knowledge, belief or reasonable suspicion that a child has been harmed, is being harmed or is at risk of being harmed. The definition of 'harm' in the legislation includes assault, ill-treatment, neglect or sexual abuse of a child. The duty to report arises where such information is obtained by a mandated person in the course of his or her employment or profession. The report must be made as soon as practicable. The legislation provides for exceptions in certain circumstances to the reporting requirement.[5] Definitions of 'ill-treatment' and 'neglect' are set out in the legislation.[6] It also contains a list of the offences which constitute 'sexual abuse' in this context.[7] There is a definition of 'child' in the legislation.[8]

Reckless endangerment of children is an offence.[9] It arises where a person who has authority or control over a child or an abuser, intentionally or recklessly causes or permits any child to be placed or left in a situation which creates a substantial risk to the child of being a victim of serious harm or sexual abuse. It also arises where such a person intentionally or recklessly fails to take reasonable steps to protect a child from such a risk while knowing that the child is in such a situation. The legislation contains definitions of 'abuser', 'serious harm' and 'sexual abuse'.[10] It also has a definition of 'child'.[11]

It is an offence to withhold information about the commission of certain offences against children or vulnerable persons.[12] This arises where a person knows or believes that an offence (listed in the legislation) has been committed against a child or vulnerable person.[13] The person must have information which he or she knows or believes might assist to apprehend, prosecute or convict the perpetrator for that offence, and the person fails without reasonable excuse to disclose that information, as soon as practicable, to a member of the Gardaí. The legislation provides for defences in certain circumstances where information is not disclosed.[14] It also contains a definition of 'vulnerable person'[15] and a definition of 'child'.[16]

References

1 Protections for Persons Reporting Child Abuse Act 1998, section 3 (1).

2 'Child' is defined in section 1 of the Protections for Persons Reporting Child Abuse Act 1998 as meaning 'a person who has not attained 18 years of age'.

3 Children First Act 2015 ('the 2015 Act'), section 14 with effect from 11 December 2017.

4 'Mandated persons' are listed in Schedule 2 of the 2015 Act with effect from 11 December 2015.

5 The 2015 Act, section 14 (3) and (4).

6 The 2015 Act, section 2.

7 Offences constituting 'sexual abuse' were designated with effect from 11 December 2015 in section 2 of the 2015 Act (as amended); this is by reference to the list of such offences contained in Schedule 3 of the 2015 Act, as amended by section 55 of the Criminal Law (Sexual Offences) Act 2017.

8 'Child' is defined in section 2 of the 2015 Act as having 'the same meaning it has in section 2 of the Child Care Act 1991', that is 'a person under the age of 18 years other than a person who is or has been married'.

9 Criminal Justice Act 2006, section 176.

10 Criminal Justice Act 2006, section 176 (1).

11 'Child' is defined in section 176 (1) of the Criminal Justice Act 2006 as meaning 'a person under 18 years of age, except where the context otherwise requires'.

12 Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012 ('the 2012 Act'), sections 2 and 3.

13 The 2012 Act, Schedule 1 lists offences against 'children' and Schedule 2 lists offences against 'vulnerable persons'.

14 The 2012 Act, section 4.

15 The 2012 Act, section 1 (1).

16 'Child' is defined in section 1 (1) of the 2012 Act as meaning 'a person who has not attained 18 years of age'.

7:6 Investigation and Prosecution of Sexual Offences

Criminal investigation of sexual offences is carried out by An Garda Síochána (the Gardaí). When an investigation has been completed, they send the investigation file to the Office of the Director of Public Prosecutions (DPP) for a decision on whether or not a prosecution should take place.

7:6.1 Gardaí Conduct Criminal Investigations

The investigative role of the Gardaí and the prosecution role of the DPP are separate, distinct and independent of each other. The Office of the DPP does not investigate criminal offenses.

There are many offences which can be prosecuted by the Gardaí without first having to send an investigation file to the Office of the DPP. Where the offence is of a sexual nature, however, the decision as to whether a prosecution should or should not be instituted (and the choice of charge) must be made by the DPP and prosecutors in the Office of the DPP.[1]

References

1 General Direction No. 3 under Section 8 of the Garda Síochána Act 2005, paragraph 2 (d), available at www.dppireland.ie.

7:6.2 Gardaí Assess the Needs of Victims of Crime

Legislation gives the Gardaí an important role in making an assessment of the protection needs of victims of crime.[1] Child victims are presumed by the legislation to have protection needs.[2]

The assessment process is based on a number of factors set out in the legislation[3] which are: the type and nature of the alleged offence; the circumstances of the commission of the alleged offence; whether the victim has suffered considerable harm due to the severity of the alleged offence; the personal characteristics of the victim, including his or her age, gender, gender identity or expression, ethnicity, race, religion, sexual orientation, health, disability, communications difficulties, relationship to, or dependence on, the alleged offender and any previous experience of crime; whether the alleged offence appears to have been committed with a bias or discriminatory motive, which may be related to the personal characteristics of the victim; the particular vulnerability of victims of terrorism, organised crime, human trafficking, gender-based violence, violence in a close relationship, sexual violence or exploitation and victims with disabilities.

The Gardaí will identify the protection needs, if any, of the victim and will ascertain whether and to what extent the victim might benefit from protection. The victim might benefit from protection measures and special measures during the investigation[4] or the course of criminal proceedings[5], due to their particular vulnerability to secondary and repeat victimisation, intimidation and retaliation. The Gardaí in carrying out the assessment on whether the victim would benefit from protection measures and special measures during the course of an investigation of the alleged offence, and during the course of any criminal proceedings relating to the alleged offence, will consult with the victim in relation to that assessment, and take into account the views of the victim in relation to any protection measures or special measures identified during the assessment process.[6] This assessment will be passed on to the ODPP, who will decide, in consultation with the victim and the Gardaí, what special measures will be required if a prosecution is directed. The victim's protection needs are kept under constant review.

References

1 The Criminal Justice (Victims of Crime) Act 2017, section 15 with effect from 27 November 2017.

2 The Criminal Justice (Victims of Crime) Act 2017, section 15 (7).

3 The Criminal Justice (Victims of Crime) Act 2017, section 15 (2).

4 Special measures or protection during investigations may include advice on personal safety – including safety orders and barring orders; applications to remand the accused in custody or seek conditions on bail; interviews being carried out in appropriate premises by specially trained persons, and (in the case of sexual or gender based violence), by a person of the same sex as the victim.

5 Special measures in court proceedings allow evidence to be given through live television link or from behind a screen. Translation and/or interpretation services will be made available for those victims who do not have English as their first language. In cases involving children, judges and barristers will not wear wigs or gowns during the trial. Other measures allow a court to exclude the public from proceedings and/or restrict questioning regarding the victim's private life. The court can also allow the use of intermediaries to assist in the questioning of any victim who has particular vulnerabilities, for example, learning, intellectual, speech or other difficulties.

6 The Criminal Justice (Victims of Crime) Act 2017, section 15(4).

7:6.3 DPP Decides Whether to Prosecute or Not

The decision whether or not to prosecute sexual offences (and the choice of charge) is made exclusively by the DPP and prosecutors in the Office of the DPP.[1]

Deciding whether or not to prosecute is a two stage process:

1. Is there a *prima facie* case? – This requires "admissible, relevant, credible and reliable evidence which is sufficient to establish that a criminal offence known to the law has been committed by the suspect. The evidence must be such that a jury, properly instructed on the relevant law, could conclude beyond a reasonable doubt that the accused was guilty of the offence charged."[2]

2. If there is a *prima facie* case, does the public interest require a prosecution? – "Once the prosecutor is satisfied that there is sufficient evidence to justify the institution or continuance of a prosecution, the next consideration is whether, in light of the provable facts and the whole of the surrounding circumstances, the public interest requires a prosecution to be pursued."[3]

You will find more information about the decision whether or not to prosecute in Chapter 4 of *Guidelines for Prosecutors* (4th Edition October 2016) available on the website of the DPP at www.dppireland.ie.

References

1 General Direction No. 3 under Section 8 of the Garda Síochána Act 2005, paragraph 2 (d), available at *www.dppireland.ie*.

2 Guidelines for Prosecutors (4th Edition October 2016), para. 4.10.

3 Guidelines for Prosecutors (4th Edition October 2016), para. 4.18.

Figure 6: The Independent Roles of An Garda Síochána and the DPP in Sexual Offence Cases.

Gardaí and DPP Roles are INDEPENDENT of Each Other

An Garda Síochána:

- Investigate offence and prepare file
- Send file to DPP for a decision whether or not to prosecute
- Cannot charge a sexual offence without consent of DPP

Office of the DPP:

- Receives file from the Gardaí
- Exclusively makes decision whether or not to prosecute in sexual offences

Decision-making is a two-stage process

1. Is there a *prima facie* case?

   Admissible, relevant, credible and reliable evidence that a crime has been committed by an identified suspect.

2. If there is a *prima facie* case – does the public interest require a prosecution to be pursued?

7:7 Disclosure of Relevant Materials to Lawyers for Accused

After a decision to prosecute is made and criminal proceedings have begun, the Office of the DPP is under a legal duty to disclose to the accused's lawyers all 'relevant material' in the prosecutor's possession, or which is within the prosecutor's power to obtain.[1] Material is 'relevant' if it could help the accused establish a defence, either by damaging the prosecutor's case, or by giving a lead to other evidence.

Therefore, it is important for victims to understand that the expectation of confidentiality, which usually arises where information passes between patients and doctors or other medical personnel, does not apply in circumstances where they have made a formal report of a sexual offence. All material generated on foot of a SATU examination, including notes or records[2] generated as a result of the provision of SATU care and Forensic Clinical Examination, are likely to be considered 'relevant' and therefore disclosable to an accused, in criminal proceedings.

Ordinarily, the SATU legal report is served within the Book of Evidence. All other material, notes, charts etc. are served on the accused as part of general disclosure after the accused has received the Book of Evidence. Copies of any original notes, charts, diagrams etc. are disclosed to lawyers representing the accused only, with strict conditions as to how they are kept and used.

By virtue of Section 19A of the Criminal Evidence Act 1992, as inserted by section 39 of the Criminal Law (Sexual Offences) Act 2017, with effect from 30 May 2018, the prosecutor must alert the accused of the existence of any counselling record in relation to the victim. The permission of the Court is required for the contents of the record to be given to the accused where the victim does not consent to its release. In those circumstances the victim has a right to a court hearing on whether their counselling notes should be disclosed for the purpose of a criminal trial of a sexual offence. These provisions apply to such trials when conducted in the Circuit and Central Criminal Courts but not to hearings in the District Court. The Court will hear from the prosecution and defence in making a determination as to whether those notes will be made available to the accused. The victim, the person who has possession or control of the counselling record

and any other person to whom the counselling records relate are entitled to appear and be heard by the Court at the application hearing. The victim is also entitled to their own legal representation at the hearing, free of charge.[3] Victims in a sexual offence prosecution are entitled to free legal advice and can, if they wish, seek legal advice on whether they should or should not consent to disclosing their counselling records.

References

1 There are a limited number of exceptions to this general statement, such as relevant material which is protected by a recognised form of legal 'privilege'.

2 'Notes or records' may include: medical notes, psychological or psychiatric reports and notes or reports by nurses or social workers; if the victim or witness to whom the relevant material relates does not consent to such disclosure, the accused's right to a fair trial may be in doubt and it may not be possible to proceed with the prosecution.

3 This measure is applicable to the sexual offences contained within Schedule 1 of the Sex Offenders Act 2001 (as amended).

7:8 Which Criminal Court Will Hear the Case?

Once the decision to prosecute has been made and specific charges have been chosen, it is the nature and seriousness of the particular offence(s) that determines which criminal court will hear the case against the accused. Broadly speaking, less serious sexual offences are dealt with by the District Court, more serious ones by the Circuit Criminal Court, and the most serious ones by the Central Criminal Court.

Every rape offence or aggravated sexual assault must be tried by the Central Criminal Court. A 'rape offence' includes the offence of rape under section 4 of the Criminal Law (Rape) (Amendment) Act 1990.

The District Court may deal with a prosecution for sexual assault if: (a) the District Court Judge is of the opinion that the facts proved or alleged constitute a minor offence which is fit to be tried summarily; and (b) if the DPP consents; and (c) the accused (on being informed of the right to be tried by a jury) does not object to being tried summarily in the District Court.[1] Also, where an accused decides to plead guilty to sexual assault in the District Court, the case can be dealt with if the District Court Judge is satisfied that the accused understands the nature of the offence and the facts alleged, and if the prosecutor consents.[2]

All other sexual offences are dealt with in the Circuit Criminal Court.

You will find further information about the criminal courts on the website of the Courts Service at www.courts.ie.

References

1 Criminal Law (Rape) Act 1981, section 12 (1) as amended by section 16 of the Criminal Law (Rape) (Amendment) Act 1990 with effect from 18 January 1991.

2 Criminal Procedure Act 1967, section 13 (2) as substituted by section 10 (3) of the Criminal Justice Act 1999 with effect from 1 October 2001.

7:8.1 Will the Case be Heard in Public?

Sexual offences are normally heard 'otherwise than in public'. This means the judge will generally exclude from court all people who do not need to be there. The accused is allowed to have a family member or a friend present. The victim[1] is allowed to be accompanied by a family member or other person present. This can include a support person from the Rape Crisis Centre, or Victim Support at Court Service (see www.vsac.ie). Bona fide members of the press will be allowed in court and will be allowed to report on proceedings. They will however be subject to restrictions on reporting the identity of the victim or the accused, as outlined in the following section.

References

1 A victim who is a child has the right to be accompanied in court by an appropriate person; see section 18 (3) of the Criminal Justice (Victims of Crime) Act 2017 with effect from 27 November 2017.

7:8.2 Can Victims Remain Anonymous?

Following the decision to charge a sexual offence, no information likely to lead to the identification of the victim may be published without the express permission of the judge (such permission is very rare).

7:8.3 Is the Victim Entitled to Legal Advice?

For certain sexual offences where a prosecution is brought, legal advice is available free of charge to victims who wish to seek it through the Legal Aid Board under the Civil Legal Aid Act 1995. The victim's entitlement in such cases to free legal advice does not apply to all sexual offences but only those listed in the legislation.[1] They include prosecutions for rape, aggravated sexual assault, engaging in a sexual act with a child, incest and some other sexual offences. Information on how to apply is available on the website of the Legal Aid Board at www.legalaidboard.ie.

References

1 Civil Legal Aid Act 1995, section 26 (3A) as inserted by section 78 of the Civil Law (Miscellaneous Provisions) Act 2008 with effect from 20 July 2008.

7:8.4 Is the Victim Entitled to Legal Representation?

Victims of crime are not usually entitled to be represented by their own lawyer during criminal proceedings. However, an exception is allowed by law in the particular circumstances set out below.

In a prosecution for a 'sexual assault offence', where the accused's lawyer intends to ask a question or introduce evidence relating to any sexual experience of the victim with any person (other than that to which the charge relates), permission must first be obtained from the trial judge in the absence of the jury.[1] The accused must notify the prosecutor in advance of the intention to make that application to the trial judge.[2]

In those circumstances, the victim is entitled to be heard in relation to the accused's application, and also to be legally represented by a lawyer engaged by the Legal Aid Board for that purpose, during the hearing

of the application.[3] Those entitlements do not extend to every 'sexual assault offence'. They are available in respect of rape offences, aggravated sexual assault offences, engaging in sexual acts with children and some other sexual offences.[4] If requested by the victim, the prosecutor will contact the Legal Aid Board who will arrange for legal representation in those circumstances.[5]

As outlined above in section 7:7 a victim is entitled to legal representation when an application for disclosure of counselling records is made.

Further information is available on the website of the Legal Aid Board at *www.legalaidboard.ie*.

References

1 Criminal Law (Rape) Act 1981 ('the 1981 Act'), section 3 (1), as substituted by section 13 of the Criminal Law (Rape) (Amendment) Act 1990 with effect from 18 January 1991, and section 3 (2).

2 The 1981 Act, section 4A (2) as inserted by section 34 of the Sex Offenders Act 2001 with effect from 27 September 2001.

3 The 1981 Act, section 4A (1).

4 The 1981 Act, section 4A (6).

5 *Guidelines for Prosecutors* (4th Edition October 2016), paragraph 12.34 (c), available at www.dppireland.ie.

7:8.5 Making a Victim Impact Statement

Legislation provides[1] that all victims of crime (and their family members[2] in some circumstances) have the right, but not the obligation, to make a Victim Impact Statement to assist the court in its sentencing process. The Victim Impact Statement is only given following a conviction. It can be given to the court by the victim orally, or in writing and either handed to the Judge or read out by a member of the Gardaí to the Court. The legislation requires a sentencing court to take into account the effect of a crime upon the victim. The court may order the production of a Victim Impact Statement for that purpose.

The sentencing court may, in the interests of justice, order that such victim impact evidence, or a part of it, is not to be published or broadcast. If no request is made to give such evidence, the court is not allowed to draw an inference that the offence had little or no effect.

References

1 Criminal Justice Act 1993, section 5 as substituted by section 4 of the Criminal Procedure Act 2010, and as amended by section 31 of the Criminal Justice (Victims of Crime) Act 2017.

2 A 'family member' of a victim includes: a spouse, civil partner or cohabitant of the victim; a child or step-child of the victim; a parent or grandparent of the victim; a brother, sister, half-brother or half-sister of the victim; a grandchild of the victim; an aunt, uncle, nephew or niece of the victim; and any other person who is or, where the victim is deceased, was dependent on the victim, or who a court, or the Gardaí, or the Director of Public Prosecutions, considers has or, where the victim is deceased, had a sufficiently close connection with the victim as to warrant his or her being treated as a family member.

7:9 Legal Considerations Re: Option 3 Collection and Storage of Forensic Evidence Without Immediate Reporting to An Garda Síochána

I. The primary purpose of *Option 3: Collection and Storage of Forensic Evidence Without Immediate Reporting to An Garda Síochána* (See 2:21), is the removal of barriers to reporting, investigating and prosecuting recent sexual offences. This is achieved by securing and preserving forensically obtained samples, materials and information as potential evidence to support a future prosecution in circumstances where the victim has yet to decide to make a formal complaint to the Gardaí.

II. Delayed reporting and the consequential loss of forensic evidence may be a significant impediment to potential prosecution, particularly where sexual contact with the victim is denied or the victim lacked the capacity in law to consent.

III. There is no 'statute of limitation' or time limit for prosecuting serious offences. In and of itself, delayed reporting is not necessarily a barrier to prosecution. One of the most significant cases on this point was the Supreme Court's decision in *O.H. v. Director of Public Prosecutions* [2007] IESC 12. The Court considered a number of cases over the last decade where there have been accusations of child sexual abuse and a significant delay between the alleged abuse and the complaint. The Court was of the opinion that a key issue in each case is the constitutional right to a fair trial. In reality, the key question is not so much the reason for a delay in making a complaint by a victim, but rather whether the accused will receive a fair trial or whether there is a real or serious risk of an unfair trial. The fact that a person who was the victim of a serious crime had delayed in bringing the commission of that crime to the notice of the State authorities is not of itself a ground upon which the State should refuse to bring a prosecution or the courts to entertain one. It is important to note that delayed reporting can be seen in particular circumstances to affect the credibility of a victim. However, that should not, in general, be a ground for preventing a trial proceeding. The prosecutor should decide whether there is evidence of sufficient weight to warrant a charge being preferred, and it is also the duty of the prosecutor to consider whether a fair trial can be afforded to an accused person.

IV. Developments in the criminal justice system reflect a growing awareness of, and sensitivity to, the general issues surrounding delayed reporting. However, it is important to note that if someone delays in making a report to the Gardaí, then he or she will almost certainly be asked to explain the particular reason(s) for the delayed report in their case.

7:10 Legal Resources and Further Reading

O'Malley, T. *Sexual Offences*, 2nd edition, Round Hall, 2013.

Mc Gee, H., Garavan, R., de Barra, M., Byrne, J., and Conroy, R. *The SAVI Report, Sexual Abuse and Violence in Ireland, A National Study of Irish Experiences, Beliefs and Attitudes Concerning Sexual Violence.* Dublin: The Liffey Press, Dublin Rape Crisis Centre. 2002.

Corr, M., O'Mahony, P., Lovett, J., & Kelly, L. *Different systems, similar outcomes?: Tracking attrition in reported rape cases in eleven countries.* April 2009. Available at: www.cwasu.org

Hanly, C. Healy D. and Scriver, S. *Rape & Justice in Ireland: A National Study of Survivor, Prosecutor and Court Responses to Rape*. Rape Crisis Network Ireland (RCNI) Dublin: Liffey Press. 2009. https://www.google.ie/ - #

Irish Statute Book at www.irishstatutebook.ie

SECTION 8:
CHILD AND ADOLESCENT FORENSIC MEDICAL ASSESSMENTS FOLLOWING DISCLOSURE OR CONCERNS OF CHILD SEXUAL ABUSE

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8:1 Introduction and Overview

The World Health Organisation defines child sexual abuse as the "involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violates the laws or social taboos of society"[1] and further notes that "children can be sexually abused by both adults and other children who are – by virtue of their age or stage of development – in a position of responsibility, trust or power over the victim"[1].

Child sexual abuse is thought to be highly prevalent but under-reported. A large study of the prevalence of sexual abuse and violence in Ireland surveyed over 3000 randomly selected Irish adults[2]. One in five women (20.4%) reported having experienced contact sexual abuse in childhood[2]. The term "contact abuse" refers to any type of abuse that involves physical contact with the child and includes penetrative sexual abuse. Non-contact abuse refers to other acts of child sexual abuse that do not involve direct physical contact with the child. Examples include grooming and persuading a child into performing a sexual act, including via social media and/or internet. A further one in ten women (10%) who participated in the SAVI survey reported having experienced non-contact sexual abuse during childhood[2]. Similar numbers of Irish men reported having experienced child sexual abuse. One in six men (16.2%) reported contact sexual abuse in childhood and one in fourteen (7.4%) reported having experienced non-contact sexual abuse[2].

According to best international practice, children should be referred for forensic healthcare services including holistic assessment and care whenever there is an allegation of sexual abuse, sexual abuse has been witnessed, or when there is a suspicion by the referring agency that sexual abuse has occurred, whether this be acute or non-acute. Adolescents 14 years and upwards, in an acute time-frame are referred to adult SATU services from the first instance.

The term child and adolescent forensic medical assessment refers to both the assessment of acute (i.e. those where forensic samples are taken) and non-acute cases. In adult patients and pre-pubertal children there are time frames within which forensic samples should be obtained (i.e. 7 days for adults and usually 72 hours for pre-pubertal children). Peri-pubertal children may not fall into either category and require a case-by-case decision in respect of forensic sampling, taking into account additional factors (e.g. pubertal status, washing, type of suspected abuse, potential for healing of physical signs, etc.). For further details on time-frames in relation to forensic sampling, refer to flow chart later in this chapter. The best interests of the child are always of paramount importance.

The child and adolescent forensic medical assessment must be patient-centred. The approach will be tailored according to the unique circumstances of each case. The assessment aims to promote healing by taking a therapeutic approach, empowering the child and caregiver and avoiding causation of any further distress. In the majority of cases child and adolescent forensic medical assessment does not cause undue distress to a child. Most children tend to react in the same way as they do to attending a Doctor/Nurse for any other reason.

Accompaniment/Introduction

Children and adolescents who attend for forensic medical assessment will normally be accompanied by a caregiver (parent, guardian and/or social worker), who can provide consent for the assessment, along with a member of An Garda Síochána in some cases. On arrival at a Sexual Assault Treatment Unit (SATU), or other appropriate location for child and adolescent forensic medical assessment, the child and caregiver are welcomed by the multi-agency response team. This will normally include the Support Nurse, the Forensic Clinical Examiner (Doctor or Nurse) and a crisis worker (e.g. CARI volunteer). A "settling in" time is usually provided, to allow the child to become familiar and comfortable in the surrounds of the SATU. A child-friendly environment should be provided. Photo-documentation of the intimate examination is a

recommended component of the child examination and for adolescents where available and appropriate. With the agreement of the person or agency providing consent, the child will be offered the opportunity to decide who he/she wants in the room during the examination.

History-taking

The Forensic Clinical Examiner will meet with the caregiver, Garda and/or social worker, if present, in order to obtain consent for the assessment. Depending on the developmental level of the child, they may or may not be included in the consent process. A brief history of the disclosure and/or reason for referral will be obtained, usually in the absence of the younger child so as to avoid possible prejudice of the child's account of events. An adolescent may prefer to give an account of events in privacy. A standardised proforma and careful documentation is essential. The Forensic Clinical Examiner will proceed, in so far as possible depending on the level of information available, to obtain a past medical history, past surgical history, medication, vaccination and allergy history, social history, family history, sexual history, menstrual history and enquiry will be made in respect of relevant ano-genital symptoms. Behavioural issues that could be relevant to child sexual abuse may be explored.

Examination

After the history taking is complete, the Forensic Clinical Examiner, Support Nurse, child and caregiver will normally proceed to the examination room in order to commence the physical examination. The environment must take account of risks of DNA contamination. Consideration should be given to having a forensically decontaminated room for acute forensic medical assessments versus an examination suite for non-acute assessments. Advice should be taken from FSI (Section 5). The examination room itself is a child-friendly environment including access to toys and/or entertainment equipment which can assist with distraction and provide reassurance (taking account of DNA-decontamination requirements). In accordance with each child's individual wishes, the caregiver can sit with the child for the entire examination. Physical examination has dual aims. First and foremost, the examination seeks to identify injuries and other medical needs, including sexually transmitted infections. Many patients who present for forensic examination will be found to have pre-existing unmet medical issues (e.g. poorly controlled asthma).[3] Second, the examination aims to gather evidence that can be used in the investigation of suspected child sexual abuse. Evidence may take the form of physical injury, biological material (i.e. semen and/or DNA), sexually transmitted infection and/or pregnancy.

General Physical Examination

This includes measurement of the child's vital signs, weight and height, top-to-toe physical examination and targeted systems examination. Demeanour, behaviour, hygiene and developmental concerns should be documented. Where concerning general body injuries (i.e. outside the anogenital area) are identified, consideration should be afforded to Crime Scene Photography by An Garda Síochána in complement to written description and annotated body diagram.

Anogenital examination

The anogenital examination would be photo-documented with dynamic imaging under targeted light and magnification and additional still images may be obtained. The child will normally be positioned in a supine frog-leg position (genital) and later moved to the left lateral position (anal). For a small child, examination may be carried out whilst positioned on the caregiver's lap, so as to avoid distress. For female children the prone knee-chest position is recommended for confirmation of posterior hymenal appearances if adequate

views have not been obtained thus far. Additional techniques for hymenal examination may include floating with sterile water, use of a cotton-tipped swab and/or Foley™ catheter. Green filter light is an adjunct for evaluation of bruising and scars. Internal speculum and proctoscopic examinations are not routinely performed in pre-pubertal children. In older children, the need for internal examination is determined on a case-by-case basis.

Sampling

Forensic swabs may be taken to sample for semen and/or DNA (Section 2:6). A sexually transmitted infection screen may be carried out as part of the examination, including oropharyngeal, anogenital and serum samples as indicated (Section 8:6). Where clinically indicated, identified medical needs may be investigated (e.g. a full blood count for suspected anaemia, etc.).

Emergency Contraception

Refer to Section 2:17.

Follow-up care

This is determined on a case by case basis. The need for review might depend on the complexity of the case, identified health needs, the age of the child/adolescent and whether or not the assault/abuse is acute or non-acute. Each Child and Adolescent Sexual Assault Treatment Service in Ireland, should have guidelines in place to ensure that all patients have access to a broad range of services and expertise. This may involve scheduled review clinics with a Paediatrician. A follow-up review does not necessarily involve repeat intimate examination. Review of any initial intimate photo-documentation (if undertaken) may be helpful at follow-up review, especially in evaluating the healing process.

8:2 Who Should Conduct a Child and Adolescent Forensic Medical Assessment?

A child and adolescent forensic medical assessment should only be conducted by a Doctor or Nurse with the requisite experience and core competencies.

In the Irish context, for a Doctor appropriate qualifications may include:

- a Postgraduate Certificate/Diploma in Sexual Assault Forensic Examination/Sexual Offences Medicine or equivalent

  and/or

- a Degree of Master of Science in Forensic and Legal Medicine or equivalent

  and/or

- Membership of the Faculty of Forensic and Legal Medicine (United Kingdom) or equivalent.

It is recognised that there are senior medical practitioners with extensive experience and competency in child and adolescent forensic medical examinations, who by virtue of their seniority and expertise, fulfil all core competencies without a formal qualification. In a court setting, the credibility of these practitioners should be recognised.

In addition, it is recommended that Doctors hold membership of a relevant college (i.e. MRCEM, MRCOG, MRCPCH, MRCPI and/or MICGP or equivalent). For new forensic Doctors, it is necessary to have evidence of significant recent relevant experience prior to independent conduct of child and adolescent sexual assault forensic medical assessments. This might include significant experience working with adult patients who disclose sexual violence and experience of assessments of children and adolescents conducted jointly with a suitably experienced Doctor or Nurse skilled in sexual offences medicine.

From a nursing perspective, as it stands in Ireland currently the Clinical Nurse Specialist (Sexual Assault Forensic Examiner) (CNS (SAFE)), Registered Advanced Nurse Practitioner (Sexual Assault Forensic Examination & Sexual Health) or Forensic Nurse Examiner examining adolescents > 14 years within the Adult SATU services must:

- Be registered in the Register of Nurses and/or Midwives, kept by Nursing and Midwifery Board of Ireland
- Have at least 5 years post–registration nursing experience.
- Have at least two years' experience in relevant areas of clinical practice.
- Obtain a Post Graduate/Higher Diploma/Degree in Sexual Assault Forensic Examination/Advanced Forensic Practice or equivalent.

For children < 14 years, in Ireland dedicated Forensic Nurse Examiners (Child and Adolescent) will require to have the above qualifications and experience and:

- Be certified as a Paediatric Sexual Assault Nurse examiner which may be achieved through the SANE-P course awarded by the International Association of Forensic Nursing or equivalent.

For both Doctors and Nurses working in this area, there must be a commitment to Continuous Professional Development, attendance at regular Peer Review meetings (in person or through videoconference) – at least quarterly, to include review of photo-documentation; and evidence of recent clinical work to ensure competencies are maintained. Practitioners should not work in isolation.

Peer-review of photo-documentation and reports is recommended. An arrangement put in place locally to enable this process, may best be done through a dedicated Child and Adolescent Clinical Director, ensuring quality standards and support for the team.

A child and adolescent Forensic Examiner should have core skills in both pre-pubertal child and peri/post pubertal adolescent examinations, or alternatively undertake a joint examination with another Forensic Examiner who has complimentary skills.

8:3 Consent For Examination

Legal Basis for Consent

The Child Care Act 1991[4], the Children Act 2001[5] and the Mental Health Act 2001[6] define a child as a service user under the age of 18 years-of-age, or than a service user who is or has been married. Section 23 of the Non-Fatal Offences Against the Person Act 1997[7] provides that a person of 16 and 17 years can give consent to medical, surgical or dental treatment and it is not necessary to obtain consent for this treatment from his or her parent(s) or legal guardian(s). The age of consent for the purposes of DNA sampling is also set by the Criminal Justice (Forensic Evidence and DNA Database System) Act 2014[8] at

16 years-of-age. Of note under the Criminal Law (Sexual Offences) Act 2017[9] the age of common consent for male and females for sexual activity, including penile-vaginal and penile-anal intercourse is 17 years-of-age.

Consent for a child and adolescent forensic medical examination should be obtained from the person with legal parental responsibility. This might be the child's own parent or, in the case of a child subject to a Full Care Order, a social worker. Court direction may be required in cases of children subject to other types of care order or when those with parental responsibility object to examination. In some cases, it may not be immediately clear who has parental responsibility and/or it may be deemed too detrimental to the child's wellbeing to seek consent from the person with parental responsibility (e.g. a suspected perpetrator or suspected to be complicit with abuse). The best interests of the child should always take precedence.

Age of Consent/The Mature Minor

In Ireland, in medical consent terms, a child is a minor if aged under 16 years. Many jurisdictions recognise the concept of a "mature minor" but this "right" to autonomy of a "mature minor" has not been tested or legislated-for in Irish law. For example, in England the 1985 Gillick case[10] established that a Doctor had discretion to give contraceptive advice or treatment to a girl under the age of 16 years without her parents' or legal guardians' knowledge or consent provided the girl had reached an age where she had a sufficient understanding to enable her to understand fully what was proposed. Hence, the concept of a 'mature minor' is dependent on the child's level of maturity, with no lower age limit defined. The HSE National Consent Policy[11] document has declared that the National Policy, "acknowledges that in health and social care practice it is usual to involve parent(s) or legal guardian(s) and seek their consent when providing a service to a minor under sixteen years". However, the minor may seek to make a decision on their own without parental involvement. In such circumstances it is best practice to encourage and advise the minor to communicate with and involve their parent(s) or legal guardian(s). It is **only in exceptional circumstances** that, having regard to the need to take account of an objective assessment of both the rights and the best interests of the person under 16, health and social care interventions would be provided for those under sixteen years without knowledge or consent of parent(s) or legal guardian(s).

A determination of the "mature minor's" capacity to consent, must include an assessment as to whether the minor has sufficient maturity to understand the information relevant to the decision and an appreciation of the potential consequences; that the minor's views are stable and a true reflection of his or her core values and beliefs, taking into account any physical or intellectual factors that affect his or her ability to exercise independent judgement; that the minor understands the nature, purpose and usefulness of the treatment i.e. forensic examination and treatment; that the minor understands the risks and benefits of the treatment, including the production and distribution of a medical report, as well as the possible prosecutorial process and examination of the information obtained.

It is recommended that for all children under the age of eighteen years, and deemed to have capacity to consent, all efforts should be made, if it is in the child's best interests, to have both a person with parental responsibility and the child providing consent. As determined by National Consent Policy (2013) however the best interests of the child should guide decision making, but the rationale underlying any decision making in the mature minor should be documented. It is best practice to seek a second opinion in these cases of "mature minors".

Standard Consent

A standard consent form such as that contained within the Faculty of Forensic and Legal Medicine proforma document[12] should be used. Each item on the consent form should be addressed individually and explanation provided as needed. The person providing consent should be given the opportunity

to ask questions and should only be asked to sign the consent form when they indicate satisfactory understanding. That consent can be withdrawn at any stage of the examination should also be especially highlighted. Consistent with the general statement included in the national SATU documentation, patient/caregivers should be informed of inclusion in audit process: "Audits of various aspects of care are regularly undertaken to ensure that we continue to provide a high quality service. No personal details or identifiable factors will be included in such audits."

Consent will normally be obtained in both verbal and written forms. In some circumstances it may be necessary to proceed with examination on the basis of verbal consent only. For example, the person with parental responsibility may be unable to attend or it may be considered inappropriate for them to attend and consent is obtained by telephone.

Prior to giving consent a "mature minor" must be informed that confidentiality cannot be assured as his/her parent(s)/legal guardian(s) may have rights-of-access to the minor's records under Freedom of Information Act 1997.

All children who have the capacity to understand should be informed that in certain circumstances there may be a legal obligation on the health care provider to report sexual activity due to the age of the child (i.e. under 17 years of age). The child should be informed of any intent to report.

Consent to Photo-documentation

Prior to undertaking the forensic examination, written informed consent for photo-documentation should be obtained from the person with parental responsibility, as well as from the child where appropriate. This should be contained within the standardised consent form/proforma. Particular care should be taken to explain photo-documentation and the storage of intimate images. It should be explained that the intimate images may be viewed by other medical experts and, in exceptional circumstances, they may be disclosed to a court. Where consent for photo-documentation is refused, that choice should be respected and documented. That consent can be withdrawn at any stage of the examination should also be especially highlighted. The discussion regarding photo-documentation should describe data storage, data-sharing and confidentiality. This consent process is documented in the notes including the consent for intimate images to be used for teaching, peer review or research purposes.

Consent for Complainat DNA collection by An Garda Síochána

Refer to Section 1:7.

Right to Refuse Examination and/or Treatment by Minor

The right to refuse treatment of 16 and 17 year-olds is unclear. The Non-Fatal Offences Against Person Act 19977 recognises the legal capacity of the 16 and 17 year-olds to consent to treatment but does not include an express entitlement to refuse treatment. The HSE National Consent Policy[11] proposes that where a child of 16 and 17 refuses treatment or a service that refusal should be respected in the same way as it is for adults (18 and over). If that treatment however involves life sustaining treatment advocacy or third party mediation should be employed. Failing agreement High Court adjudication and direction will be required. The minor would have independent legal representation at that adjudication.

Right to Refuse Examination Treatment and/or Treatment by parent(s)/legal guardian(s)

The HSE National Consent Policy recognises that parent(s)/legal guardian(s) are generally considered to be those best placed to safeguard the health and wellbeing of their children. Forensic service providers must recognise the parent(s)/legal guardian(s) expertise in looking after their children and afford them due courtesy and respect, as well as adequate information and support to dealing with any proposed intervention. Any request for a second-opinion by parent(s) /legal guardian(s) should be facilitated.

Where the examination and treatment of children suspected of being victims of sexual abuse is concerned there is often an allegation of one parent or the other being the perpetrator of that abuse. There is, as a consequence, the small possibility of a parent or legal guardian withholding consent for their child to undergo examination or treatment to avoid incrimination. In this circumstance, or in other circumstances where consent for examination and/or treatment is withheld, then the service provider in the best interests of the child, may apply to the courts to have this refusal overruled. This action is provided for by Article 42(5) of the Constitution[13] which states that where a child's parents have failed in their duty to the child the State may intervene to safeguard the welfare of the child.

8:4 REFERRAL PATHWAY

The following children should be referred for consideration of a child and adolescent forensic medical assessment:

1. Children under 14 years for acute and non-acute sexual abuse.
2. Children between 14 and 17 years who report acute sexual abuse in Ireland are currently referred to adult SATU services, however joint examination with a child and adolescent examiner should be considered where available on a case by cases basis after initial triage by the adult examiner.
3. Children under 18 years for non-acute sexual abuse. Non-acute abuse is abuse that is thought to have occurred more than 1 week previously. Photo-documentation is undertaken in many international jurisdictions and should be considered in Ireland when available, especially for patients who have not previously been sexually active apart from the alleged assault.

The following categories of referral are appropriate:

1. A child who has made an allegation about sexual abuse
2. Where sexual abuse of a child has been witnessed
3. Where there is a strong suspicion that child sexual abuse may have occurred but the child has not made a clear disclosure nor was abuse witnessed. In these cases decisions to examine should be made on a case by case basis: if in doubt a discussion should take place between the referring party, the Forensic Clinical Examiner, Tusla, and the carer, if carer is not the alleged perpetrator.

The following scenarios should be considered for referral:

- Sexually Transmitted Infection
- Pregnancy
- Siblings or other children exposed to identical risk factors for sexual abuse as an index case
- Sexualised behaviour when considered to be in excess of age appropriate sexual exploration

- Anogenital warts (especially in older children)
- Anogenital bleeding where no reasonable medical explanation has been identified and there are other concerning features in the medical or social history
- Chronic vaginal discharge where there are other concerning features in medical or social history
- Soiling/encopresis/incontinence where there are other concerning features in medical or social history.

In children where physical and/or emotional abuse is suspected without any significant concerns as to possible sexual abuse, referral to Child and Adolescent Sexual Assault Services is not appropriate. Such children should be referred directly to the local hospital paediatric service and Tusla. In cases of suspected physical abuse the local hospital consultant on call should be contacted for urgent assessment.

The Emergency Department is not a suitable environment for non-acute assessment of child abuse unless the child/adolescent has urgent medical needs (e.g. bleeding/acute severe injury/burns/suspected fractures). Every effort should be made to liaise with the child and adolescent Forensic Clinical Examiner on call, for cases of Child Sexual Abuse, or with the local Paediatric Consultant on call for other forms of abuse, who should arrange an appropriate time and venue for comprehensive assessment in privacy as indicated.

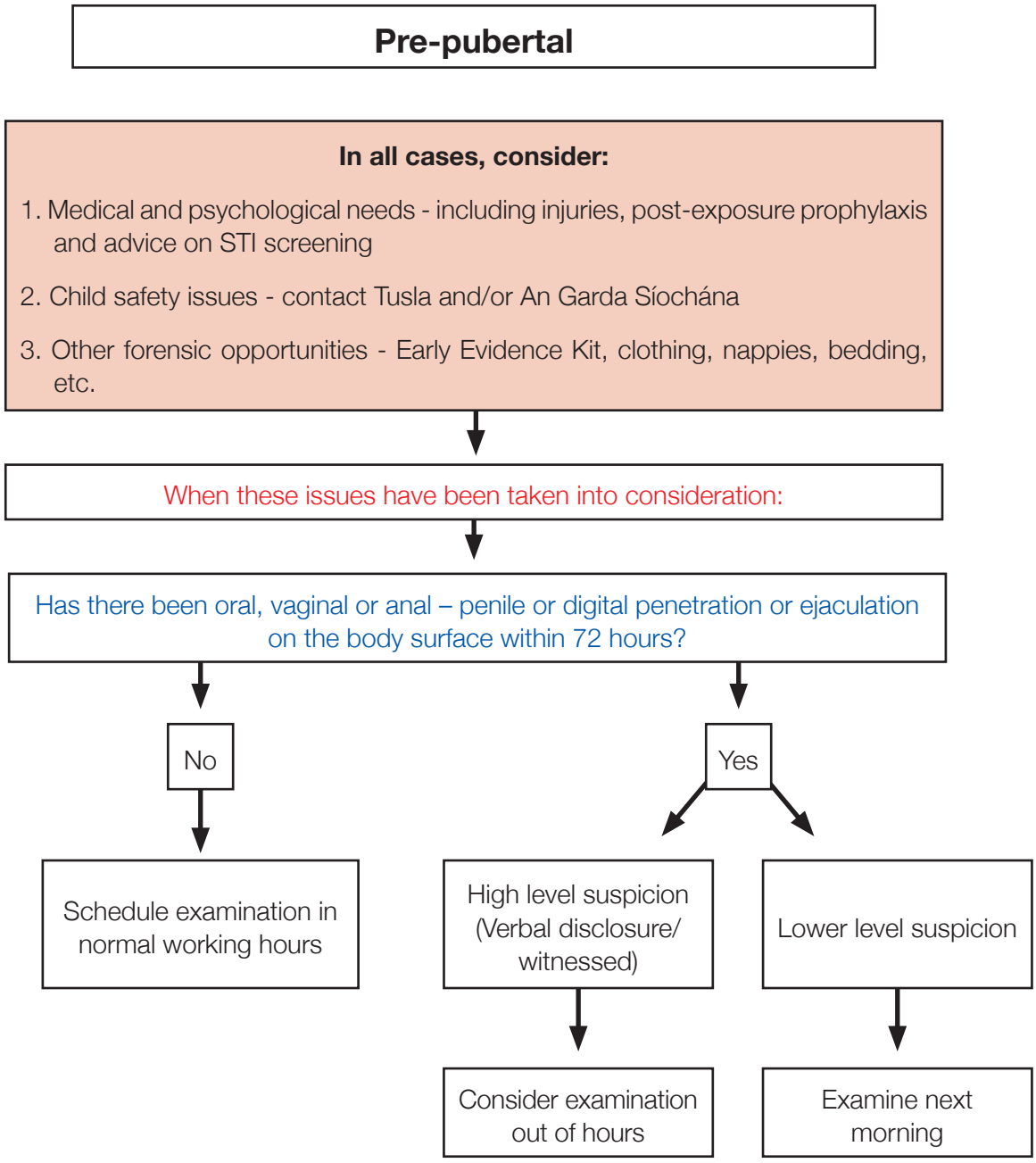
In all cases the child's safety is paramount and must be assured and needs of siblings or co-habiting children addressed.

These referral criteria are based upon the following best practice guidelines:

- Royal College of Paediatrics and Child Health (2015) Service specification for the clinical evaluation of children and young people who may have been sexually abused. Royal College of Paediatrics and Child Health and Faculty of Forensic and Legal Medicine of the Royal College of Physicians, London[14]
- Faculty of Forensic and Legal Medicine (2012) Guidelines on Paediatric Forensic Examinations in Relation to Possible Child Sexual. Faculty of Forensic and Legal Medicine of the Royal College of Physicians, London[15].
- Royal College of Paediatrics and Child Health (2013) Child Protection Companion. Royal College of Paediatrics and Child Health, London[16]

The following are examples of referral pathways adapted from St Mary's Sexual Assault Referral Centre in Manchester. Similar pathways should be developed locally for each Child and Adolescent Sexual Abuse Treatment Service to meet individual service availability and resources.

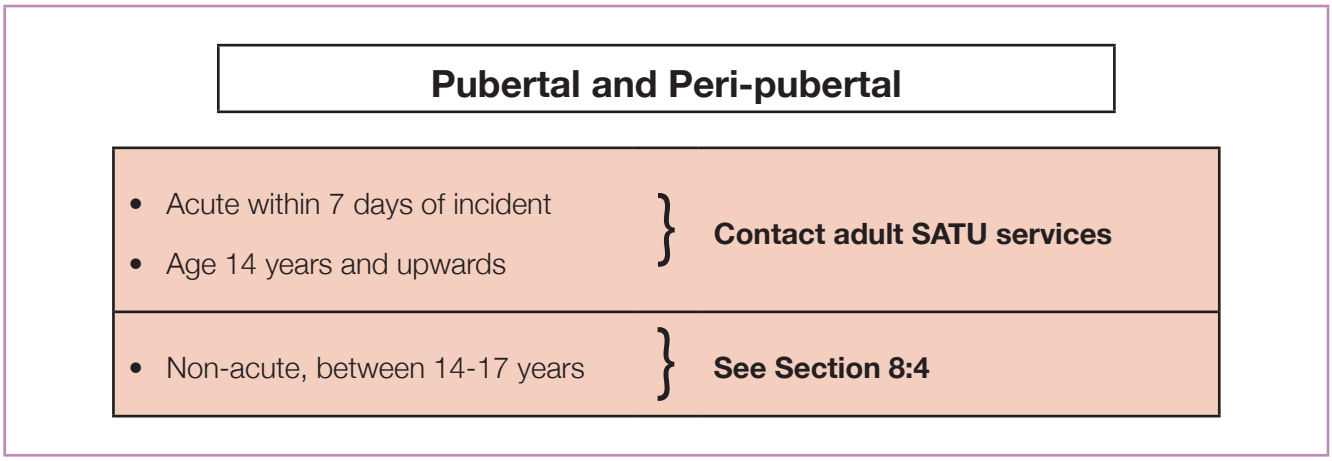
Figure 7: Forensic examination of acute sexual offences in children



N.B.
This flowchart is for use by forensic doctors and nurses to help the decision making process.

It is intended only as a guide – decisions must be made on a case-by-case basis.

A discussion should take place between the referrer and the forensic doctor / nurse to the appropriate timing for the forensic medical examination.



8:5 Photo-Documentation of Intimate Examination

The Royal College of Paediatrics and Child Health and the Faculty of Forensic and Legal Medicine provides detailed recommendations addressing photo-documentation[16] within the paediatric forensic examination. Their guidance states that photo-documentation is a recommended component of the child and adolescent forensic examination. "Intimate images" are defined as a "photograph, digital or video image of the genitalia, anus or naked female breast of a child, young person or adult"[17].

There are different methods of obtaining photo-documentation and magnification. Traditionally, a colposcope has been used to provide magnification and a focussed light source; and linked to image-capture equipment, photo-documents findings of examination. This may provide essential evidence as both still photographs and dynamic recordings of an examination can be documented. Other forms of photo-documentation equipment with high quality magnification and image-capture are acceptable. The aim of this photo-documentation is to support the clinical examination by demonstrating clinical findings and also enables additional medical opinions to be obtained regarding interpretation and description of findings, which may (but not exclusively) preclude further examination(s). Images should be of suitable quality to support clinical findings and where they do not, reasons for this should be clearly recorded in the notes. It is important that the child/carer is aware that photo-documentation reflect findings at the time of examination and may not reflect initial findings due to healing or the onset of puberty.

Written informed consent for photo-documentation is detailed in Section 8:3.

Storage of intimate Images

The Irish Data protection Acts (1988 and 2003)[18] describe legal requirements for employees within the HSE to maintain verbal professional confidentiality and secure storage of electronic and paper patient records. Official reports should not include photographic materials, although details and professional interpretations of images should be disclosed and the images retained with the medical records. These images should be stored as per local policy in keeping with national guidelines and statutory requirements. Photo-documentary data should be coded, cross-referenced and anonymised to protect patient recognition. When recording intimate images, special care should be taken to avoid recording the patient or caregivers face on the same recording. Both the hard-drive and the working copy of the images should be password protected/encrypted and electronic files and discs dated and marked with the patient's case number in indelible marker.

Statutory Instrument 391 (1998) of the Irish Statute Book[19] states that medical reports or copy medical reports should not be provided to any third party other than with the consent of the patient/caregiver or otherwise as required by law i.e. as a procedure in a criminal case or directed by order of the Court.

8:6 Sexually Transmitted Infection Screening

Sexually Transmitted Infections (STI) in the pre-pubertal child and in adolescents reporting first sexual contact

The timely diagnosis and management of STIs in children can prevent negative long-term health effects and have important forensic implications. The presence of an STI in a child or in those reporting no sexual contact prior to sexual abuse, may support the patient's disclosure and certainly raises the index of suspicion for abuse.

This is contrary to the consensually sexually active adolescent and adult population where infection may pre-date a sexual assault. As such screening for sexually transmitted infection plays a very important role in the assessment and management of children who may have been sexually abused and is undertaken at baseline, on first presentation of the child to forensic medical services and repeated (as clinically indicated) at follow up.

A negative baseline STI screen following an acute sexual assault which is later positive at follow up may add circumstantial evidence with respect to the timing of an assault and (assuming non-sexual transmission has been excluded) supports sexual contact as having occurred. Initial STI screening is usually undertaken without change of evidence (COE), however if there is a positive result arising, repeat sampling is indicated and consultation with a Microbiologist and/or the NVRL with COE recommended (COE must be followed ideally with the involvement of an Garda Síochána in transferring samples, if the presence of an STI is to be used in medico-legal proceedings).[20]

The risk of a child acquiring an STI is dependent on several factors including the type of abuse and the local prevalence of STIs which varies nationally and internationally. The epidemiology and demography of STIs in Ireland is referenced elsewhere in this publication (Section 4.1) however the overall prevalence of STIs in sexually abused children in Ireland is unknown. It is likely to be low, probably no more than 2%[21] but dependent on ethnic and demographic variations. In a recent American study[22]; of the 1319 patients (0-17 years) who were tested for Chlamydia Trachomatis (CT) and Neisseria Gonorrhoeae (NG), 120 (9%) had at least 1 infected site. CT was identified in 104 patients (7.88 %) and NG was found in 33. (2.5%).

Important STIs to be considered include CT, NG, anogenital warts, genital herpes simplex virus (HSV), HIV, Hepatitis B, Hepatitis C, Treponema Pallidum (Syphilis) and Trichomonas Vaginalis. Whilst there is insufficient data in children to determine the significance of bacterial vaginosis in relation to child sexual abuse, testing for this should be considered in symptomatic female children and adolescents with vaginal discharge, for health reasons as it may be amenable to antibiotic treatment. Candida is not considered an STI but can be screened for and treated in symptomatic individuals.

Prophylaxis for STIs

Overall the risk of acquiring an STI is low. Risk varies according to the type of abuse and will depend on whether violence was involved (ano-genital injuries with bleeding); characteristics of the alleged abuser and number of perpetrators, prevalence of a particular STI and the transmissibility. Routine prophylaxis against STI is not recommended for children less than 14 years but there are a small number of high risk situations.

For most up-to-date guidance refer to Children's HIV Association (CHIVA) and British Association of Sexual Health and HIV (BASHH) guidelines (www.chiva.org.uk and www.bashh.org).

Chlamydia and Gonorrhoea

In child and adolescent complainants of sexual abuse/assault, where the abuse represents a first sexual experience, antibiotic prophylaxis against chlamydia and gonorrhoea is not routinely recommended unless:

- the alleged assailant is known to have an infection or is deemed to be high risk
- the child/adolescent is unlikely to return for treatment if an STI is detected
- Multiple assailants.

Consider antibiotic prophylaxis on a case by case basis especially where testing for chlamydia and gonorrhoea is not able to be undertaken/declined.

Syphilis

Prophylaxis should be considered if alleged perpetrator is known to have infectious syphilis.

Hepatitis B

Hepatitis B vaccine is part of the childhood vaccination programme in Ireland since 1st July 2008. If a child/adolescent has not been previously vaccinated and presents within 6 weeks of the last alleged assault, there is some evidence that it can prevent infection following exposure. The standard vaccination course of 0, 1 and 6 months is used or accelerated courses may be considered if the risk of the exposure is considered to be high. Hepatitis B immunoglobulin should be considered if the alleged perpetrator is Hepatitis B positive and the child/adolescent presents within 7 days – liaise with Paediatric Infectious Diseases Specialist for expert opinion.

HIV

Overall risk is very low, but consideration should be given to every case that presents within 72 hours of the most recent abuse. Refer to BASHH, CHIVA guidelines and EMI Toolkit www.hpsc.ie/a-z/EMIToolkit/EMIToolkit.pdf for current guidance. Liaise with Paediatric Infectious Diseases Specialist for expert opinion. There is an on-call rota for Paediatric Infectious Diseases in Our Lady's Children's Hospital, Crumlin, Dublin. The decision to treat must balance the risk of acquiring infection with the risks of therapy and the likelihood of compliance. Factors to consider are the type of sexual activity, violence, HIV status of alleged perpetrator and prevalence rate in the alleged perpetrator's community. Baseline serology for HIV must be taken prior to starting treatment and repeated at 4 and 8 weeks.

Reasons for testing for STIs:

- To detect an infection that may require treatment.
- To reassure the child and parent(s)/carer.
- To gain additional evidence which may be used in child protection/legal proceedings (an STI may be of medico-legal significance in supporting a diagnosis of CSA. Results need to be interpreted based on the limitations of the tests used).
- To help link an alleged perpetrator to a complainant.

CRITERIA FOR STI SCREENING

- Any child being examined in a Child and Adolescent Sexual Assault Treatment Unit
- Disclosure or strong suspicion of penetrative sexual abuse (oral, vaginal and/or anal)
- Physical signs of penetrative sexual abuse
- Siblings exposed to identical risk factors for penetrative sexual abuse
- Consensual sexual activity
- Pregnancy
- Genito-urinary symptoms e.g. vaginal discharge, ano-genital warts, ulcers (herpes)

STI SCREENING SCHEDULE ACUTE (< 3 DAYS PRE-PUBERTAL; < 7 DAYS PUBERTAL)

Immediate: establishes baseline: serology (HIV, Hep B &C, syphilis). STI swabs and urine as below

2 - 4 weeks: STI swabs and urine as below

Consider combining these visits for patient convenience

4 - 6 weeks: Serology (HIV, syphilis, Hep B and C)

3 - 6 months: Serology (HIV, syphilis, Hep B and C) to coincide with 3rd Hep B vaccine (6 months) or if not being vaccinated do at 3 months

STI SCREENING SCHEDULE NON ACUTE

Immediate: serology (HIV, Hep B &C, syphilis). STI swabs and urine as below

Further screening only indicated if initial examination occurred within 3 months of assault on case by case basis

e.g.

4 - 6 weeks: Serology (HIV, syphilis, Hep B and C) to coincide with 2nd Hep B vaccine

3 - 6 months: Serology (HIV, syphilis, Hep B and C) to coincide with 3rd Hep B vaccine (6 months) or if not being vaccinated do at 3 months

Sites to be sampled

Deciding which sites to sample can be difficult, as abuse of a particular orifice may not always be disclosed even when abuse elsewhere has been established. It is suggested that where there has been allegation of any abuse then sampling of all sites should be considered. Where there is only suspected abuse then decisions should be made on a case-by-case basis, including factors such as symptoms, signs, and probability of abuse.

Techniques for sampling

For prepubertal girls, introital swabs inside the labia minora but avoiding the hymen should be used.

Self-sampling can be considered where age appropriate:

- The child/adolescent should be instructed to insert the swab about five centrimetres into the vagina and gently rotate the swab for 10 to 30 seconds. Then place the swab in the appropriate transport medium.

Genital blisters or ulcers:

- Swab for HSV NAAT
- Swab for T.Pallidum NAAT (if available)
- HSV serology for IgM and IgG, paired serology at 3 week intervals
- Swab for bacterial culture
- T.Pallidum serology repeated at 4 to 6 weeks

Figure 8: STI Screen for Prepubertal Females (No speculum)

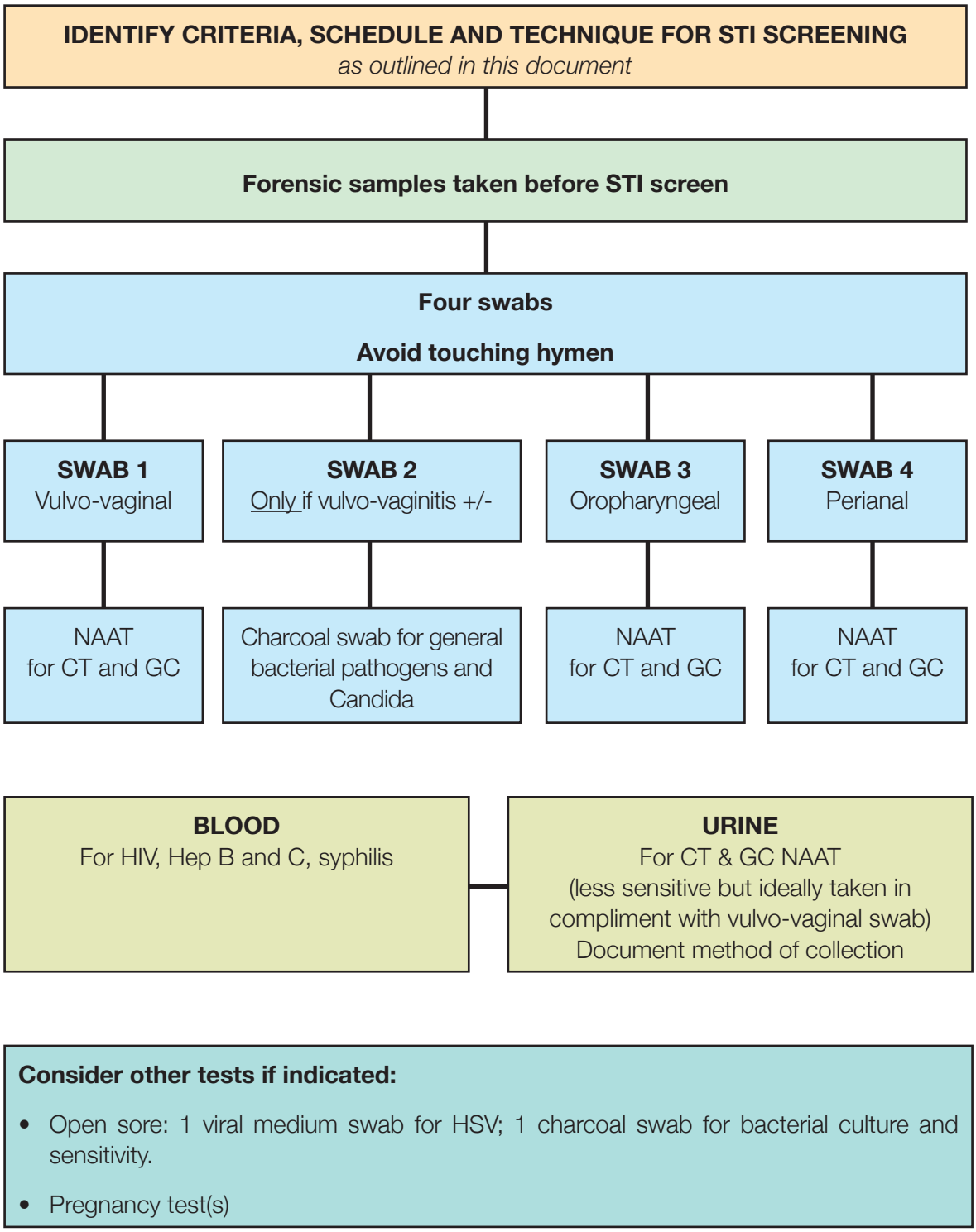


Figure 9: STI Screen for Peri-pubertal and Pubertal Females intolerant of Speculum

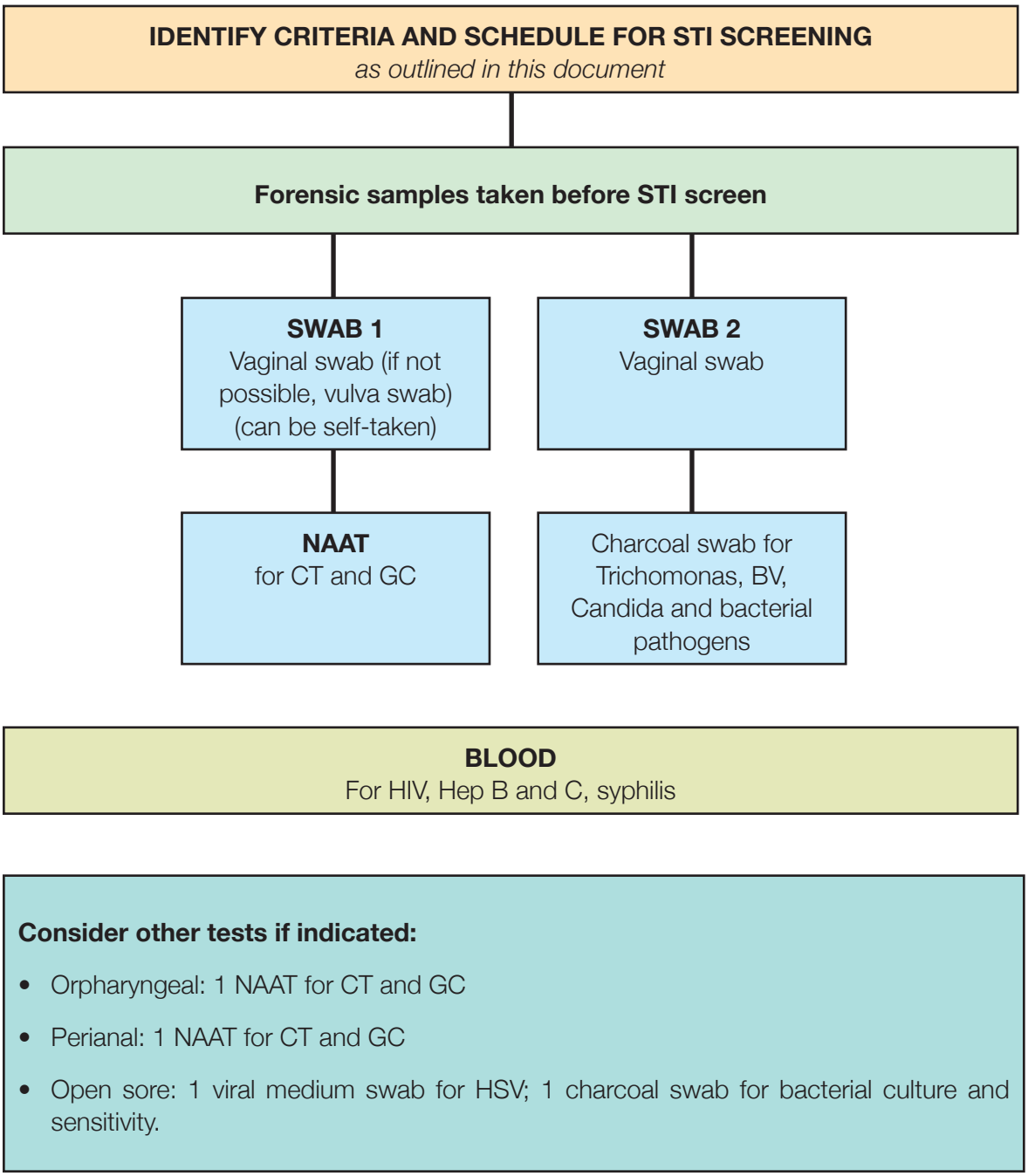
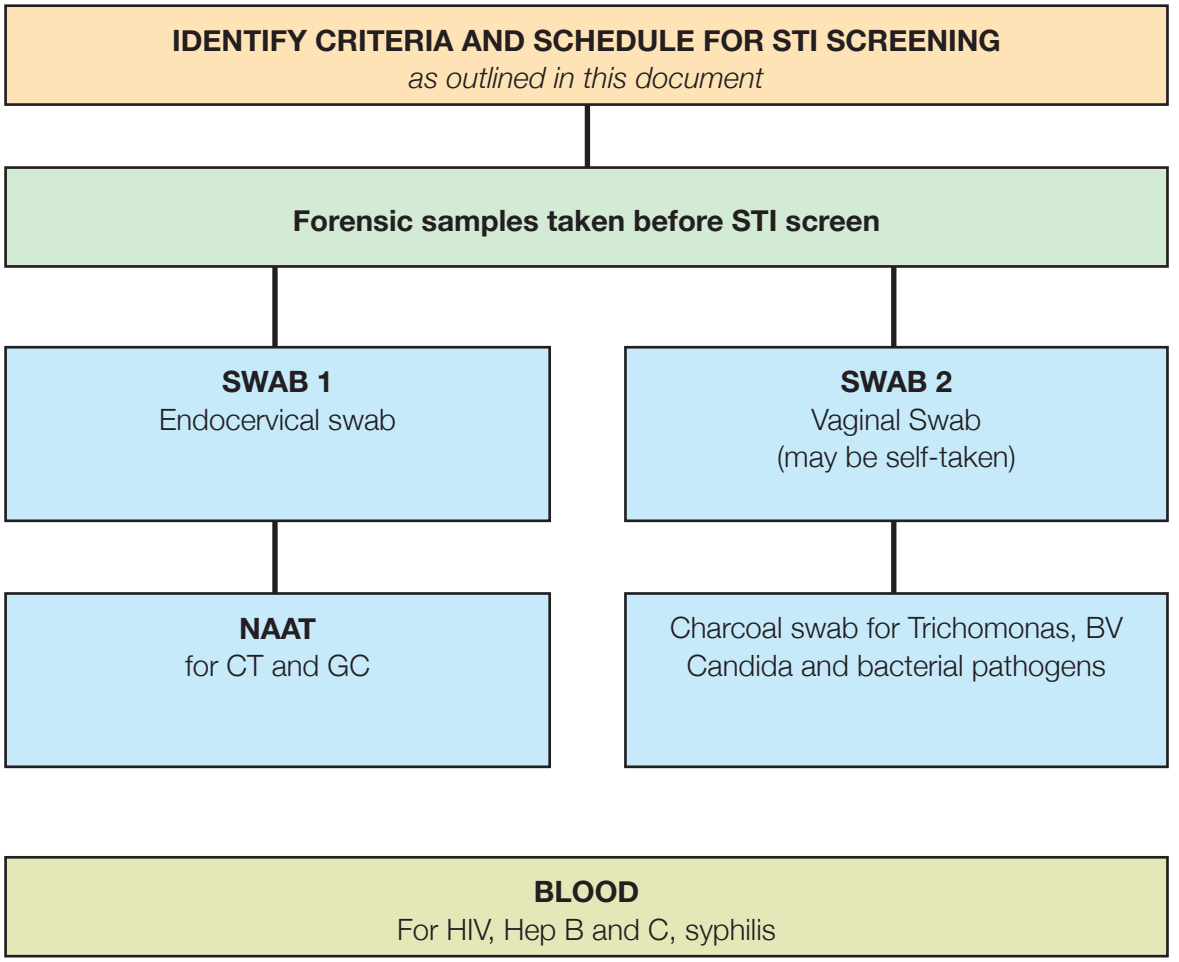


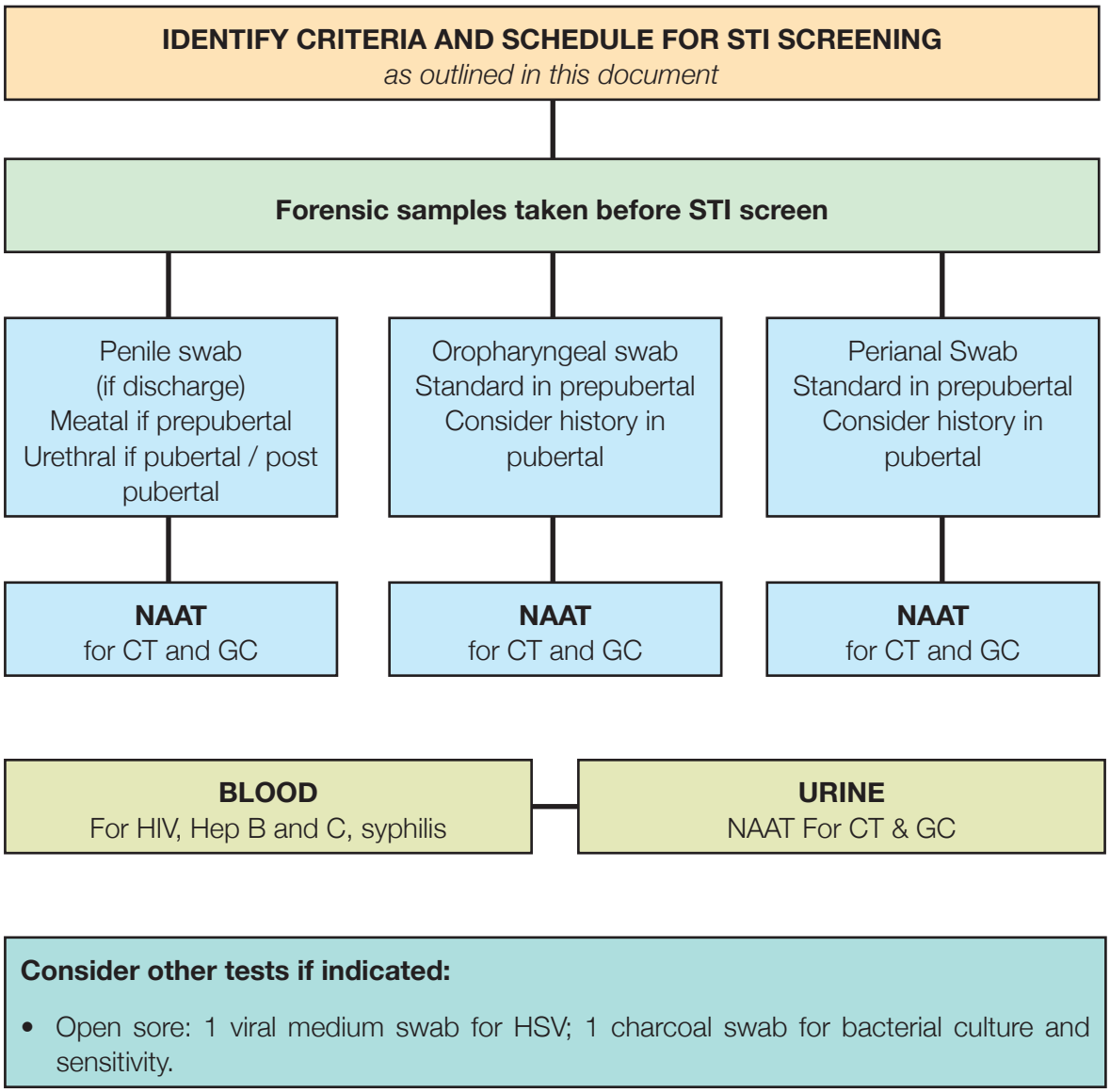
Figure 10: STI Screen for Pubertal Females (Tolerant of Speculum)



Consider other tests if indicated:

- Oropharyngeal: 1 NAAT for CT and GC
- Perianal: 1 NAAT for CT and GC
- Open sore: 1 viral medium swab for HSV; 1 charcoal swab for bacterial culture and sensitivity.
- Pregnancy test(s)

Figure 11: STI Screen for Prepubertal and Pubertal Males



Consider other tests if indicated:

- Open sore: 1 viral medium swab for HSV; 1 charcoal swab for bacterial culture and sensitivity.

8:7 Follow-Up Care

Tusla Referrals – child protection and welfare concerns

Responding to child sexual abuse must be an interagency response. Children First Act 2015[23] places a legal obligation on Forensic Clinical Examiners as mandated persons. Mandated persons have two main legal obligations under the Children First Act 2015[23]:

- To report the harm of children above a defined threshold to Tusla;
- To assist Tusla, if requested, in assessing a concern which has been the subject of a mandated report

There may be other agencies in addition to Tusla who will need further correspondence from child/adolescent forensic medical services. Tusla will be involved in the majority of case.

If Tusla are not involved, the decision not to involve them must be clearly documented (e.g. if child/adolescent was referred to the service for the assessment of a medical condition where CSA could not be out ruled until a definitive diagnosis was made). There are exemptions from requirements to report as clearly defined by Children First National Guidance 2017[24].

- If the mandated person is satisfied that ALL of the following criteria are met, a mandated report to Tusla is not required:
    - The young person(s) concerned are between 15 and 17 years old
    - The age difference between them is not more than 24 months
    - There is no material difference in their maturity or capacity to consent
    - The relationship between the people engaged in the sexual activity does not involve intimidation or exploitation of either person
    - The young persons concerned state clearly that they do not want any information about the activity to be disclosed to Tusla.

All persons, including mandated persons, must uphold the key principle that the welfare of the child is paramount and if you have any concerns, even where all the above criteria are met, a report can be made to Tusla.

- Tusla will often be involved prior to the child's/adolescent's attendance in the forensic medical services. Where there is any doubt that a timely report is not made from another agency, a Mandatory referral must be made from the Forensic examiner following a child/adolescent assessment.
- The Tusla web portal[23] should be used for professionals to submit referrals. Telephone communication with the Duty Social Worker in addition to online referral is encouraged and is essential in high risk cases. Documentation of referrals/reports received and sent should be noted in the patients chart.
- Correspondence with other appropriate professionals or agencies should also be noted in patient's chart e.g. GP, Allocated Social Worker, Mental Health professionals, Emergency Department etc.
- A strategy discussion on receipt of notification is recommended in Children First Guidance (2017)[23]. This process should be initiated by Tusla on receipt of referral from Forensic Medical Services if not already in use. A strategy meeting may follow and all agencies should engage with this process.

Reports, Correspondence and Information Showing

- Following forensic medical assessment, a medico-legal report is forwarded to a named member of An Garda Síochána who is involved in the investigation. If An Garda Síochána are not involved, a copy of the medical report should be forwarded to the referrer. Should An Garda Síochána become involved at a later date, a medico-legal report can be formulated with reference to contemporaneous notes within a standardised proforma and photo-documentation as indicated.
- As the focus of health provision in Ireland is aimed at primary care, correspondence with the child/family's GP/primary care service should be encouraged. This should be discussed with the parent/guardian at initial attendance, written consent is obtained and documented in the patient's chart.
- The child/family's GP and named Tusla Social Worker should be copied into correspondence from the child and adolescent forensic medical service.
- Information sharing in accordance with Children First Guidance[24], should always take place in the best interests of the child.
- Consideration should be given to assessment of siblings/close child contacts of the child/adolescent referred to the service. There would have to be a strong argument not to examine siblings/close child contacts and this would need to be clearly documented. This decision making process may need to be discussed with Tusla – possibly at an interagency strategy meeting.

Follow-up review

Appropriate follow-up care is determined on a case-by-case basis.

- **Injuries and health needs:** If a child has an acute injury (genital or body), review in a short timeframe may be appropriate. The review should be carried out by a Forensic Doctor with expertise in child and adolescent health, in a timely manner. Photo-documentation is used to document the current injury and compare to previous findings. Photo-documentation of a healing injury may be beneficial in determining timeframes of injury in acute presentation. However the presence of a scar cannot infer the timing of an abusive event[21].
- Identification and listing of the child or adolescent's health needs should be documented to ensure appropriate treatment and follow-up. These details should be included in the GP letter.
- **Sexual health screening:** Section 8:6.
- **Hepatitis B vaccine programme:** Hepatitis B vaccine became part of the childhood primary vaccination schedule in 2008. Children born on or after 1/7/2008 should have received a full course of Hepatitis B vaccine as part of their primary immunisation schedule[25]. It is appropriate to check with the parents about their child's vaccination record. Children born before this date, should be offered the standard schedule of Hepatitis B vaccine – 0, 1 and 6 months. Many times the second and third doses will be followed up with the GP. Arrangements for subsequent vaccine doses will need to be clarified with the parents/carers.
- Referral to Infectious Diseases services may be necessary depending on the individual circumstances for the child/adolescent. Consultation with and/or referral to a Paediatric Infectious Diseases Team may be indicated. The Paediatric Infectious Diseases Team in Our Lady's Children's Hospital Crumlin are available for consultation in acute cases 24/7, or local arrangements may be available for individual services.

- Other areas which should be considered during follow-up assessment include the child/adolescent's psychological wellbeing. The follow-up review appointment is an ideal opportunity to screen for any acute issues which may have arisen for the child/adolescent such as mood changes, self-harm, changed affect or sleep disturbances. Urgent referral to appropriate follow-up services locally should be made at this stage.
- Other specific areas of care which may require review (e.g ongoing child protection concerns) should be arranged on an individual basis in conjunction with the interdisciplinary team.

8:8 Ano-Genital Warts

Anogenital warts are caused by a virus, the human papillomavirus (HPV). In adults anogenital warts are most frequently acquired through sexual transmission. In very young children (< 4 years) the most common route of transmission is vertical. However, the older the child the more likely transmission is through sexual contact[21, 26, 27, 28]. There are 4 possible mechanisms of transmission.

1. **Vertical transmission (Perinatal Acquisition):** where a baby, usually during the process of vaginal delivery, is exposed to, and acquires the papillomavirus HPV, from an infected mother who has anogenital warts herself. In such cases the infant/child may show no visible sign of the infection until several weeks, months or years later. HPV is known to survive in normal appearing cells and remain quiescent (latent) for weeks, months even years before generating visible lesions (warts). This latent period can vary from child to child. There is a lack of evidence to support a cut-off age below which vertical infection can be assumed to occur[21]. However, it is considered rare for anogenital warts, acquired vertically, to present for the first time after the age of 4-5 years.

2. **Horizontal Transmission**: Warts may be transferred from a non-genital part of the body such as a hand or finger, to the anogenital area by direct touch. This could be postulated to occur when a child with non-genital warts touches/scratches him or herself in the genital area and transfers the virus from one part of the body to the other (autoinoculation) or when another person e.g. a mother with non-genital warts, touches the child's genital area during bathing/changing a nappy etc. (heteroinoculation). Whilst there is limited scientific evidence to support this type of transmission i.e. autoinoculation or heteroinoculation, within the worldwide scientific medical community, autoinoculation/heteroinoculation is generally accepted as a possible method of transmission, especially in young children[26].

3. **Fomites:** A fomite is an inanimate object or substance (e.g. towel/toilet seat/toothbrush) that is capable of transmitting infectious organisms from one individual to another. It has been postulated that anogenital warts may be transmitted via fomites. Whilst it may be theoretically possible to transmit warts in this manner, the likelihood of fomite transmission actually causing active infection and clinical disease is small. Within the worldwide scientific medical community, this is not generally accepted as a **probable** method of transmission[27].

4. **Sexual contact: (genital - genital/oral - genital transmission):** In studies of children (0-17 years in age) with anogenital warts, sexual abuse was reported in between 4.8%-58% of cases[21, 29]. Older children with anogenital warts are more likely to have sexual transmission confirmed or proven. In one study of 55 children with anogenital warts, < 13 years of age, those over 8 years of age were more than 12 times more likely to have been sexually abused than the youngest children. Whilst this study did not evaluate adolescents ≥ 13 years, it concludes that children over 8 years of age with anogenital warts are **70% likely to have been sexually abused**[28].

Best Practice in the Evaluation of a Child Who Presents With Anogenital Warts

Sexual abuse must be considered in any child presenting with anogenital warts[21, 25, 26, 27].

The older the child, especially over 4 years, the higher the index of suspicion for sexual abuse.

In adolescents with anogenital warts, the possibility of consensual sexual activity should always be explored. Best practice is to explore possible consensual sexual activity with the patient through confidential and sensitive questioning. Consideration should be given to adolescent interview with a health professional alone and in privacy, where possible.

HPV typing is not considered to be helpful in determining whether or not anogenital warts have been acquired through sexual means.

The evaluation of a child who has anogenital warts for possible Child Sexual Abuse should include the following:

1. History of potential "wart" contacts amongst family/primary caregivers including direct questioning in relation to caregiver concerns about sexual abuse.
2. Consider a specialised interview with the child regarding possible child sexual abuse, if the child is verbal (>3-4 years). Interview should be performed by a person(s) trained in interviewing children and who is familiar with acceptable interview techniques for determining the likelihood of child sexual abuse. In Ireland, current practice is that a verbal child will be interviewed by Specialist Gardaí/Tusla Interviewers for suspected child sexual abuse, when there has been a specific disclosure/allegation by that child.
3. Perform an inventory of signs symptoms and behaviours that occur in children who have been sexually abused (e.g. anger, sleep disturbance, wetting and/or soiling, sexualised behaviour, excessive masturbation etc). Such inventories can be found in standardised proformas e.g. those recommended by the Faculty of Forensic and Legal Medicine (UK) and in published guidance for best practice[21].
4. Perform a thorough physical examination, looking for any evidence of physical or sexual abuse. If the index for child sexual abuse is high, such an examination should be undertaken with gold standard equipment and facilities (magnification and photo-documentation) in a specialised centre dedicated to sexual assault[21].
5. Screen for other sexually transmitted infections including testing for GC, CT, trichomonas, HIV, Hepatitis B, C and syphilis depending on the circumstance of the child, age of the child and time since last potential sexual contact.
6. Consider referral to child protection agencies, and, where the index of suspicion is high, to dedicated Child and Adolescent Sexual Assault Treatment Services as appropriate. In Ireland, children with suspected child sexual abuse, about whom there are "reasonable grounds for concern", should all be referred to Tusla [24].

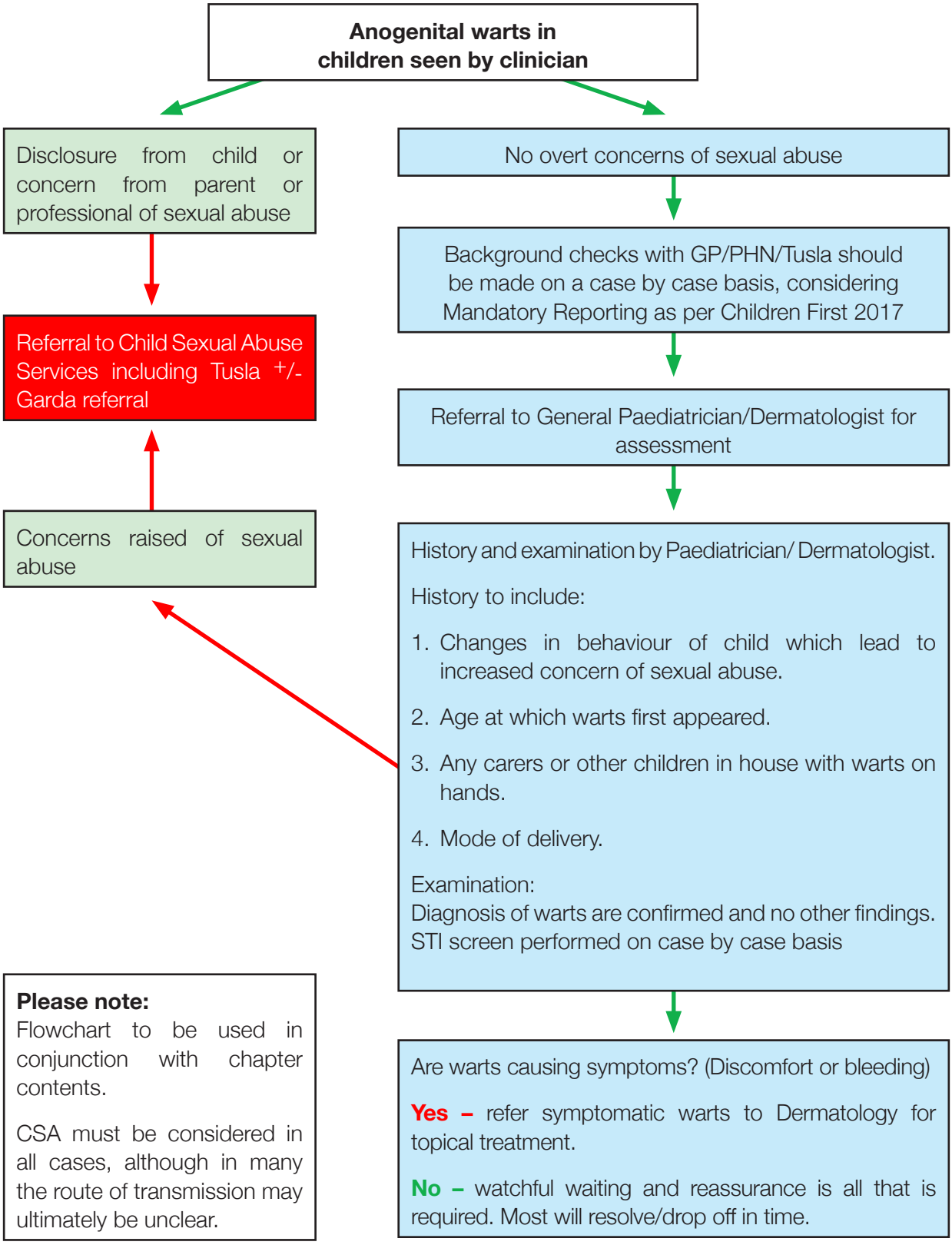
Treatment

75% anogenital warts will self-resolve in children with healthy immune systems without active treatment within months to years and can be left to do so unless causing distress to the patient or family, significant irritation, itch or secondary infection/bleeding[30]. Those present beyond 2 years are less likely to self-resolve.

If treatment is clinically indicated options depend on the age of the child and confidence/competence of the caregiver. Referral to a Dermatologist may be appropriate.

Traditional non-surgical approaches include Podophyllin and Podofilox. Surgery is rarely indicated but may be indicated it topical treatment is ineffective (usually due to inappropriate use).

Figure 12: Anogenital warts in children seen by clinician



Adapted from: St Mary's Centre – Anogenital warts in prepubertal children: referral and management guidelines. 2013.

8:9 Crisis Worker

Crisis workers are recommended to provide on-site support to the child and family/carer throughout the forensic medical examination and assessment process. Depending on local service arrangements, the crisis worker may provide other support services such as telephone advice/aftercare.

Crisis workers should be appropriately trained and supervised and may come from a variety of backgrounds. For example, CARI (www.cari.ie) provide an accompaniment service for children and families attending CASATS, Galway and Rotunda SATU. They provide an empathic, supportive and informative space.

8:10 Emotional/Psychological Support

Emotional support for the child and family should begin at first point of contact with any professional service (voluntary and statutory agency). The clinical team, including the crisis worker, throughout the forensic medical assessment should provide emotional support.

Age appropriate early counselling and therapeutic services including links with CAMHS should be available on referral. This should be decided on a case-by-case basis, depending on the needs of the individuals[13].

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Appendix 1:

Record of Request for SATU Services

SATU and Hospital/Healthcare Logo/s identifiers should be added			
RECORD OF REQUEST FOR SATU SERVICES			
A. REQUEST DETAILS			
Date request received:		**Time request received (24 hour clock):**	
Garda or Contact Person:		**If Garda, enter Station:**	
Contact's Mobile No:		**Contact's Landline No:**	
Request for Services by: ☐ An Garda Síochána ☐ R.C.C. ☐ G.P. ☐ Self Other:	**Nature of SATU Services request:** ☐ Advice ☐ Forensic Clinical Examination ☐ Health Check Comment:		

B. DETAILS OF PERSON INVOLVED IN THE INCIDENT AND INCIDENT TIMES					
Person is medically stable	Yes ☐ No ☐ **If NO Advise: Emergency Dept/GP**				
Age:		**Gender:**	☐ Female ☐ Male		
Person's first language		**Garda or other Interpreter reqd.**	☐ Yes ☐ No	(If an interpreter is needed see National Guidelines, 2014; p. 49)	
Incident date:		**Incident time: (24 hr clock)**		**Time interval from incident:**	
Travel time to SATU approx:			**Early Evidence Kit used?**	☐ Yes ☐ No	
Able to give CONSENT? Yes ☐ No ☐ **If NO:** ☐ Parent/guardian required ☐ Temporary loss of capacity (e.g. alcohol) ☐ Permanent loss of capacity ☐ Vulnerable adult Other:	Comments:				

C. FORENSIC CLINICAL EXAMINATION OR HEALTH CHECK BOOKED FOR:		
Date:	**Time:** (24hr clock)	**SATU Team contacted:** Forensic Clinical Examiner ☐ Support Nurse ☐ RCC Psychological Support ☐ **If there is a delay of more than 3 hours please complete section D overleaf.**
Comments:		

Signed:	**Role:**
Printed Name:	

D. COMPLETE IF DELAY OF MORE THAN 3 HOURS FROM REQUEST TILL EXAMINATION COMMENCES:	
Please indicate reason for delay of more than 3 hours ☐ No Forensic Clinical Examiner available ☐ No Assistant Nurse/Midwife available ☐ No female Garda available ☐ No RCC Psychological Support available ☐ No Interpreter available ☐ Distance Other (please state):	☐ Patient request ☐ No Sexual Offences Exam Kit ☐ SATU Unavailable for use ☐ Obtaining consent ☐ Medical reason ☐ Not indicated within 3 hours (e.g. non-urgent health check)
Length of delay in hours:	**hours**

Signed:	**Role:**
Printed Name:	

Appendix 2:

SATU Legal Report Template

NB. The SATU legal report template included in the following pages gives a suggested layout, with some guidance for the author of the legal report. The SATU legal report template should be viewed as a dynamic tool. As such, the SATU legal report template can have relevant sections added, removed, or adjusted by the author.

Hospital & SATU identifiers & logos

CONFIDENTIAL
FORENSIC CLINICAL EXAMINATION REPORT

Sexual Assault Treatment Unit,
Address

SATU Tel. Number:

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

Contents Page

Paragraph Number	Paragraph Contents	Page Number
1.	Introduction	
2.	The Report Author's Details	
3.	Patient Details	
4.	Consent to Forensic Clinical Examination	
5.	Forensic Clinical Examination Details	
6.	Relevant Health History	
7.	Patient's Brief Account of the Incident	
8.	General Examination: Head-to-Toe	
9.	Genital Examination	
10.	Anal Examination	
11.	Forensic Swabs/Specimens	
12.	Clothing	
13.	Photographs	
14.	Continuity of Evidence	
15	Pre-discharge	
16	Summary of Forensic Clinical Examination	
Appendix 1	Glossary of Terms	

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

1.	**Introduction**
	Subject matter: This is a confidential Forensic Clinical Examination report
2.	**The Report Author**
	Name: **Title:** **Professional P.I.N.** **Work Address:** **Work Telephone Number:** **Professional Qualifications:** **Relevant Experience**
	Position of employment at time of writing this report At the time of writing this report I am a ***enter role***, at ***enter SATU name***, ***Hospital Name, Address.*** I was on duty on ***xx/xx/xxxx*** as the Sexual Assault Forensic Examiner, for the SATU, when I carried out the Forensic Clinical Examination outlined in this report.

3.	**Patient Details**
	Name: **SATU Chart Number:** **Address:** **Date of Birth:** **Age at time of Examination:** **Gender:**
4.	**Consent to Forensic Clinical Examination**
	Following full explanation of the Forensic Clinical Examination procedures to the patient, I obtained signed consent, prior to commencing the Forensic Clinical Examination. ***If there are any special considerations regarding consent then they should be outlined.*** ***If an interpreter was used then their details should be entered.***
5.	**Forensic Clinical Examination Details**
	Date of examination: ***xx/xx/xxxx*** **Time examination commenced:** ***00.00 hours*** **Location:** The Forensic Clinical Examination was carried out in ***enter location*** ***NB. If the location was other than a SATU then the reason should be recorded.*** ***Sexual Offences Examination Kit*** I opened the Sexual Offences Examination Kit in the presence of: Garda: ***complete*** Registration No: ***complete*** Garda Station: ***complete*** The Sexual Offences Examination Kit expiry date was: ***enter number*** The opened Sexual Offences Examination Kit bag number was: ***enter number*** ***NB. If An Garda Síochána was not present and evidence was stored see 2:21*** **Also present during the Forensic Clinical Examination** ***Note any other person present during the Forensic Clinical Examination and their role e.g.*** ***SATU Team Support Person: xxxxxx***
6.	**Relevant Previous Health History**
	Sexual Intercourse Within the Previous 7 Days Record: • ***Date/s and time/s.*** • ***Type/s of sexual intercourse.*** • ***Condom/s used.***

7. Patient's Brief Account of the Incident

Date of the incident: ***xx/xx/xxxx*** **Time of the incident:** ***00.00 hours***
Time interval from the incident till the examination: ***enter time interval***

I took the following brief account of the incident, to guide the care given, the Forensic Clinical Examination and forensic evidence collection. Where the patient's own words are used they appear in inverted commas.[1]

It is important that the clinician does not stray into the role of an investigator. Keep the details recorded to those which seem relevant to the clinician's role.[2] The full history of the incident and recording of the statement is the remit of An Garda Síochána, not the Forensic Clinical Examiner.

The purpose of the brief account taken by the Forensic Clinical Examiner is to guide and facilitate:

- ***Care***
- ***The Forensic Clinical Examination and forensic evidence collection***
- ***Safe discharge planning and follow-up care.[2]***

Key practice points re: taking and recording the brief account of the incident:

- ***The account must accurately and precisely reflect what the patient says.***
- ***To ensure accuracy, the recorded account may be read back to the patient.[1]***

Actions Since the Incident

If relevant record whether since the incident, the patient has:

- ***Eaten/brushed teeth/washed mouth (if allegation of oral assault)***
- ***Bathed or showered***
- ***Changed clothes, including panties/underpants***
- ***Passed a bowel motion (if allegation of anal assault)***
- ***Passed urine: If yes: how often and time last urinated.[4]***

8. General Examination: Head-to-toe

Height: *enter height* **Weight:** *enter weight* **Body Mass Index (BMI)** *xx* kg/m^2

Put in other observations as appropriate:

Findings:

8.1. Head

8.2. Face

8.3. Neck

8.4. Shoulders

8.5. Back

8.6. Buttocks

8.7. Right arm hand and fingers*

8.8. Left arm hand and fingers

8.9. Chest and breasts

8.10. Abdomen

8.11. Right leg: upper, lower and foot

8.12. Left leg, upper, lower and foot

Wounds:

- ***Use standard descriptive terms for classification and documentation of wounds (See 2:12 and Table 9, p. 84)***

State

- ***Anatomical position***
- ***Distance from a fixed point.***
- ***Shape***
- ***Size in measurement of all dimensions where possible***
- ***If appropriate borders or edges***
- ***Colour***
- ***Contents: e.g. any foreign body***
- ***If apparent: course or direction***

Record

- ***Physical deformities***
- ***Previous scar/s pre-dating the incident***

General Examination

All sections should be completed, if relevant. Completion acts as confirmation that you have examined each area, unless details of the case indicate otherwise. Important negative findings show the clinician as being objective in reporting all findings.[2]

****Example of recording a finding***

Bruise: Right upper arm, posterior (back) aspect, 4 cm proximal (above) the tip of the olecranon process (tip of the elbow joint), there was an oval shaped purple bruise, 4cm width x 2 cm length.[2] The bruise had clearly defined margins and was tender and indurated (hard) on palpation (See 2:12.1).

The general examination may also include general appearance / presentation / behaviour. Factual behavioural observations are recorded e.g. crying / sobbing / shaking.

NB. Subjective assessments should not be used
E.g. distressed / very distressed / upset / very upset / upset a little / calm etc.

9. General Examination: Female

Patient's Position for Genital Examination

Example: With the use of additional lighting, I examined the patient's genital area, using the modified lithotomy position (i.e. the patient lying on their back, knees bent, with the heels together and legs apart).

I noted and recorded the following:

Genital injuries: (See 2:11)

Record use of:

- ***Speculum; proctoscope; Foley Catheter***
- ***Lubricant type if used***

9.1 Inner Thighs

9.2 Mons Pubis area

9.3 *Labia majora*

9.4 *Labia minora*

9.5 *Vestibule*

9.6 *Clitoral hood/glans*

9.7 *Urethral orifice*

9.8 *Fossa navicularis*

9.9 *Posterior fourchette*

9.10 *Hymen*

9.11 *Perineum*

9.12 Pubic Hair

Internal Examination

The vagina and cervix were examined using a ***small*** plastic speculum (an instrument designed for internal vaginal examination), which was lubricated using ***enter name of lubricant if used.***

9.13 Interior vaginal wall

9.14 Cervix

9. General Examination: Male

Patient's Position for Genital Examination

Example: With the use of additional lighting, I examined the patient's genital area while he was lying in the supine position (i.e. the patient lying on their back, with their arms by their sides).

9.1 Inner thighs

9.2 Mons Pubis area

9.3 *Foreskin*

9.4 *Frenulum*

9.5 *Glans*

9.6 *Coronal sulcus*

9.7 Penile shaft

9.8 *Scrotum*

9.9 *Testes*

9.10 *Perineum*

9.11 Pubic Hair

10. Anal Examination

Patient's Position for Anal Examination.

Example: The patient was lying in the left lateral position (lying on their left side), with both knees bent up to their chest.

10.1 *Natal fold*

10.2 *Perianal/anal region*

The rectum was internally examined using a ***small*** proctoscope (plastic instrument designed for internal rectal examination) lubricated with ***enter name of lubricant if used.***

10.3 *Internal rectal findings*

11. Forensic Swabs/Specimens

I took the following swabs/specimens:

List

- *The swabs/specimens taken and how many taken*

Toxicology:

List

- *Toxicology specimens taken*

NB. *If the Forensic Clinical Examination was done without the presence of An Garda Síochána and the evidence stored in the SATU see 2:35.3 and Appendix 3.*

12. Clothing

If clothing was taken and given to the Garda state:

- *Was this clothing worn at the time of the incident*
- *Item*
- *Colour*
- *Wet, dirty, blood stained etc.*

NB: *If wet/heavy blood stained state how packaged (See 1:5)*

13. Photographs

Photograph taken:

- *If photographs were taken in the SATU: State the name and details of the Garda Photographer or person who took the photographs*
- *For continuity of evidence state: the Garda photographer maintained possession of the camera containing the photographic evidence*

14. Continuity of Evidence

Sexual Offences Examination Kit

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

Toxicology Specimens

The toxicology specimens I packed in the Toxicology tamper evident bag no: ***enter number***

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

15. Pre-discharge

The following medication/s were given: ***entry***

The appropriate support contact information and follow up information were given.

Any other relevant information can be entered here

16.	**Summary of Forensic Clinical Examination**

Enter a summary of your findings, which should include any wound/s or injuries found. The inclusion of a copy of any relevant line drawing body map/s is helpful.

One of the following range of phrases could be chosen as appropriate for interpretation of the findings in the Forensic Clinical Examination report:

- ***Precludes***
- ***Does not preclude***
- ***Consistent with***
- ***Suggests***
- ***Strongly suggests***

<u>Example</u>

To conclude xxxx is an xx year old fe/male who presented to the xxxx SATU on xx/xx/xxxx.

The patient gave a brief account of the incident as having been xxxxx on xx/xx/xx (See Section 7).

<u>Findings on Examination</u>

Bruise: Right upper arm, posterior (back) aspect, 4 cm proximal (above) the tip of the olecranon process (tip of the elbow joint), there was an oval shaped purple bruise, 4cm width x 2cm length.[2] The bruise had clearly defined margins and was tender and indurated (hard) on palpation (See 2:12.1). This injury was consistent with the history given of ……..

<u>Genital Examination – No Injury/Injury</u> (See 2:11)

If no genital injury is found on examination then it is helpful to include the following caveat:

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

or

On genital examination there was no sign of recent genital injury. No genital injury, does not rule out the possibility of unconsented sexual intercourse.

<u>Injuries which are Recorded but Not Commented On</u>

If a wound or injury is documented, but not commented on, state why it is not commented on e.g.

The wound on …….. is not commented on, as it pre-dates this incident.

Date examination finished: ***xx/xx/xxxx*** **Time examination finished:** ***00.00 hours***

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

A copy of my contemporaneous notes which were used to generate this report is available (from xxx) on request.

Forensic Medical Examiners include:
I hereby certify the foregoing pursuant to Section 25 of the Non-Fatal Offences against the Person Act 1997.

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

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

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Appendix 3:

Addendum to Legal Report – When Evidence has been Stored

NB. When using the SATU legal report template (p. 202) follow instructions 1 - 5 below

1. REMOVE THE CLOTHING SECTION FROM THE REPORT

2. CONTINUITY OF EVIDENCE SECTION: COMPLETE THIS SECTION

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

Toxicology Specimens
The blood and urine specimens I packed in the Toxicology tamper evident bag no: ***enter bag number***

3. ADD THE FOLLOWING TO THE CONTINUITY OF EVIDENCE SECTION

Sealing and Storing of Forensic Evidence Kits ***(If both kits taken otherwise amend)***
I sealed and signed both the Sexual Offences Examination Kit and the Toxicology Kit tamper evident bags, containing the forensic specimens. I placed the above tamper evident bag**/s** containing the kit**/s** in the locked freezer in the password controlled secure storage area on ***xx/xx/xxxx*** at ***00.00*** hours.

This was witnessed by ***enter the name of the witness*** **Grade** ***enter their grade***

4. COMPLETE THE SUMMARY SECTION, SIGN, PRINT NAME AND DATE

5. IF THE FORENSIC SPECIMENS ARE RELEASED TO AN GARDA SÍOCHÁNA ADD

Release of the Forensic Samples to An Garda Síochána ***(If both kits taken otherwise amend)***

On receipt of written instruction from the patient, the above Sexual Offences Examination Kit and the Toxicology Kit tamper evident bags were removed from the locked freezer on ***xx/xx/xxxx*** at ***00.00*** hours; by ***enter the name of person who signed as removing the kit/s from freezer and grade*** and released to
Garda ***enter Garda name who signed as witnessing removal of the kit/s from freezer*** Reg. No ***enter Garda Reg. Number*** attached to ***enter*** Garda Station.

Sign & Grade ***Sign & Grade*** **Printed Name** ***print name*** **Date** ***xx/xx/xxxx***

Appendix 4:

Information Regarding Freezers

Objectives

- Reliable freezing for preservation of biological forensic evidence.
- Safe forensic evidence storage, to ensure compliance with continuity of evidence requirements.

Purchasing the Freezer

The freezer:

- Is purchased following consultation with the Hospital Clinical Engineering Dept.
- Must have a locking mechanism and a digital temperature display unit.
- Should have an audio/visual alarm system which can be programmed to alert via text the key holder's mobile phone should a power failure occur.
- Be of sufficient size to accommodate the projected number of tamper evident bags containing the Sexual Offences Examination Kits and the tamper evident bags containing the Toxicology Kits.

Location of the Freezer

- The freezer must be held in a password or swipe card protected secure area.
- The area where the freezer is located should have a generator back up electricity supply.

Operating, Calibrating, Maintenance, Service and/or Repair of the Freezer

- The manufacturer's instructions are adhered to.
- Freezer temperature adjustment is according to the manufacturer's instructions.
- Calibration of the freezer temperature is carried out by the Hospital Clinical Engineering Department.
- Calibration should be done:
    - On all new freezers
    - Annually on all freezers
    - Following any maintenance, service and/or repair.[1]
- Service maintenance is according to the manufacturer's instructions.
- A record is kept of the service maintenance, repairs and/or calibrations performed.[2]

Monitoring of Freezers

- The required temperature for storage of forensic evidence is between minus 10º to minus 30º centigrade.[1]
- The freezer temperature should be monitored at least weekly.[1, 3]
- Any adjustment to the freezer temperature should be noted in the comments section of the temperature record sheet.
- Freezer temperature records should be monitored over time for any significant drift or trend in the temperature.[1, 2] If observed this should be reported to the Hospital Clinical Engineering Department.
- Completed temperature record sheets and service maintenance records are archived.[3]

Local Policy Development

A local policy should be developed incorporating key stakeholders covering:

- Monitoring and recording of the freezer temperature at least weekly.
- If the freezer provides an electronic printout of the freezer temperature, this printout should be retained.
- Annual service maintenance and calibration check of the freezer.
- Recording of all maintenance, repairs and calibration of the freezer.
- Procedure in place in the event of a freezer breakdown:
  - During weekdays
  - Out of hours.
- Storage of freezer record archives.
- The policy should clearly indicate roles and responsibility.

References

1 Forensic Science Ireland: *Calibration of Temperature Monitored Equipment*. FSLBTS007

2 Appendix 9: Form for Recording Freezer Maintenance/Service/Repair/Calibration p. 193

3 Forensic Science Ireland: *Temperature Monitoring DNA*. FSLBTS071

Appendix 5:

List of Key Personnel with Access to the Password Protected Area

Hospital Healthcare Logos should be added

Name	Grade/Role	Date access commenced	Date access finished

Appendix 6:

Stored Evidence Record for Continuity of Evidence: Incorporated into the SATU National Patient Documentation, p. 25

NB. STORED EVIDENCE RECORD - FOR CONTINUITY OF EVIDENCE					
SECTION A. COMPLETED BY THE FORENSIC CLINICAL EXAMINER					
Patient's Name		**DOB**		**SATU Ref Number**	
Date of Examination		**Time of Examination**			
Sexual Offences Examination Kit Tamper Evident Bag No		**Toxicology Kit Tamper Evident Bag No (If no toxicology write N/A)**			
COMPLETED BY FORENSIC CLINICAL EXAMINER					
Date Kit/s put in Freezer		**Time Kit/s put in Freezer**			
Signature of Forensic Clinical Examiner who placed the kit/s in the freezer		**Printed Name of Forensic Clinical Examiner who placed the kit/s in the freezer**			
Witness Signature (i.e. either Forensic Clinical Examiner, or Reg. Nurse/ Midwife)		**Printed Name of Witness (i.e. either Forensic Clinical Examiner, or Reg. Nurse/ Midwife)**			
SECTION B. COMPLETE: WHEN REMOVING KIT/S FROM FREEZER					
Date Kit/s Removed from Freezer		**Time Kit/s Removed from Freezer**			
Signature of person who removed Kit/s from Freezer (i.e. either Forensic Clinical Examiner, or Reg. Nurse/ Midwife		**Printed Name of person who removed Kit/s from Freezer (i.e. either Forensic Clinical Examiner, or Reg. Nurse/ Midwife**			
Signature of Witness (NB. If Garda signs, also enters Reg. No and Garda Station. 2 photocopies of completed form handed to the Garda).		**Printed Name of Witness:**			

Tick Reason for Removal of Kit/s from Freezer

- ☐ A = 1 year has elapsed since Forensic Clinical Examination and specimens were frozen, with no request for an extension.
- ☐ B = Extended time which had been requested has expired.
- ☐ C = Patient has signed a request to have the specimens destroyed and disposed of.
- ☐ D = Released to An Garda Síochána, the patient is making a formal complaint.
  Garda signs as witness to removal of evidence from the freezer for continuity of evidence.
  - o Two photocopies of this completed form are handed to the Garda with the forensic evidence;
  - o One copy is retained by the Gardaí (true copy) as exhibit for court; the second copy is taken with the evidence to the Forensic Science Lab.

Appendix 7:

Freezer Temperature Monitoring Record: Sample

Hospital/Healthcare Logo/s should be added				
SATU Freezer Temperature Monitoring Record **NB. The freezer temperature should be between minus 10° to minus 30° centigrade.**				
Freezer Make **Purchased from** **Clinical Eng. Dept No**			**Model** **Date purchased** **Emergency Call Out Number**	**ID Number**
Date	**Time**	**Temp**	**Any Comments**	**Signed**

Appendix 8:

Freezer Maintenance/Service/Repair/Calibration Record: Sample

Hospital/Healthcare Logo/s should be added[1]				
SATU Freezer Maintenance/Repair/Calibration Record **NB. The freezer temperature should be between minus 10º to minus 30º centigrade.**				
Freezer Make **Model** **ID Number** **Purchased from** **Date purchased** **Clinical Eng. Dept No** **Emergency Call Out Number**				
Date	**Time**	**Reason: Maintenance/Service/Repair/Calibration**	**Comments**	**Signed**

[1] Health Service Executive (HSE) *Standards and Recommended* Practices *for Healthcare Record Management. Part 3: Recommended Practices for Clinical Staff*. QPSD-D-006-3, Version 3: 2011. www.lenus.ie

Appendix 9:

Consent authorising release of stored evidence and a legal report to An Garda Síochána

Consent for Release of Stored Forensic Evidence and a Legal Report from the Sexual Assault Treatment Unit to the Custody of An Garda Síochána

Name _____ **Date of Birth** _____

SATU _____ **Date of Examination** _____

I give my consent for the release/handover from the above Sexual Assault Treatment Unit, to the custody of An Garda Síochána of the following:

- All forensic samples both intimate and non-intimate that were collected during the Forensic Clinical Examination
- A legal report of the Forensic Clinical Examination

I understand that the forensic samples will be sent to Forensic Science Ireland and that the findings of the laboratory tests and the legal report may also be released to the courts for use in evidence.

Signed by complainant _____ Date _____

Signed by Garda _____ Date _____

Appendix 10:

Checklist for releasing stored forensic evidence and legal report

NB: The unique SATU identifiers and Hospital/Healthcare Logo/s should be added. This checklist should be securely attached to the documentation in line with best practice.[1]

Checklist when Releasing Stored Forensic Evidence and a Legal Report to An Garda Síochána

Name _____ **D.O.B.** _____

SATU Number_____ **Date of Examination**_____

Person removing the stored forensic evidence and giving it to An Garda Síochána

1. Check the Garda has a completed consent form authorising the release of stored forensic evidence and a legal report to An Garda Síochána ☐
2. Make a copy of the completed consent authorisation form for the patient's SATU records ☐
3. Locate the patient's documentation by checking the patient's name, date of birth and date of examination ☐
4. Locate the correct stored tamper evident bag/s, cross-checking the patient's name, date of birth, SATU reference number, date of examination and the tamper evident bags numbers ☐
5. The integrity of the tamper evident bag/s are checked in the Garda presence ☐
6. The Stored Evidence Record form is completed by the SATU Staff member and the Garda receiving the forensic evidence ☐
7. Two photocopies of the stored evidence record are made: original is filed in the patient's documentation; the two copies are given to the Garda ☐
8. The Forensic Clinical Examiner who carried out the Forensic examination is notified to complete the legal report addendum, prior to the release of the legal report to the Gardaí ☐
9. The database is updated at the appropriate section to reflect the case has converted from storage of evidence to making a formal report to An Garda Síochána. ☐

[1] Health Service Executive (HSE) *Standards and Recommended* Practices *for Healthcare Record Management. Part 3: Recommended Practices for Clinical Staff*. QPSD-D-006-3, Version 3: 2011.www.lenus.ie

Appendix 11:

Checklist for Destruction and Disposal of Forensic Samples

Name _____ **D.O.B.** _____
Date of Examination _____ **SATU Number**_____
Sexual Offences Examination Tamper Evident Bag No: _____
Toxicology Kit Tamper Evident Bag No: _____

Checklist	Tick
The patient's details were checked against the patient's SATU Documentation.	
The tamper evident bag/s were opened.	
Both the samples and the empty tamper evident bags were placed in a rigid yellow container.	
The forms accompanying the Kit/s were shredded.	
The container was sealed and tagged and signed by the person destroying the Kit/s and the witness.	
The tag number, the date and the signature of the person destroying the Kits and the witness was entered in the appropriate place on the patient's SATU notes.	
The sealed clinical waste container was delivered to the central waste collection.	
The Porter is notified and a C1 (or appropriate form) is completed with the date and Tag number entered.	
The individual patient's stored evidence record was completed.	
Signature of SATU Staff Member (i.e. either a Forensic Clinical Examiner or Registered Nurse/Midwife) destroying/disposing of Forensic Kit/s (Plus grade):	Date:
Witness signature (Plus grade):	Date:

[1] Health Service Executive (HSE) *Standards and Recommended* Practices *for Healthcare Record Management. Part 3: Recommended Practices for Clinical Staff*. QPSD-D-006-3, Version 3: 2011. www.lenus.ie

Appendix 12:

Key Performance Indicators (KPIs) and Monitoring and Evaluation in Irish SATUs

SATU Key Performance Indicators (KPIs)
SERVICE ATTENDANCE ACTIVITY
• % of patients who attended a SATU, who have reported/or are reporting the incident to An Garda Síochána, at the first SATU visit. • % of patients who attended a SATU, who chose to have a Health Check, at the first SATU visit. • % of patients attending a SATU, who had already attended a SATU for this incident and were referred, SATU to SATU, to facilitate follow up care. • % of patients who attended a SATU, who chose to receive advice only, at the first SATU visit. **NB.** Return visits see: Follow-up care – Sexually Transmitted Infections (STIs).
QUALITY OF RESPONSE
• % of patients, seen by a Forensic Clinical Examiner, within 3 hours of a request to a SATU, for a Forensic Clinical Examination. • % of patients, who had the opportunity to speak with a Psychological Support Worker, at the first SATU visit.
QUALITY OF CARE
Prophylactic care • % of female patients, who presented within 120 hours and appropriately received emergency contraception (EC). • % of patients aged 14 years and over, who were appropriately given prophylactic Hepatitis B vaccination, at the first SATU visit. • % of patients offered prophylactic treatment, against Chlamydia Trachomatis, at the first SATU visit.

Patient Safety

- % of patient SATU documentation completed, with regard to safety of home environment, on discharge from the first SATU visit.
- % of patients less than 18 years of age, who had a referral made to the Child and Family Agency (Tusla), at the first SATU visit.
- % of victims/survivors attending a SATU for the first time, who were given the appropriate contact information, by the RCC Psychological Support Worker.

Follow-up care – Sexually Transmitted Infections (STIs)

- % of patients who attended the SATU who were given an STI review appointment.
- % of patients who attended a scheduled first STI review appointment, following the first SATU attendance.

QUALITY OF FORENSIC SERVICE

- % of cases who had a Forensic Clinical Examination and had a legal report prepared.
- % of legal reports were prepared within eight weeks of the Forensic Clinical Examination.

QUALITY OF SERVICE

- % of records of attendance of first SATU visit were entered on the database, within 10 working days post the patient's first SATU attendance.
- % of Parliamentary Questions (PQs), answered within 15 working days.

SATU Monitoring and Evaluation

Possible areas for audit using a structure, process and outcome approach are tabulated below.[1]

Table 18: Structure, Process and Outcome Audit.

STRUCTURE	PROCESS	OUTCOME
Resources: Appropriate Staff education e.g. • Education criteria to fulfil practitioner role • Specialised induction packages • Continuing professional development. **Buildings Appropriate:** • Physical space and equipment for: SATU care, Forensic Clinical Examination and follow-up. • Patient and security measures. • Forensic quality check: Environmental monitoring carried out twice yearly. **Documentation Use:** • Standardised best practice documentation, policies, protocols, guidelines etc. • Standardised prospective data collection, data analysis and production of clinical reports. • Ensure availability of National Guidelines on Referral and Forensic Clinical Examination Following Rape and Sexual Assault (Ireland). 4th Edition 2018 **Service:** • Available 24 hours a day 365 days a year. • All SATU Response Options are available (See p. 16). • STI follow-up in the SATU **Finance** • Ring fenced local and national budgets	**Processes:** **Explicit evidence of communication lines e.g.** • Referral pathways to SATU • Distinct referral processes from SATU to other relevant disciplines. • Defined links with relevant Hospital support services e.g. Laboratory, Information Technology (IT), Human Resources (HR), laundry, post etc. • Inter-agency/disciplinary Liaison meetings (a minimum of 2 per year held) with agenda, action plan and minutes. • Partnership approach to a coordinated inter-disciplinary response. • Cross-sectoral cooperation in line with national strategies. • Readily available and accessible service information e.g. clear appropriate patient information, specific training packages, use of websites, etc. **Confidentiality** • Explicit systems are in place to ensure patient confidentiality. **Service Expansion** • Ensure knowledge of services is available to all sections of the population. **Forensic Quality checks** • Encourage provision of DNA reference elimination profiles by all Staff.	**Key Performance Indicators for each specialist area should be defined. Examples for use within the SATU include the following:** • Ensure quality and appropriateness of response from victim/survivor's perspective: ▶ Service received ▶ Staff response ▶ Suitability of environment **Measure against the Key Performance Indicators (KPIs) in the following categories:** • Service attendance activity • Quality of response • Quality of care • Quality of forensic service • Quality of service For a full list of the KPIs relevant to the above categories, please see previous page. The SATU KPI Metadata document outlining the development of each individual KPI and Staff involvement in the development is available from all SATUs
Evaluation using clinical audit methodologies should take place both from an individual agency/discipline standpoint and from the collective Integrated Inter- Agency response.		

References:

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

Appendix 13:

Critical Readers List

1. Bell, Ms. Bridin, CNS (SAFE) SATU Letterkenny, University Hospital, Co Donegal.
2. Budds, Mr. Conan. Senior Prosecutor, Prosecution Policy and Research Unit, Office of the Director of Public Prosecutions, Infirmary Road, Dublin 7.
3. Boland, Dr. Clara. Forensic Scientist, Forensic Science Ireland, Garda Headquarters, Phoenix Park, Dublin 8.
4. Derham, Dr. Roger. Consultant Gynaecologist and Forensic Physician, CASATS, Galway.
5. Donnelly, Ms. Margaret. Pharmacist (MPSI), Rotunda Hospital Parnell Square, Dublin 1.
6. Eogan, Dr. Maeve. Obstetrics and Gynaecology Consultant, Medical Director, National SATU Services, Rotunda Hospital, Parnell Square, Dublin 1.
7. Farrell. Mrs, Noelle. SATU Clinical Nurse/Midwife Manager, Rotunda Hospital Parnell Square, Dublin 1.
8. Flanagan, Dr. Lorna. Forensic Scientist, Forensic Science Ireland, Garda Headquarters, Phoenix Park, Dublin 8.
9. Kennedy, Dr. Kieran. General Practitioner, Lecturer in Clinical Practice (NUI Galway) and Forensic Medical Examiner (Child, Adolescent and Adult Sexual Assault), Sexual Assault Treatment Unit, Hazelwood House, Parkmore Road, Galway.
10. Kennedy, Mr. Denis Legal Researcher Prosecution Policy and Research Unit,Office of the Director of Public Prosecutions, Infirmary Road, Dublin 7.
11. Lyons, Dr. Fiona. Consultant in Genitourinary and HIV Medicine, St. James's Hospital, Dublin 1.
12. Marshall, Ms. Deborah, Advanced Nurse Practitioner (SAFE), SATU, Midlands Regional Hospital, Mullingar, County Westmeath.
13. McGilloway, Ms. Connie, CNS (SAFE) Donegal SATU, Letterkenny General Hospital, High Road, Letterkenny, County Donegal.
14. Marnell, Ms. Órlaitha, Legal Researcher in Prosecution Policy and Research Unit, Office of the Director of Public Prosecutions, Infirmary Road, Dublin 7.

15. Nelson, Dr. Joanne Consultant Paediatrician, Forensic Physician and Clinical Director, Child and Adolescent Sexual Assault Treatment Service (CASATS), Galway.

16. Noonan, Ms. Margo CNS (SAFE) South Infirmary-Victoria University Hospital Old Blackrock Road, Cork.

17. Nurse, Ms. Diane. National Lead: Social Inclusion, National Social Inclusion Office, Primary Care Devision, HSE, Mill Lane, Palmerstown, Dublin 20.

18. O'Dowd, Dr. Yvonne. Forensic Scientist, Forensic Science Ireland, Garda Headquarters, Phoenix Park, Dublin 8.

19. Pucillo, Mrs. Christine. SATU Support Nurse Rotunda Hospital, Parnel Square, Dublin 1.

20. Roughneen Mr. Alan. National Crime Prevention Unit, Dublin 2, Ireland.

21. Walsh, Ms.Aideen. Paediatric Forensic Medical Unit Co-Ordinator, Our Lady's Children's Hospital, Crumlin, Dublin 12.

22. Wilkinson, Dr. Andrew. Forensic Physician, Oxford; Foundation Fellow and Vice President (Forensic Practitioners), Faculty of Forensic and Legal Forensic and Legal Medicine, Royal College of Physicians of London; Emeritus Lecturer in Medicine, UCD Dublin.

23. White, Dr. Cath Clinical Director, Saint Mary's Sexual Assault Referral Centre, Saint Mary's Hospital Manchester University NHS Foundation Trust, UK.

Operational Definitions and Glossary of Terms

Abrasion: Superficial injury to the skin caused by the application of blunt force. Produced by a combination of contact pressure and movement applied simultaneously to the skin (p. 79 for different types of abrasions).[4,19]

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

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

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

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

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

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

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

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

Bruise: An area of haemorrhage beneath the skin[4, 19] (See 2:12 p. 79 and 2:12.1, p. 82).

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

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

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

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

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

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

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

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

Dentate line: See anorectal line.[14]

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

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

Erythema: Redness of the skin and/or mucous membranes caused by dilatation of the underlying capillaries.[17]

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

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

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

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

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

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

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

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

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

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

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

Human Trafficking: The Palermo Protocol states: "Trafficking in persons" shall mean the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other

forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation or the prostitution of others or other forms of sexual exploitation, forced labour or devices, slavery or practices similar to slavery, servitude or the removal of organs. [23]

Hymen: A membranous collar or semi collar inside the vaginal introitus [14] (See 2:7.1, Table 4: Anatomical variations and terms relating to the hymen).

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

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

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

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

Laceration: Ragged or irregular tears or splits in the skin, subcutaneous tissues or organs resulting from blunt trauma (e.g. trauma by impact) [4, 19] (See 2:12, p. 79).

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

Mons Pubis: Mound of fatty tissue lying over the pubic symphysis.[25]

SATU National Patient Documentation: The standardised individual patient record ("chart") which is used in Irish SATUs.

Online Sexual Exploitation: Online Sexual Exploitation is an act or acts committed, by use of the Internet, that are Sexual Assaults. Injured parties are deceived or coerced into producing indecent images of themselves or engaging in sexual chat or sexual activity over webcam and then in some cases coerced into producing more material in an effort to prevent disclosure online to family and friends.

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

Penis: Male organ of reproduction and urination, composed of erectile tissue, through which the urethra passes. It has a shaft and glans (head); the glans may be covered by the foreskin.[14, 18] (See 2:8, Table 7)

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

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

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

Rape: Definitions for rape as legally defined in Irish law available at: http://irishstatutebook.ie.

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

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

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

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

Sexual Assault: Definitions for sexual assault as legally defined in Irish law available at: http://irishstatutebook.ie.

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

Sexual Violence: A term covering a wide range of crimes, including rape, sexual assault, incest and buggery available at: http://irishstatutebook.ie.

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

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

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

Stranger: Someone whom the person has never met.

Swab: A swab in the context of a Forensic Clinical Examination is a one ended 'cotton bud.' Each swab comes in its own individual cylindrical container.

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

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

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

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

Trafficking: (See Human Trafficking)

Urethral Orifice: Opening into the urethra.

Vagina: A fibromuscular sheath extending upwards and backwards from the vestibule.[16] (See 2:7.2, Table 5: Descriptive terms for the vagina).

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

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

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

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

Wounds: See Table 8: Standard Descriptive Terms for Classifying Wounds, p. 82.

Abbreviations

BASHH:	British Association for Sexual Health and HIV
BMI:	Body Mass Index
CHP:	Countries of High Prevalence
Cu-IUD:	Copper containing intrauterine contraceptive device
CN/MS (SAFE):	Clinical Nurse /Midwife Specialist (Sexual Assault Forensic Examination)
DNA:	Deoxyribonucleic acid
DOB:	Date of Birth
DOHC:	Department of Health and Children
DOJ:	Department of Justice
DPP:	Director of Public Prosecutions
DVSAIU:	Domestic Violence Sexual Assault Investigation Unit
EC:	Emergency Contraception
ECP:	Emergency Contraceptive Pill
FFLM:	Faculty of Forensic and Legal Medicine
FGM:	Female Genital Mutilation
FVU:	First Void Urine
GP:	General Practitioner
hCG:	Human Chorionic Gonadotropin
HIV:	Human Immunodeficiency Virus
HQ:	Head Quarters
HR:	Human Resources
HSE:	Health Service Executive.
ICGP:	Irish College of General Practitioners
IT:	Information Technology
IVDA:	Intravenous Drug Addict/s
KPI:	Key Performance Indicator
LMP:	Last Menstrual Period
LNG:	Levonorgestrel
MSM:	Men who have Sex with Men
NAATs:	Nucleic Acid Amplification Tests

NCBI:	National Council for the Blind of Ireland
NHO:	National Hospitals Office
OMC:	Office for the Minister for Children and Youth Affairs
PCC:	Post Coital Contraception
PEP:	Post-Exposure Prophylaxis
PEPSE:	Post-Exposure Prophylaxis following Sexual Exposure
RCC:	Rape Crisis Centre.
RCNI:	Rape Crisis Network Ireland.
RCOG:	Royal College of Obstetricians and Gynaecologists
SATU:	Sexual Assault Treatment Unit.
SLIS:	Sign Language Interpreting Service
STI:	Sexually Transmitted Infection/s
UPA:	Ulipristal Acetate
WHO:	World Health Organisation

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