

STATE OF CONNECTICUT

TECHNICAL GUIDELINES

For

**Health Care Response
To Victims of Sexual Assault**

In accordance with Connecticut General Statutes Section 19a-112a

Commission on the Standardization of the Collection of Evidence
in Sexual Assault Investigations

2017

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INTRODUCTION

History

In 1988, the Connecticut General Assembly passed Public Act 88-210, *An Act Concerning Collection of Evidence in Sex Offense Crimes*. The law created a multi-disciplinary Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations under the authority of the Department of Public Health, and directed it to select a standardized assault evidence collection kit and recommend a hospital protocol for sexual assault evidence collection.

In 1993, Public Act 93-340, *An Act Concerning Sexual Assault Investigations*, provided for the appointment of additional Commission members and transferred administrative responsibility for the Commission activities to the Division of Criminal Justice. The new Commission designed a sexual assault evidence collection program for use throughout the State of Connecticut. This program included a customized kit, to replace the standard kit selected by the 1988 Commission, and standardized forms for use by all health care facilities. The Commission also developed the *State of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual Assault* (hereinafter referred to as *Technical Guidelines*), to replace the Hospital Protocol for Victims of Sexual Assault, created by the 1988 Commission. Additionally, the Commission established a uniform video training program and procedures for the payment of the evidence collection portion of sexual assault examinations.

The State of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual Assault was released in 2010 and revised in 2013. In 2015, a standing subcommittee of the Commission was formed to annually review the *Technical Guidelines* and make recommendations to the full Commission for revision.

In acknowledgment that some sexual assaults are drug facilitated, the Commission has created a separate kit and conducted training for law enforcement investigators and health care providers.

Purpose

It is the goal of the Connecticut General Assembly and this Commission that, to the extent possible, sexual assault examinations be standardized throughout the state. To accomplish that goal, it is necessary that health care personnel who encounter or treat sexual assault victims have knowledge of what constitutes a proper and sensitive response: best practices in medical treatment, evidence collection, and follow-up services. The *Technical Guidelines* establish a standardized model for health care response to victims of sexual assault and the collection of sexual assault evidence.

A law enforcement agency submits the kit, including a copy of the medical report, to DESPP - Division of Scientific Services.

The *Technical Guidelines* do not purport to establish a standard for the medical care and treatment of sexual assault victims. All documentation generated under the *Technical Guidelines* shall become part of the patient's medical record.

Pursuant to the authority granted to this Commission in Public Acts 88-210 and 93-340, the requirements of sexual assault evidence shall be set forth in the Regulations of Connecticut State Agencies.

Nothing in the *Technical Guidelines* is intended to create a basis in court for evidentiary standards or exclusionary motions regarding documentation or evidence. Failure to adhere to the *Technical Guidelines* is not intended to limit the admissibility of any documentation or evidence in a court of law or any other legal proceeding.

Acknowledgements

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ORDERING INFORMATION: SEXUAL ASSAULT KITS

There are 2 types of evidence collection kits used in health care facilities:

- (1) CT100B Sexual Assault Evidence Collection Kit
- (2) CT400A Toxicology Screen Evidence Collection Kit

TO ORDER:

- Call (860) 263-2767
- Leave a message with the following information:
 - Your name (in case additional information is required)
 - Telephone number where you can be reached
 - Name of health care facility
 - Mailing address of health care facility
 - Quantity of each item requested

Note: CT100B Sexual Assault Evidence Collection Kits are used more frequently than CT 400A Toxicology Screen Evidence Collection Kits. Each Kit contains blood collection tubes with expiration dates. Facility stock may be used so long as the preservatives in the tubes are identical to those listed on the tubes from the Kits. Orders should be commensurate with usage.

I. CONSIDERATIONS

Sexual Assault Forensic Examiners (SAFEs)

A Sexual Assault Forensic Examiner (SAFE) is a health care provider who has fulfilled specific requirements, didactic and clinical, which enables them to perform knowledgeable and skilled medical-forensic examinations and to ensure the integrity, preservation, and documentation of forensic evidence.

- The criteria set by the International Association of Forensic Nurses (IAFN) and the Department of Justice (DOJ) for becoming a SAFE includes current licensure, a minimum of 2 years of clinical practice, successful completion of a SAFE course which includes a minimum of 40 continuing education contact hours of classroom instruction, and “sufficient supervised clinical practice until determined competent” (Department of Justice [DOJ] National Protocol, 2013).
- A Sexual Assault Forensic Examiner is a broad term that may include physicians as well as nurses. A Sexual Assault Nurse Examiner (SANE) is also a SAFE, but as the description is limited to nurses, the term SAFE is used so as to be inclusive of other health care providers.
- In Connecticut, the role and responsibilities of the Sexual Assault Forensic Examiner are established by statute [Connecticut General Statutes (CGS) §19a-112(g)].
- Some states have an advisory board which sets clinical and education requirements, as well as renewal requirements of the SAFE designation, upon expiration, usually every 3 years. Connecticut currently does not have such a board or continuing education requirements.
- The Gail Burns-Smith SAFE Program, a Judicial Branch, Office of Victim Services program, currently responds to 8 acute care hospitals and the University of Connecticut, Storrs Campus. The SAFE Program offers a SAFE Training Program, inclusive of both didactic and clinical. Certificates awarded to those who complete the training have a three year expiration date and are renewed automatically by those who are in the SAFE Program in good standing.
- Patients who present as victims of sexual assault at any Connecticut acute care facility may have a medical-forensic exam and evidence collection conducted at that hospital, in accordance with the *Technical Guidelines*, even if a SAFE is not available.

Barcodes - CT100B Sexual Assault Evidence Collection Kits

Rationale and Use:

For questions about CT100B Sexual Assault Evidence Collection Kit tracking, barcodes, or software, please email dss.saktracking@ct.gov.

Tracking all CT100B Sexual Assault Evidence Collection Kits within the state, coupled with recently enacted legislation requiring law enforcement agencies to submit all Kits to the Division of Scientific Services within 10 days, will eliminate the important public safety issue of unsubmitted Kits in the state of Connecticut.

In order to track all CT100B Sexual Assault Evidence Collection Kits within the state, the manufacturer has placed a unique barcode on the side of each Kit in addition to a sticker with the lot number/expiration date, as shown in Figure 1 below.

Figure 1: Showing barcode location on side of the Kit, located in top corner



The barcode has the following sequences, either CT-####-#### or CT-#####, as shown in Figures 2 and 3. This six-digit number is unique and represents only 1 CT100B Sexual Assault Evidence Collection Kit. Software that allows tracking of the CT100B Sexual Assault Evidence Collection Kits was also recently installed.

Figure 2: Showing barcode with code CT-###-###



Figure 3: Showing barcode with code CT-#####



- If a CT100B Sexual Assault Evidence Collection Kit is going to be used for anything other than a sexual assault examination (training, demonstration, opened but not used, etc.) please email dss.saktracking@ct.gov with the barcode number, the facility name, and the reason for using the kit in another manner (training, demonstration, opened but not used, etc.).
- If a CT100B Sexual Assault Evidence Collection Kit will be going to an out of state jurisdiction for testing, please email dss.saktracking@ct.gov with the barcode number, the name of the health care facility, and the state to which the Kit will be transferred.

This will ensure that all CT100B Sexual Assault Evidence Collection Kits are tracked.

Timeline for Evidence Collection

- CT100B: Evidence should be collected up to 120 hours (5 days) from time of assault.
 - This time frame has been shown to have the most potential for the collection of semen. Evidence collected outside this time frame adds to the trauma of the patient without added benefit.
- CT400A: Blood should be collected within 48 hours (2 days) of the suspected drugging incident. Urine should be collected within 120 hours (5 days) of the suspected drugging incident.

Consent for Medical/Forensic Examination and Evidence Collection

- Consent is required for a medical/forensic exam and evidence collection [CGS §19a-112a (d)].

No one should be forced against his/her will to undergo a sexual assault evidence collection examination.

The CT100B Sexual Assault Evidence Collection Kit

- Prior to opening the Kit, briefly describe the evidence collection and examination process with the patient. Ensure that communication is being provided in the patient's preferred language.
- The patient must have the capacity (be oriented to person, place, time, and able to participate in care and make their wishes known) in order to provide consent.
- Consult your facility's policies and procedures for obtaining consent for incapacitated patients, persons with cognitive disability, proxy-decision care takers (including but not limited to any specific policies for a patient that is conserved or has an appointed healthcare representative, and/or is severely injured or incoherent due to drugs or alcohol intoxication).
- The Kit contains a written consent form: *Authorization for the Sexual Assault Medical Exam and Release of Payment Information*. After reviewing the consent form, have the patient or patient's representative sign the form.
- The white original of the signed, completed authorization form should be placed in the patient's medical record.
- As the medical-forensic examination is performed, explain each step with the patient before taking action on that step - the patient can decline any part of the exam. Document the reason the step was declined on the step envelope.
- Report to Law Enforcement:
 - There is no requirement that law enforcement be notified in order for evidence to be collected. Only notify law enforcement with patient consent (verbal will suffice). Please note the patient is able to change their mind at any time.

- o Consult your facility's policies and procedures for mandatory reports to law enforcement that may still apply.
- o If the patient is undecided about whether to report to law enforcement, explain the importance of prompt evidence collection, and that the evidence can be held for 5 years to give them time to decide.
 - Explain that the evidence can be submitted anonymously and held up to 5 years.
 - Explain also that during the 5-year period the evidence will be identified by a control number, not by their name.
- o Please note that law enforcement should not be included among those allowed in the examining room during the exam and evidence collection process.
- A Sexual Assault Crisis (SAC) Advocate:
 - o A sexual assault advocate should be allowed to explain their role directly to the patient prior to services so that the patient can make an informed decision as to whether or not they desire advocacy services.
 - o A sexual assault advocate should be allowed to accompany the patient throughout the process with patient consent (verbal will suffice).
 - o See *Appendix F* for further information on obtaining a SAC Advocate.
- The CT400A Toxicology Screen Evidence Collection
 - o Testing for the presence of drugs and/or alcohol in the system of a sexual assault patient is not suggested or required unless medically indicated or indicated by the patient's case history. If the decision is made to collect samples for toxicology testing:
 - Review the Consent for Toxicology Screen form contained within the CT400A Kit with the patient.
 - Have the patient or patient's representative sign the consent form.
 - The white original of the signed and completed consent form should be placed in the patient's medical record.

- Minors: Considerations for Obtaining Consent:
 - o Consent for the medical-forensic exam and evidence collection of a minor (anyone under the age of 18) should be obtained from the parent or guardian (verbal will suffice).
 - o Any known or suspected child sexual abuse/assault should be reported to law enforcement and to the Department of Children and Families (DCF) [CGS §17a-101(a-e)] - consult your facility's policies and procedures on mandatory reporting.
 - o In the rare event that a minor presents with a parent/guardian who refuses to consent to the examination of the child, consult your facility's policies and procedures regarding refusals of consent by parents/guardian.
 - o If it is determined that the child is in danger from her/his surroundings and requires immediate attention, the attending physician can take the child into custody at the hospital for 96 hours [CGS §17a- 101(f)] – this allows for health care personnel to provide diagnosis and treatment, and child protective and law enforcement agencies to investigate any sexual abuse/assault while protecting the child from further immediate danger).

Law Enforcement

- When the patient wants to report to law enforcement at the time of the exam:
 - o Law enforcement needs to obtain basic facts from the patient in order to identify the assailant and to locate primary and secondary crime scenes. The primary being where the actual assault occurred and a secondary being where items of evidence may have been left by the patient (i.e. bedroom clothes hamper if they changed clothing).
 - o The quicker law enforcement can identify the crime scene and secure it, the higher the likelihood useable evidence may be collected to support the patient's allegations.
- When the patient does not want to report to law enforcement at the time of the exam:
 - o The role of law enforcement in the case where a patient does not want to report the incident is more of a guardian of the evidence. If an anonymous

Kit is completed, then the law enforcement agency within the health care facility's jurisdiction will be responsible for collecting the Kit from the facility and transporting it back to the department.

- Purpose and scope of patient's statements made to law enforcement:
 - Statements made by a patient to a law enforcement officer can be admitted as evidence by that officer. These statements can corroborate the patient's allegations. Law enforcement needs to identify who the patient may have confided in prior to coming to the health care facility. This person can testify regarding statements/allegations made by the patient and are admissible as an exception to the hearsay evidence rule. These statements may also be made to the examiner during the medical-forensic exam.

- Informational needs of law enforcement:
 - Identification of suspect or description of suspect.
 - Location (specific) where the assault occurred.
 - Identification of witnesses.
 - Permission from the patient to retrieve clothing and other evidence from their residence.

In depth follow up interviews will be conducted in the days following the initial report. In most instances, basic facts of the case are all that is needed at this point to facilitate actions of law enforcement.

- Law Enforcement presence in the exam room:
 - Law enforcement has no need to be present during the forensic exam. All items of evidentiary value are collected by the forensic-medical examiner and are sealed in evidence bags per the Kit instructions.
 - Law enforcement can be allowed access post-exam if the patient is capable and consents to further questioning. Otherwise law enforcement will take possession of the completed evidence Kits.

- How law enforcement handles anonymous Kits (Kits not reported at the time of the exam):

- The protocol for the processing of anonymous Kits is the same both within and outside the State of Connecticut.
- The anonymous Kits are received from the medical-forensic examiner after the chain of custody form is completed.
- The anonymous Kits are transported to the police department where the medical facility is located, called the department of jurisdiction.
- The department of jurisdiction will ensure that the anonymous Kit is transported to the Forensic Lab within 10 days of receipt. According to Public Act 15-207, the anonymous Kit will be retained by the Forensic Lab for 5 years.
- Victims of sexual assault have up to 5 years to report from date of assault.
- Maintaining chain of custody from healthcare:
 - Of primary importance for a criminal prosecution for sexual assault is maintaining the chain of custody. This is particularly true of the sexual assault evidence Kit.
 - In the legal sense the chain of custody is the electronic or written documentation of transfer of the collected evidence from the party who collected it, to the party responsible for storage, to the party responsible for scientific testing and processing, and ultimately for presentment in court as evidence.
 - Each time the evidence changes hands it is signed for by the receiving party to document that the evidence is the same as collected and it remains substantially the same upon presentment in court.
 - The chain begins when the medical-forensic examiner collects the evidence and then seals it within the Kit. The examiner signs the chain of custody form, which in turn is signed by the officer receiving the Kit. This establishes the legal reliability of the evidence upon presentment in court.
 - Failure to follow the chain of custody allows for the legal challenge of the reliability of the evidence at trial.
- Identify what information law enforcement may need from health care providers within the boundaries of patient privacy laws:

- Interviews of patients who are reporting at the time of the exam are critical to law enforcement in order to establish a base line or their version of events.
- The patient may identify their assailant or witnesses to the act; they may also identify where the assault occurred or identify articles of evidence that may be lost or destroyed by the suspect.
- Visual evidence gathered by the medical-forensic examiner will also provide valuable evidence to support the information provided by the patient. Articles of torn clothing and defensive type wounds or injury all support the claims that force was used.
- This information is valuable for the criminal investigator who may be tasked with the initial interviews of a potential suspect to dispel claims that the patient willingly participated in the act.
- Law enforcement does not need information about unrelated medical history which may be obtained during the medical exam.

II. THE MEDICAL-FORENSIC EXAM PROCESS

Initial Contact and Triage

- Sexual assault patients are trauma patients and should be triaged as priority patients regardless of whether physical injuries are evident.
- Assess for safety concerns upon arrival and identification of the sexual assault patient.
- Assess for injuries and provide medical care and treatment prior to collecting evidence. Clothing should be placed in paper, rather than plastic, bags.
- Provide a private area in which the patient can await both intake and treatment.
- Assess age, communication ability and health condition. Modify response accordingly.
- If translation services or a sign language interpreter is needed, follow health care facility policy in accordance with federal requirements, and record on CT100B forms.
- If a patient must go to the bathroom, explain that semen or other evidence may be present in pubic, genital, and rectal areas, and not to wash or wipe away those secretions until after the examination.
- Health care facilities participating in the Gail Burns-Smith Sexual Assault Forensic Examiners Program (SAFE Program) may activate an on-call SAFE according to protocol.
 - The SAFE will call the local sexual assault crisis program to activate an advocate.
- For non-participating health care facilities, follow the *Technical Guidelines*, in addition to your facility's protocol, for care of the sexual assault patient.

Advocacy – The Connecticut Alliance to End Sexual Violence

- There are 9 sexual assault crisis programs in Connecticut. Each center provides the same core services:
 - o 24-hour toll free confidential hotline.
 - o Certified sexual assault victim advocates.
 - o Medical, police, and court accompaniment and advocacy.
 - o Support groups.
 - o Spanish-speaking and male advocates, upon request.
 - o Information and referral .
 - o Community education.
 - o Short term supportive counseling.
- To contact the program that covers your area, please consult the program map in *Appendix F*.
- You can also call the hotline at 1-888-999-5545 from your facility's landline and you'll be connected to the local sexual assault crisis program.
- Health care facilities should call the advocate as soon as the patient arrives.
- When calling an advocate please be sure to tell them:
 - o Patient's age
 - o First name of the patient or nurse they should ask for
 - o If a Spanish-speaking advocate is needed
- Once the advocate arrives, with the patient's verbal consent, the advocate should be allowed into the room to introduce themselves to the patient and explain their role.

- Sexual assault victim advocates will support the patient throughout their time in the health care facility.
 - This includes, but is not limited to:
 - Providing immediate crisis counseling and advocacy.
 - Informing the patient of their rights and available resources.
- Unless the patient requests otherwise, the advocate will stay with them throughout the entirety of the exam, and their stay in the hospital.
- With the patient's consent, the advocate will also sit with them while they are giving their statement to law enforcement.
- When notifying the advocate, let the advocate know roughly what size clothing to bring for the patient to wear upon discharge.
- Spanish-speaking victim advocates are available. However, they cannot act as the interpreter. Please follow facility policies.
- If the patient does not want the advocate to stay, the advocate will leave contact and general program information with the patient.
- Advocates are not there to help with the evidence collection, but to support the patient, and to ensure the patient is informed about their options.

Sensitivity and Cultural Concerns

- Treat the patient with dignity and respect. Introduce yourself, acknowledge the trauma they have experienced, and explain the exam process. Give the patient time to respond. Do not rush.
- Keep in mind that the medical-forensic exam and evidence collection is likely to be the first significant physical contact that a patient will have following an assault.
- Ask for permission before touching the patient in any way. Allow the patient to regain control and to make their own decisions.

- Avoid asking “why” questions; instead use open-ended questions such as, “what, how, where, tell me..., describe...” Avoid judgmental responses and facial expressions.
- Be aware and tolerant of the patient’s language skills and communication barriers, which may be worsened by crisis.
- Coordinate with staff to avoid asking the patient to repeat their account of the assault numerous times (e.g., triage, nurse, physician, social worker).
- Keeping the patient’s needs in mind, exercise discretion and sensitivity when discussing patient’s case with other personnel.
- Be aware that discussing sexual assault or sexual terms may be associated with shame and embarrassment in some cultures, and that in some cultures the loss of virginity is devastating.
- Recognize that beliefs about women, men, sexuality, sexual orientation, race, culture, religion, and sexual assault may be very different among patients – never assume anything.

Supplies for the Medical-Forensic Exam and Evidence Collection

- A private examining room, with attached bathroom, is best for the sexual assault patient. A gynecologic stretcher should be used for the exam.
- A stocked sexual assault cart stored in the designated examining room will eliminate the need to gather essential examining equipment after the patient has arrived.

Needed items:

- o Non-powdered gloves
- o Masks
- o Disposable gowns
- o Disposable bonnets
- o Disinfectant wipes
- o Sealed CT100B and CT400A Kits
- o Sterile saline solution

- o Several cotton-tipped swab packets
- o Speculum-assorted sizes
- o Alternate light source or Woods Fluorescent Lamp
- o Tape
- o Pen and pencil
- o Swab dryer or Styrofoam/paper cups
- o Large brown paper bags (grocery type)
- o Portable bedside table

Recommended Items:

- o Sterile gauze packets
 - o Stapler and staples
 - o Locked refrigerator designated as an evidence storage unit
- If a swab dryer is not available, have a stable table/counter space available for air drying specimens away from people in the room.

Preparation for the Medical-Forensic Exam and Evidence Collection

DNA - Touch DNA:

- Also called “contact DNA”. This is DNA from skin cells left behind from touching or coming into contact with an object/person.
- The amount of DNA left behind depends on multiple factors, such as: length of time in contact, type of substrate, whether the individual is a “shedder,” and amount of pressure or friction applied.

DNA - Testing:

- DNA testing has increased in sensitivity greatly over recent years. DNA profiles can be detected from as few as 1-2 human cells.
- It is imperative that extraneous DNA contamination be prevented from DNA samples that will be examined in a forensic laboratory.
- To prevent cross-contamination and ensure a clean environment when collecting evidence:

- Gloves should be worn and changed frequently: between steps and between evidentiary locations, as well as after touching any potentially contaminated objects (pens, stethoscopes, etc.).
- Disposable gown or covering for clothing. This keeps cells that are on daily worn clothing from contaminating samples.
- Face masks should be worn by all within 3 feet of the evidence. The mask should be worn over both mouth and nose.
- Bonnets or hairnets should be worn.
- Use sanitation procedures at the health care facility including disinfectant wipes and/or cleaning solutions. Equipment used, such as pens, pencils, and, cameras should also be cleaned.

Presence of Others in the Exam Room

- Generally, only the examining and attending health care providers should be in the room during the examination. With patient consent, a sexual assault advocate may also be present.
- If the patient requests the presence of a close friend or family member, this request should be honored after discussing possible legal ramifications of being present during the history, exam, and collection of evidence.
- Advocates have privileged communications; they cannot be compelled to testify without patient consent. All others present during the forensic exam may be subpoenaed.
- There is no medical or legal reason for a law enforcement officer (male or female) to be present during the forensic history and exam.

Documentation

General Points:

- Use objective neutral wording. Do not use “alleged” or “claims,” instead write “Patient states.” Also, write “declined” rather than “refused.” In health care, the patient is a patient, not a victim nor a survivor.

- Describe objectively what is observable with the senses. Avoid vague terms such as “poor” or “good.”
- Do not use abbreviations.
- Read back the patient’s responses in order to ensure accuracy.
- Review all CT100B and CT400A forms at the end of the exam to ensure they are completely filled out and signed. Distribute white, yellow and pink copies as noted on the bottom of the pages.
- The original of the CT100B and CT400A forms (white pages) should be retained and scanned – front and back – by the health care facility as part of the medical record.

The Medical-Forensic History

General Points:

- The history is not the same as an investigative interview. It is a history of the assault, as relayed by the patient, as part of the medical-forensic exam, and will become a part of the medical record.
- The history is intended to guide the exam, evidence collection, and forensic lab analysis of the findings. The Division of Scientific Services uses the history to “triage” their examination of the Kit.
- The history takes place after medical care for acute injuries, but before evidence collection.
- Presence of family members, friends or other persons in the room, aside from the advocate, may influence, or be perceived as influencing, patient history. They should be aware they may be subpoenaed.
- These other individuals should only be present if patients (including minors) choose to have them present. They should not answer questions for the patient, interrupt the patient or make facial expressions in response to answers so as to influence the account of the assault.

- Taking the history:
 - Sit at eye level with the patient, at the head of the bed. It is not necessary to wear gloves or mask during the history, which can be perceived as a barrier.
 - Explain to the patient that the account of the assault needs to be taken verbatim. In the history, identify the patient as the historian (e.g., “Patient states....”). Use quotes.
 - Writing firmly and legibly, record the account of the assault as it is relayed by the patient.
 - Do not ask leading questions. Do not paraphrase or summarize.
 - It may be necessary to ask the patient to speak slower, take a break for you to catch up, and/or read-back to the patient what is written in order to ensure accuracy.

Photography

- Specific written informed consent should be obtained according to facility policies prior to photography.
- Photographs should be taken by a knowledgeable photographer, preferably by law enforcement with appropriate equipment. Findings should be photographed without a scale, and then with a scale for reference.
- Colposcopy photographs and other images of the genital area should not be taken unless the patient provides written consent.
- Transfer or Storage of images should be in accordance with facility policy.
 - Photographs should not be placed inside the CT100B kit.

Exam and Evidence Collection

It is important to understand the evidentiary purpose of the exam. According to the National Protocol, “The findings in the exam and collected evidence provide information to help reconstruct the details about the events in question in an objective and scientific manner.” Patients should understand the exam is not about routine medical care.

Note: On September 19, 2016, the Commission voted to omit the head and pubic hair pull steps in accordance with a request from the Division of Scientific Services as hair analysis is no longer conducted.

Steps for CT100B Evidence Collection

Step 1: Known Blood Sample – Rationale and Use: Evidence samples from sexual assaults may contain DNA mixtures of more than 1 individual. It is important to know the DNA profile of the patient so that evidentiary DNA profiles can be interpreted as accurately as possible.

- A sample of blood is superior over a known buccal or known oral swab because these samples may be contaminated due to an oral sexual assault or oral contact.
- If the CT400A Toxicology Screen Evidence Collection Kit is to be collected, blood samples from this kit should be collected prior to the CT 100B blood sample. Blood needed for hospital tests should be drawn in conjunction with, but after, forensic tubes are collected.
- Order of Draw:
 1. CT 400A gray top tubes
 2. CT 100B purple top tube
 3. Hospital labs
- Expired tubes from the Kits may be replaced with the same from facility stock, so long as tube preservatives are identical to those listed on the blood collection tubes from the Kits. Document replacement on step envelope.

- Procedure:
 - o Wear gloves, mask, disposable gown, and hairnet/bonnet.
 - o Ask permission to draw blood.
 - o Draw blood using order of draw above.
 - o Place patient label, date and initial, on tube(s).
 - o Replace purple top blood tube in enclosed bubble pack bag, using adhesive strip to seal.
 - o Once known blood sample is collected, seal and label envelope in accordance with instructions on Evidence Integrity.
 - o If blood is drawn for the CT400A, return tubes to the cardboard holder in the CT400A Kit.

Step 2: Oral Swabs and Smear – Rationale and Use: This sample may be tested for semen in the patient's oral cavity. Blood may be tested to show force. The swabs may be forwarded for DNA analysis.

- When indicated by patient history, samples may be collected from around the exterior mouth and lip area. The sample should not be collected as an oral specimen, but as a dried secretion specimen for Step 6.
- Procedure:
 - o Change gloves, wear mask, disposable gown, and hairnet/bonnet.
 - o Ask permission to swab mouth.
 - o Assemble swab boxes.
 - o The collector's initials and date should be on the outside of the slide container.
 - o Ensure that the frosted side of the slide is face up.
 - o Using enclosed pencil, write the following on the frosted area of the slide: patient's initials, date, "oral."

- o Use the first set of 2 unmoistened swabs to simultaneously swab between the buccal and the gingival line around the oral cavity.
 - Turn swabs between thumb and forefinger while swabbing. This ensures that all swab surfaces are exposed to sample.
- o Use this first set of swabs to make a smear: Roll one swab across the slide in a 360° roll. Repeat this with the second swab directly underneath the first roll.
- o Dry swabs and place into the swab box labeled “Oral Smear.”
- o Repeat swabbing of oral cavity with second set of 2 unmoistened swabs.
- o Dry swabs and place in the second swab box labeled “Oral Swabs.”
- o Once swabs and smear are collected, seal and label envelope in accordance with instructions on Evidence Integrity.

Step 3: Clothing – Rationale and Use: Analysis is conducted for debris, fluids, and other evidence. All testing of evidence taken from clothing, including cuttings and swabbing will be conducted by the DESPP-DSS (Department of Emergency Services and Public Protection, Division of Scientific Services).

- o Do not cut through any holes, rips or tears in clothing when removing from patient. Ask and document if damage to clothing was due to the assault.
- o Leave obvious debris intact on clothing, and package as found.
- o Document if clothing has been changed since the assault. If original clothing worn during assault is at a different location, document location. Relay information to law enforcement so clothing can be collected and submitted to the Forensic Lab.
- o Collect underwear worn/removed during the assault. Collect underwear changed into after the assault. Document each bag clearly.
- o Use additional clean paper bags, as needed. Never use plastic bags.

- Procedure:
 - o Change gloves, wear mask, disposable gown, and hairnet/bonnet.
 - o Place clean hospital sheet on floor. Place unfolded paper sheet from kit on top of hospital sheet.
 - o Have patient stand on paper sheet and disrobe. Protect modesty.
 - o Ask permission for each item of clothing collected.
 - o Collect each clothing item as it is removed.
 - o Place each item separately in the appropriate bag. Use extra bags as needed.
 - o Separate visible stains and moist areas with clean paper towels to avoid contamination.
 - o If items are wet or damp, air-dry as much as possible before packaging.
 - o Let law enforcement know when transferring evidence to them that items are damp so they can continue the drying process upon transfer.
 - o Refold paper sheet so that any debris is contained. Place patient label, date and initials on it before placing it into large outer clothing bag.
 - o Once all clothing evidence is collected, seal (make sure bags are sealed end to end) and label bags and envelopes in accordance with instructions on Evidence Integrity.

Step 4: Debris – Rationale and Use: Debris and trace materials noted during the forensic examination may be used to corroborate the case history.

- Debris includes (but is not limited to) the following: soil, grass, leaves, weeds, and bark (outdoors); clothing or carpet fibers, human, dog or cat hair, paint or glass chips (indoors).
- Debris is collected from the patient's body; not from the patient's clothing.

- Procedure:
 - o Change gloves, wear mask, disposable gown, and hairnet/bonnet.
 - o Ask permission to examine patient and collect debris.
 - o Collect debris observed on patient's body. Look carefully for hairs and small trace items.
 - o If the debris is too large for the envelope provided, place in a clean paper bag, secure in accordance with instructions on Evidence Integrity. Label with identification and chain of custody information.
 - o Document location of debris on envelope with anatomical location where debris was found on the patient's body. Use words and arrows to show location.
 - o Once all debris evidence is collected, seal and label envelope in accordance with instructions on Evidence Integrity.

Step 5: Fingernail Swabbings and Clippings – Rationale and Use: Document whether the patient recalls scratching the face, body or clothing of the suspect (for Touch DNA). Based on this information, or if it was a violent assault, these samples may be examined for blood and tissue like material to show force. These samples may be forwarded for DNA analysis.

- Do not clip acrylic nails. Use lightly moistened swabs (sterile saline) to swab under acrylic nails. Document this on the envelope in the space.
- If nails are too short to clip, lightly moisten swabs with sterile saline to swab the tip area of the nails, avoiding the fingertips. Document this on the envelope in the space provided.
- Procedure:
 - o This step contains 1 step envelope, 2 specimen envelopes labeled "right hand" and "left hand", 1 swab packet, 2 swab boxes labeled "right hand" and "left hand," and 1 pair of fingernail clippers.
 - o Change gloves, wear mask, disposable gown, and hairnet/bonnet.
 - o Ask permission to swab and clip fingernails.

- o Open swab packet and remove both swabs. Moisten swabs lightly with sterile saline.
- o Using 1 swab per hand, lightly swab underneath the fingernails, avoiding fingertips. Dry swabs.
- o Carefully clip the nails over the appropriate specimen envelope for each hand.
- o Seal clippers inside the step envelope, and the swab for each hand inside the appropriate swab box.
- o Complete the label.
- o Once swabs and clippings are collected, seal and label envelope in accordance with instruction on *Evidence Integrity*.

Step 6: Dried Secretion Specimen – Rationale and Use: This sample may be tested for body fluids from the patient's body. These samples may be forwarded for DNA analysis.

- Important: If the sample is of a “touch” nature and testing for a body fluid is not indicated, see Step 7 for the collection of “Touch” DNA. Unnecessary testing for a body fluid would be a waste of sample and could negatively impact the ability to get a DNA result.
- Important: Note the location and potential body fluid, as indicated by history, on the diagram. It allows laboratory personnel to conserve sample and save time.
- Use a light touch when swabbing. A heavy touch will result in a concentration of the patient's DNA, rather than the assailant's.
- An alternate light source with filter or Woods Fluorescent Lamp in a darkened room may help locate dried secretions. Collect a sample regardless of the absence of fluorescence as indicated by history.
- Procedure:
 - o Change gloves, wear mask, disposable gown, and hairnet/bonnet.
 - o Ask permission to swab indicated areas.

- o Pre-assemble swab box. Lightly moisten set of 2 swabs with sterile saline (1 or 2 drops each).
- o To Swab:
 - Start at the outside of the indicated area.
 - Swab lightly in a circular pattern, turning swabs between thumb and forefinger. This ensures that all swab surfaces are exposed to the sample.
 - Use separate swab sets for each indicated location. Use facility stock as needed.
 - Dry swabs and place into swab box. Place any extra swabs into their packets. Document location where each swab set was taken as indicated by history or alternate light source findings.
 - Once swabs are collected, seal and label envelope in accordance with instructions on Evidence Integrity.

Step 7: Touch DNA – Rationale and Use: Also called “contact DNA”. This is DNA from skin cells left behind from touching or coming into contact with an object/person. Touch DNA may be obtained from the skin when strangulation has occurred, or the patient was forcefully grabbed. Do NOT swab clothing for “Touch” DNA.

- The amount of DNA left behind depends on multiple factors, such as: length of time in contact, type of substrate, whether the individual is a “shedder,” and amount of pressure or friction applied.
- DNA testing has increased in sensitivity greatly over recent years. DNA profiles can be detected from as few as 1-2 human cells.
- Use a light touch when swabbing. A heavy touch will result in a concentration of the patient’s DNA, rather than the assailant’s.
- Procedure:
 - o Change gloves, mask, disposable gown, and hairnet/bonnet.
 - o Ask permission to swab indicated areas of touch DNA.

- o Pre-assemble swab box. Lightly moisten set of 2 swabs with sterile saline (1 or 2 drops each).
- o To Swab:
 - Start at the outside of the indicated area.
 - Swab lightly in a circular pattern, turning swabs between thumb and forefinger. This ensures that all swab surfaces are exposed to the sample.
 - Use separate swab sets for each indicated location. Use hospital stock as needed.
 - Dry swabs and place into swab box. Place any extra swabs into their packets. Document location where each swab set was taken as indicated by history.
 - Once swabs are collected, seal and label envelope in accordance with instructions on Evidence Integrity.

Step 8: Pubic Hair Combing – Rationale and Use: The purpose of this sample is to collect hairs foreign to the patient (e.g., transfer from suspect). This sample may be forwarded for DNA analysis.

- Patient may have shaven pubic region. Comb for foreign pubic hair even if shaven.
- If hair is matted with a substance, with permission, cut matted area with sterile scissors and place in Step 12 specimen envelope. Document cut specimen on front of envelope.
- If patient declines cutting of matted substance, swab area with swabs obtained from hospital stock, lightly moistened with sterile saline. Dry swabs and return to swab packet. Label swab packet with contents. Place in Step 8 envelope.
- Procedure:
 - o Change gloves, wear mask, disposable gown, and hairnet/bonnet.
 - o Ask permission to comb pubic region.

- o Place unfolded specimen envelope under patient's buttocks.
- o Comb through pubic region, retaining any loose hairs within envelope.
- o Re-fold envelope, enclosing any loose hairs and comb.
- o Once public hair combings are collected, seal and label envelope in accordance with instructions on *Evidence Integrity*.

Step 9: Genital Swabs – Rationale and Use: This sample may be tested for semen or saliva from the patient's genital area and forwarded for DNA analysis. This sample may be tested for blood to show force.

- If no vaginal swabs (Step 10) are collected for female patients, a minimum of 2 additional genital swabs should be collected.
- Note: If indicated, samples from the inner thighs should be collected as Touch DNA (Step 7) or as a Dried Secretion Specimen (Step 6), depending on case history.
- Procedure:
 - o Change gloves, wear mask, disposable gown, and hairnet/bonnet.
 - o Ask permission to swab genital area.
 - o Assemble swab boxes. Open 2 swab packets and remove swabs. Moisten swabs lightly with 1 or 2 drops of sterile saline prior to specimen collection.
 - o Females: Using first set of swabs, lightly swab in the following order: across labia minora, fossa navicularis (where the labia minora meet posteriorly), labia majora, and groin (mucosal to non-mucosal areas). See diagram on step envelope. Repeat with second set of swabs.
 - o Males: Use first set of swabs as follows: scrotum, groin, shaft of penis, and glans. Repeat with second set of swabs.
 - o Dry swabs and place into appropriate swab boxes.
 - o Place swab boxes inside step envelope. Label and seal the envelope and return it to Kit.

- o Once swabs are collected, seal and label envelope in accordance with instructions on *Evidence Integrity*.

Step 10: Vaginal Swabs and Smear – Rationale and Use: This sample may be tested for semen or saliva in the patient’s vaginal cavity and the swabs forwarded for DNA analysis. This sample may be tested for blood to show force.

- If testing for sexually transmitted infections (STIs), specimens should be performed immediately following forensic specimen collection.
- Vaginal swabs should be collected from the posterior fornix, below the cervix.
- An external genital exam should be conducted prior to specimen collection. The face of a clock, superimposed over the genital area, should be used to describe location of injuries (e.g., abrasion noted from 5 to 7 o’clock).
- Procedure:
 - o Change gloves, wear mask, disposable gown, and hairnet/bonnet.
 - o Ask permission to swab vaginal cavity.
 - o Assemble swab boxes.
 - o The collector’s initials and date should be on the outside of the slide container.
 - Ensure that the frosted side of the slide is face up.
 - Using enclosed pencil, write the following on the frosted area of the slide: patient’s initials, date, “vaginal.”
 - o Use warm water to moisten speculum. Do not use lubricant. Once speculum is in place, inspect the internal vaginal cavity for injuries, using a clock face to describe the location of any noted injuries.
 - o To collect specimens: use the first set of 2 swabs to swab the posterior fornix.
 - o Turn swabs between thumb and forefinger while swabbing. This ensures that all swab surfaces are exposed to sample.

- o Use this first set of swabs to make a smear: Roll 1 swab across the slide in a 360° roll. Repeat this with the second swab directly underneath the first roll.
- o Dry swabs and place into the swab box labeled “Vaginal Smear.”
- o Repeat swabbing of posterior fornix with second set of 2 swabs. Dry swabs and place in the second swab box labeled “Vaginal Swabs.”
- o Once swabs and smear are collected, seal and label envelope in accordance with instructions on *Evidence Integrity*.

Step 11: Anal Swabs and Smear – Rationale and Use: This sample may be tested for semen or saliva in the patient’s anal cavity and the swabs forwarded for DNA analysis. This sample may be tested for blood to show force.

- An external anal exam should be conducted prior to specimen collection. Anal folds should be gently separated to examine for injury.
- Swabs should be lightly moistened with 1 or 2 drops of sterile saline.
- Swabs should be collected from inside the anal cavity to the depth of the cotton tip of the swab.
- Procedure:
 - o Change gloves, wear mask, disposable gown, and hairnet/bonnet.
 - o Ask permission to swab anal cavity.
 - o Assemble swab boxes.
 - o The collector’s initials and date should be on the outside of the slide container.
 - Ensure that the frosted side of the slide is face up.
 - Using enclosed pencil, write the following on the frosted area of the slide: patient’s initials, date, and “Anal.”

- To collect specimens: use the first set of 2 swabs to swab anal cavity to the depth of the cotton tip of the swab.

Turn swabs between thumb and forefinger while swabbing. This ensures that all swab surfaces are exposed to sample.

- Use this first set of swabs to make a smear: Roll 1 swab across the slide in a 360° roll. Repeat this with the second swab directly underneath the first roll.
- Dry swabs and place into the swab box labeled “Anal Smear.”
- Repeat swabbing of anal cavity with second set of 2 swabs. Dry swabs and place this set in the second swab box labeled “Anal Swabs.”
- Once swabs and smear are collected, seal and label envelope in accordance with instructions on Evidence Integrity.

Step 12: Other Physical Evidence – Rationale and Use: Other physical evidence may include condoms, tampons, sanitary pads, tissue, or other debris inside vaginal or anal cavities. These items may be examined for body fluids and/or used to corroborate case history.

- Do not swab the surfaces of other physical evidence; any sample collection will be performed at the Forensic Lab.
- For moist specimens, use the yellow “Moist Evidence” sticker located inside the envelope. Place in the appropriate place on the front of the kit.
- Do not place moist specimens directly into paper envelope. Contents may leak through and contaminate other specimens.
- Procedure:
 - Change gloves, wear mask, disposable gown, and hairnet/bonnet.
 - Ask permission to collect other physical evidence.
 - Place moist specimens inside plastic bag(s) and seal.
 - Once other evidence is collected, seal and label envelope in accordance with instructions on *Evidence Integrity*.

Steps for CT400A Toxicology Screen Evidence Collection

STATE OF CONNECTICUT CT400A
TOXICOLOGY SCREEN EVIDENCE COLLECTION KIT

MEDICAL PERSONNEL
PLEASE PRINT

PATIENT'S NAME: _____ MED. REC. NO.: _____
or CONTROL NO (FACILITY NAME/PT. INITIALS/6 DIGIT KIT COMPLETION DATE): _____

EXAMINING MD/NURSE/SAFE/SANE: _____
ATTENDING NURSE: _____
HEALTH CARE FACILITY: _____
KIT SEALED BY: _____
PLACE SEALED KIT IN SECURE, REFRIGERATED STORAGE AREA

STORED BY: _____
DATE: _____ TIME: _____ AM
PM
GIVEN TO LAW ENFORCEMENT BY: _____
DATE: _____ TIME: _____ AM
PM

POLICE PERSONNEL
CHAIN OF CUSTODY

DATE: _____ TIME: _____ AM
PM
RECEIVED FROM HEALTH CARE FACILITY BY: _____
DATE: _____ TIME: _____ AM
PM
RECEIVED FROM: _____
RECEIVED BY: _____
DATE: _____ TIME: _____ AM
PM
RECEIVED FROM: _____
RECEIVED BY: _____

- Routine toxicology testing is not recommended. However, in any of the following situations, the collection of a urine and/or blood sample may be indicated:
 - The patient's medical condition appears to warrant toxicology screening (e.g., drowsiness, fatigue, light-headedness, dizziness, physiologic instability, memory loss, impaired motor skills, severe intoxication).
 - The patient or accompanying person states that the patient was or may have been drugged.
 - The patient suspects drug involvement because of a lack of recollection of the assault.
- Blood (10 mL in each tube) should be collected in conjunction with the CT100B, with the toxicology gray top tubes being first in the order of draw. Urine (60 mL) should also be obtained when doing the CT400A Toxicology Screen Evidence Collection Kit.
- Urine will not be tested for GHB (gamma-hydroxybutyric acid) when the urine collection time is more than 12 hours beyond the suspected drugging incident.
- Blood will not be tested for GHB (gamma-hydroxybutyric acid) when blood collection time is more than 8 hours beyond the suspected drugging incident.

- Neither blood nor urine will be tested for ethanol when sample collection time is more than 24 hours beyond the suspected drugging incident.
- Urine testing will not be conducted more than 120 hours (5 days) beyond the suspected drugging incident.
- Blood testing will not be conducted more than 48 hours (2 days) beyond the suspected drugging incident.

CT400A Documentation

- Required information includes, but is not limited to:
 - Date/time of assault.
 - Date/time of blood and urine collection.
 - Patient symptoms.
 - Length of time unresponsive.
 - Time lapse between suspected drugging incident and sample collection.
 - Amount of alcohol ingested.
 - Number of times patient voided before collection of urine for toxicology.
 - Case history – provides needed information to the toxicologist and allows for efficient testing.
 - Any pre-hospital (legal or illegal) or in-hospital medications that have been taken since the incident.

Blood

- To be collected within 48 hours of suspected drugging incident.
- Blood specimens will be examined for drugs/metabolites which have been identified within the associated urine specimen.

- Collect 10 mL of blood in each gray top tube, following directions provided in kit. Use only gray top tubes containing sodium fluoride and/or potassium oxalate (provided in kit). Facility stock may be used so long as blood collection tube preservatives are identical to those listed on the blood collection tubes in the CT 400A kit.
- Once blood sample is collected, seal and label accordance with instructions on Evidence Integrity.

Urine

- To be collected within 120 hours (5 days) of the suspected drugging incident.
- Urine is considered “the best” specimen for most drug-facilitated sexual assault cases.
- Collect 60 mL of urine, following directions, in the cup provided in the kit.
 - 30 mL of urine is needed for testing, but limited testing can be performed with volumes less than 30 mL of urine.
 - Once urine is collected, seal and label in accordance with instructions on Evidence Integrity.

Storage

- Blood and urine must be refrigerated after collection. While samples can be frozen, care must be taken that sample containers do not break or crack. All primary specimen containers should be stored within a secondary container (e.g., zip-lockable plastic bag) to prevent loss or contamination due to leakage.

Sexually Transmitted Infections (STIs) Evaluation and Care

The following is intended to serve as a guide for the care and treatment of the sexual assault patient.

The medical care and treatment of sexual assault patients should be consistent with current professional guidelines and accepted medical practice. The following is taken from the Centers for Disease Control (CDC) at:

<https://www.cdc.gov/std/tg2015/sexual-assault.htm>

- Baseline testing at the time of the initial exam does not typically have forensic value if patients are sexually active and a STI could have been acquired prior to the assault. However, baseline serum testing for HIV, Hepatitis B, and Syphilis should be considered on a case by case basis.
- If testing, specimens for STI testing should be performed immediately following forensic specimen collection.
- Patients who prefer prophylaxis generally do not require baseline testing.
- Assess for allergies prior to providing medication.
- Consider an antiemetic with the medication.
- The CDC offers the following empiric antimicrobial regimen for chlamydia, gonorrhea, and trichomonas.

Recommended Regimens

- **Ceftriaxone** 250 mg IM in a single dose (Gonorrhea)
PLUS
 - **Azithromycin** 1 g orally in a single dose (Chlamydia)
PLUS
 - **Metronidazole** 2 g orally in a single dose (Trichomoniasis)
OR
 - **Tinidazole** 2 g orally in a single dose
-
- If alcohol has been recently ingested or emergency contraception is provided, metronidazole or tinidazole can be taken at home rather than as directly observed therapy to minimize potential side effects and drug interactions.
 - Clinicians should counsel persons regarding the possible benefits and toxicities associated with these treatment regimens; gastrointestinal side effects can occur with this combination.
 - The efficacy of these regimens in preventing infections after sexual assault has not been evaluated.

Additional information on recommendations from the CDC can be found at:
<http://www.cdc.gov/std/tg2015/sexual-assault.htm>

Non-occupational Post-exposure Prophylaxis (nPEP)

According to the CDC, HIV seroconversion has occurred in persons whose only known risk factor was sexual assault or sexual abuse, but the frequency of this occurrence likely is low.

- In consensual sex, the per-act risk for HIV transmission from vaginal intercourse is 0.1%–0.2%, and for receptive rectal intercourse, 0.5%–3%.
- Risk for HIV transmission from oral sex is substantially lower. Specific circumstances of an assault (e.g., bleeding, which often accompanies trauma) might increase risk for HIV transmission in cases involving vaginal, anal, or oral penetration.
- CDC recommendations for post-exposure HIV risk assessment of adolescent and adult patients within 72 hours of sexual assault.
- Determination of the assailant's HIV status at the time of the assault examination is usually not possible. Therefore, health care providers should assess any available information concerning the:
 - Characteristics and HIV risk behaviors of the assailant(s) (e.g., being an MSM or using injection drugs);
 - Local epidemiology of HIV/AIDS;
 - When an assailant's HIV status is unknown, determinations regarding risk for HIV transmission to the patient should be based on 1) whether vaginal or anal penetration occurred; 2) whether ejaculation occurred on mucous membranes; 3) whether multiple assailants were involved; 4) whether mucosal lesions are present in the assailant or patient; and 5) any other characteristics of the assault, patient, or assailant that might increase risk for HIV transmission.
- Consult with a specialist in HIV treatment if nPEP is being considered.

- If the patient appears to be at risk for acquiring HIV from the assault, discuss nPEP, including benefits and risks.
- If the patient chooses to start nPEP, provide enough medication to last until the follow-up visit at 3–5 days after initial assessment and assess tolerance to medications.
- If nPEP is started, perform CBC and serum chemistry to establish a baseline.
- Perform an HIV antibody test at original assessment; repeat at 6 weeks, 3 months, and 6 months.

Note: Assistance with nPEP-related decisions can be obtained by calling the National Clinician's Post Exposure Prophylaxis Hotline (PEP Line) (telephone: 888–448–4911) 9 a.m. – 9 p.m. EST, seven days a week. Website link: <http://nccc.ucsf.edu/clinician-consultation/pep-post-exposure-prophylaxis/>

Consultation can also be made with the hospital Infectious Disease Specialist.

Emergency Contraception (EC)

Sexual assault patients should be offered prophylaxis for pregnancy, subject to informed consent and consistent with current treatment guidelines (DOJ National Protocol, 2103).

- A pregnancy test should be conducted (with patient consent) with all patients of childbearing age to establish the patient's present status.
- EC should be discussed as a treatment option. Taking EC after a sexual assault decreases a woman's chances of becoming pregnant.
- The FDA has approved Plan B pills to be initiated up to 72 hours, and Ella to be initiated up to 120 hours, but are most effective when taken within 12 hours of the assault.
- Consider providing an antiemetic with EC.
- Legislation was signed into law in October 2007 in Connecticut that establishes emergency contraception as a standard of care for acute care hospitals that provide emergency treatment to victims of sexual assault. This includes:

- o Providing each victim of sexual assault with medically and factually accurate and objective information relating to emergency contraception;
 - o Informing such victim of sexual assault of the availability of emergency contraception, its use and efficacy;
 - o Providing emergency contraception to such victim of sexual assault at the facility upon the request of such victim, except that a licensed health care facility shall not be required to provide emergency contraception to a victim of sexual assault who has been determined to be pregnant through the administration of a pregnancy test approved by the United States Food and Drug Administration; and
 - o No licensed health care facility that provides emergency treatment to a victims of sexual assault shall determine such facility's protocol for complying with the standard of care requirements on any basis other than a pregnancy test approved by the United States Food and Drug Administration.
- Three current methods of emergency contraception (EC) include:
 - o Plan B to be initiated within 72 hours after assault.
 - o Ella to be initiated within 120 hours after assault.
 - o Copper Intrauterine Device (IUD) to be inserted within 120 hours after the assault.
 - Best practice is to have patient begin EC as soon as possible.

Discharge Instructions

- Allow a patient who so desires to brush their teeth. If clothing was collected, try to ensure that the patient does not leave the facility in hospital gown and slippers.
- Whenever a sexual assault patient is discharged from the hospital or transferred to an inpatient department, the CT100B Discharge Instructions should be reviewed with the patient and a copy should be given to the patient, along with a copy of the consent form(s).

- o Referrals and resources should also be provided and discussed at this time.
- Ensure that the patient understands the importance of follow-up care in 2 weeks.
- If the patient is undecided whether to report the assault to police, place a Control Number on the front of the Kit(s) and Clothing Bag, as well as on the Discharge Instructions. See page 43 for instructions on how to create a Control Number.

Evidence Integrity – Sealing Evidence Bags

- Inner Evidence Bags:
 - o Double-fold the top of each inner bag. Staple or tape across the fold to seal. A patient sticker may also be used to seal.
 - o Place a patient sticker, along with collector’s signature, date and time on the front of the bag.
- Outer Clothing Bag:
 - o The top of the brown clothing bag is double-folded. The bag should be taped across the entire fold of the bag, from one end to the other. The bag may be stapled prior to the placement of tape.
 - o Initial 2 of the 4 *Evidence Integrity* stickers (these are fragile – handle carefully) and place a sticker around each end of the fold.

Labeling the Outside of the CT100B Kit and Clothing Bags and the CT400A Kit: Reporting and Not Reporting Control Number

- If the case is a reported case (reported at the time of the exam):
 - o The patient’s name and Medical Record number is placed on the front of the CT100B and Clothing Bag(s), and CT400A.

- If the case is not a reported case (patient is undecided at the time of the exam - or states they will report later):
 - o Control Number: Whenever a patient is undecided about reporting the assault to law enforcement, a control number must be placed on the outside of the Kits and Clothing Bag.
 - o This control number is recorded in 4 places:
 - The outside of the CT100B Kit
 - The outside of the CT400A Kit
 - The consent form (bottom of page)
 - The discharge form from the CT100B (right side of form)
 - o Control Number format: Name of Health Care Facility:Patient Initials:6 Digit Kit Completion Date. Ex: Hospital Name:ABC:mm/dd/yy.
 - A colon separates the hospital name, the patient initials and the kit completion date.
 - Example: A patient named Anne Marie Smith has a kit completed at Nutmeg Hospital on July 17, 2017. The Kit Control number would be: Nutmeg Hospital:AMS:07/17/17

Testimony Considerations

- The role of the health care provider is to provide accurate, unbiased information regarding the evaluation and treatment of the patient, including the statements made by the patient, the patient's demeanor, any injuries observed, and the collection of evidence.
- In addition to providing factual information, the health care provider may be called upon to provide expert testimony related to their advanced training, work experience with patients, and medical knowledge.
- Accordingly, doctors, nurses, and paramedics are routinely called as witnesses at trial regarding the medical evaluation and treatment rendered to a person who has been sexually assaulted.

- In the courtroom, the health care provider is a neutral unbiased professional who could be called to testify regarding the medical evaluation and treatment of the patient.

- The relationship between State's Attorneys and law enforcement is as follows:
 - Prosecutors rely on law enforcement officers to investigate an allegation that someone has committed a crime.

 - In many cases, law enforcement makes an arrest at the scene of a crime. The person arrested is then brought to court for a judge to determine if there is probable cause to believe that the arrested person committed the crime charged by law enforcement. The prosecutor then determines whether to proceed with the case. This is known as an on-site arrest case.

 - In other cases, law enforcement will not make an immediate on-site arrest, but instead, will conduct a thorough investigation and provide the information they have collected to the prosecutor. Law enforcement documents the information gathered in an arrest warrant affidavit. The prosecutor will then review the case and decide if there is sufficient evidence to present the case to a judge for the issuance of an arrest warrant. If so, a prosecutor will sign the arrest warrant and then provide it to a judge for review. If the judge determines that there is probable cause for an arrest, they will sign the arrest warrant authorizing an arrest of the accused person.

 - A prosecutor may decline to request an arrest warrant if they determine that the evidence collected by law enforcement is not sufficient to prove that a crime has been committed, or to prove who committed the crime.

 - The prosecutor also may order further investigation, either by law enforcement, or in unusual cases, by an investigatory grand jury. Once an arrest warrant is signed by a judge, the person named in the warrant is arrested and the case begins its way through the court system.

How the Medical Exception to Hearsay Rule Works

- At trial, health care providers are permitted to testify about what a patient says to them while seeking medical treatment. This is called the medical exception to the hearsay rule.
- “Hearsay” means a statement, other than one made by the declarant/witness while testifying at the proceeding, offered in evidence to establish the truth of the matter asserted. In other words, hearsay is generally understood as a rule to exclude witnesses testifying in court about statements made by another person outside of court.
- The idea behind the exclusion is that if the speaker of the statement is not present in the courtroom, then the speaker cannot be cross-examined about those statements. This makes it unfair to the side/party who did not call the witness.
- There are exceptions to this rule of excluding hearsay. One of the exceptions to the normal rule excluding out of court statements is the medical exception to the hearsay rule.
- Connecticut state courts follow the Connecticut Code of Evidence which states the medical exception to hearsay as follows:

A statement made for the purposes of obtaining a medical diagnosis or treatment and describing medical history, past or present symptoms, pain, or sensations, or the inception or general character of the cause or external source thereof, insofar as reasonably pertinent to the medical diagnosis or treatment [is not excluded under the hearsay rule].

Connecticut Code of Evidence § 8-3 (5).

Examples:

- In *State v. Griswold*, 160 Conn. App. 528, 555-558, *cert. denied*, 320 Conn. 907 (2015), the Connecticut Appellate Court held that a five year old sexual assault victim’s statements made in a forensic interview were admissible under the medical exception to the hearsay rule. The court concluded that “the victim’s statements were reasonably pertinent to obtaining medical diagnosis and treatment to bring them within the scope of the medical diagnosis and treatment section.”

- In *State v. Martin M.*, 115 Conn. App. 166, 174-176 *cert. denied*, 293 Conn. 908 (2009), the Connecticut Appellate Court held that a sexual assault patient's statements made to a certified nurse practitioner were within the "chain of medical treatment" and admissible at trial under the medical exception to the hearsay rule. Moreover, the court found that the patient's statements made nine months after the last sexual assault were still made for the purposes of ongoing medical treatment.
- In *State v. Donald M.*, 113 Conn. App. 63, 70-71, *cert. denied*, 291 Conn. 910 (2009), the Connecticut Appellate Court reaffirmed that the medical treatment exception applies to psychological as well as somatic illnesses and conditions. In other words, statements made to a psychiatrist or psychologist for purposes of diagnosis and treatment are admissible under the medical exception. *State v. Wood*, 208 Conn. 125, 133-134 (1988).
- In addition, in order to be admitted under the medical treatment exception, the statements need not have been made to a physician, as long as they were "made in furtherance of medical treatment." *State v. Slater*, 285 Conn. 162, 186 (2008) (nurse); *State v. Cruz*, 260 Conn. 1, 10 (2002) (social worker); *State v. Maldonado*, 13 Conn. App. 368, 372, *cert. denied*, 207 Conn. 808 (1988) (security guard used as translator).

The Crawford Doctrine

- An accused person on trial has the right to confront the witnesses against him/her.

Usually confrontation occurs during cross examination of the witnesses when testifying in the courtroom. In *Crawford v. Washington*, 541 U.S. 36 (2004), the United States Supreme Court made clear that if a witness is not available for cross-examination, then his/her "testimonial statements" are not admissible in court. In other words, if the witness is available for cross-examination, then that person can testify about what he/she previously said. If that person is not available for cross-examination, whether that statement can be admitted in court depends upon if it is "testimonial" or "nontestimonial."

- "Testimonial" statements in general are considered statements whose primary purpose is to establish or prove events such that the conversation essentially is an out-of-court substitute for trial testimony. For example, statements made as a result of a formal interrogation at a police station, or affidavits made under oath

are considered “testimonial.” These are all essentially statements given in anticipation of future litigation.

- “Nontestimonial” statements are those made under circumstances objectively indicating that the primary purpose of the conversation is not for future use in court. For example, statements made during an emergency situation or statements made in response to a teacher’s questions about a child’s safety at home are considered “nontestimonial.” Additionally, Connecticut courts have held that nontestimonial statements include a patient’s statements to his/her healthcare provider. Therefore, these nontestimonial statements may be admissible at trial without the patient having to testify to them.

APPENDIX

Appendix A

Specific Populations

- **American Indian and Alaska Native**
- **College Students**
- **Elderly (age 60 and older)**
- **Inmates**
- **Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ)**
- **Males**
- **Military**
- **Patients with Disabilities**
- **Undocumented Immigrants**
- **Victims of Human Trafficking**

American Indian and Alaska Native

- Recognize that Indian tribes may have their own laws and regulations, as well as their own police, prosecutors, advocates, courts, and service providers to address sexual assault.
- Responders should be familiar with procedures for coordinating services and interventions for victims from these communities and should work with community groups to develop plans for providing exams to members of Indian tribes.

College Students

- Due to the insular nature of campuses, many students may be worried about their confidentiality. It is important to remind them that their information will not be reported to their college or university without their consent.
- Students may not know that having a medical forensic exam and evidence collection done at a hospital does not impact any investigation done on campus.
- Each campus has on-campus confidential support students can access. This support may look different depending on the campus resources.

Elderly (age 60 and older)

- Elderly patients will likely experience humiliation, disbelief, and denial just as other patients do, but in addition, may also have an increased awareness of their own vulnerability.
- Elderly patients should be consulted in all decisions regarding their care, unless their history indicates they have diminished mental capacity.
- Hearing impairment and other physical conditions due to advancing age may be present. It is important not to confuse trauma with conditions sometimes associated with advanced age.
- Health care providers should take care with positioning, particularly when conducting a genital assessment and collecting evidence.
- Be aware that elderly patients may be victims of abuse perpetrated by their caretaker(s).

- Medical and counseling follow-up services should be made easily accessible, otherwise, older patients may not be willing or able to seek or receive assistance.

Guidelines and forms regarding mandatory reporting requirements when the patient is age sixty or older are in Appendix E.

Incarcerated People

- The Prison Rape Elimination Act (PREA) of 2003 gives prisoners equal rights to medical forensic exams and protects individuals from sexual assault in prison.
- Inmates should be treated the same as any other patient who presents as a victim of sexual assault.
- Medical information and treatment is confidential, as it is for other sexual assault patients.

Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ)

- Do not make assumptions about a patient's sexuality.
- Patients may be reluctant to report or consent to the medical forensic exam and evidence collection due to societal views.
- Ask the patient their preference of name and pronoun when referring to them, or speaking to others about them.
- Be aware that they may use non-standard labels for body parts. Ask for clarification when needed.
- Be mindful about possibly disclosing patient's sexuality to others that may be present.
- LGBTQ patients should not feel compelled to disclose aspects of their identity they are uncomfortable disclosing.
- "Know and Tell Why" before you ask an invasive question. Make sure it is necessary to do so as a health care provider. Also, make sure the patient is aware of why this information is necessary for health care providers to know.

Males

- Male patients may be more likely to exhibit a controlled response after the assault, expressing feelings of shock, disbelief and confusion. The assault may cause the patient to question his own masculinity. Concerns regarding sexual identity may arise for homosexual, bisexual, or heterosexual males.
- Although there may not be as many male sexual assault patients presenting to health care facilities as female patients, it is imperative that male sexual assault patients are treated with the same level of support and care as a female sexual assault patient.
- Special care should be taken in packaging the male patient's clothing, especially underpants and pants because the patient may have experienced an ejaculation. To avoid cross contamination with the offender's semen, place clean, dry paper towels between moistened areas of the garment.
- The lower back, thighs, and buttocks should be carefully examined for dried secretions using the Alternate Light Source or Woods Lamp.
- The male sexual assault patient's oral cavity, glans, scrotal, and perianal area should be carefully examined for trauma/evidence and documented.
- Male patients should be offered STI prophylaxis, including nPEP, as appropriate.

Military

- The military offers victims the option of restricted reporting or unrestricted reporting.
 - Restricted reporting allows a sexual assault victim to confidentially disclose the details of his or her assault to specified individuals and receive medical treatment and counseling without initiating an official investigative process or command notification.
 - Benefits include treatment, advocacy, counseling, time to consider options, control of personal information, and patient decides whether to move forward in process.

- Limitations include assailants going unpunished, loss of crime scene evidence, and inability to discuss with friends in the military.
- Restricted reporting can be rendered null and void if the medical facility contacts law enforcement or other professionals other than advocates, chaplains, and military sexual assault response coordinators.
- Unrestricted reporting is the reporting option for a victim of sexual assault to disclose that he or she is the victim of a sexual assault, without a request for confidentiality or restricted reporting,
 - Benefits include having a dedicated victim advocate, Commander action, victim-witness assistance, possible delay in collateral misconduct punishment, case management and monitoring, status reports, offender accountability, investigation, and possible prosecution or administrative actions.
 - Limitations include inability to change to restricted reporting, details and identities may become known, intrusive legal process, lengthy investigation or court proceedings, possible victim punishment for collateral misconduct, possible retaliation, if not properly protected by the Command.
- Sexual assault evidence collection and documentation is retained for 5 years, with the option of retaining for 50 years at Service member's request (OVCTTAC, Strengthening Military-Civilian Community Partnerships to Respond to Sexual Assault).

Patients with Developmental Disabilities

- Patients with developmental disabilities may have limited cognitive ability, impaired and/or reduced mental capacity to understand questions. They may also have limited language/communication skills to state what happened. They may not understand that they have been a victim of crime.
- Respect the patient's wishes to have, or not have, caretakers, family members or friends present during the exam. These individuals may be accustomed to speaking on behalf of the patient, but it is essential they not influence the statements of the patient during the exam.

- Speak directly to the patient, even when an interpreter or others are present.
- If a patient has communication problems, use a word board, or other assistance as needed.
- Allow additional time as necessary for explanations, evaluation, medical/forensic exam and evidence collection. Do not assume the patient needs special help. Ask permission before touching or helping.
- Guidelines and forms regarding mandatory reporting requirements when the patient is developmentally disabled are in Appendix E.

Undocumented Immigrants

- If the patient or someone in the patient's family is undocumented then they are unlikely to seek medical care.
- The State of Connecticut will reimburse health care facilities for the cost of the sexual assault exam and evidence collection, regardless of immigration status.
- Patients can receive care without Immigration and Customs Enforcement (ICE) being contacted. Victims of sexual assault may qualify for temporary immigration benefits through the Department of Homeland Security. Information may be obtained at: <https://www.uscis.gov/i-918>

Human Trafficking

Sexual assault is clearly a part of sex trafficking, but sexual assault is often a part of labor trafficking cases as well. Some considerations when working with potential sex and labor trafficking victims:

- Be mindful of your language; do not use words such as “prostitute” when speaking with or about the patient.
- In cases of sex trafficking, a patient may be branded with a tattoo of the pimp’s name.
- Because of the grooming process, many sex trafficking victims may not openly identify as being a victim of trafficking.

- Labor trafficking victims may fear reporting to law enforcement, especially if they are immigrants and their papers are being held by their traffickers.
- In Connecticut, no one under the age of 18 can be arrested for prostitution. This may be beneficial information to share with patients.

If a patient is suspected of being a victim of human trafficking, call the DCF Careline immediately at 1-800-842-2288.

Appendix B

Pediatric Population

- **General Information**
- **Consent for Exam and Evidence Collection**
- **Counseling and Support**
- **Algorithm for Care**

General Information

- The *Technical Guidelines* is intended as a reference for the adult and adolescent sexual assault patient. However, the information contained in this Appendix is intended to be used as a resource when a pre-pubescent child presents as a patient.

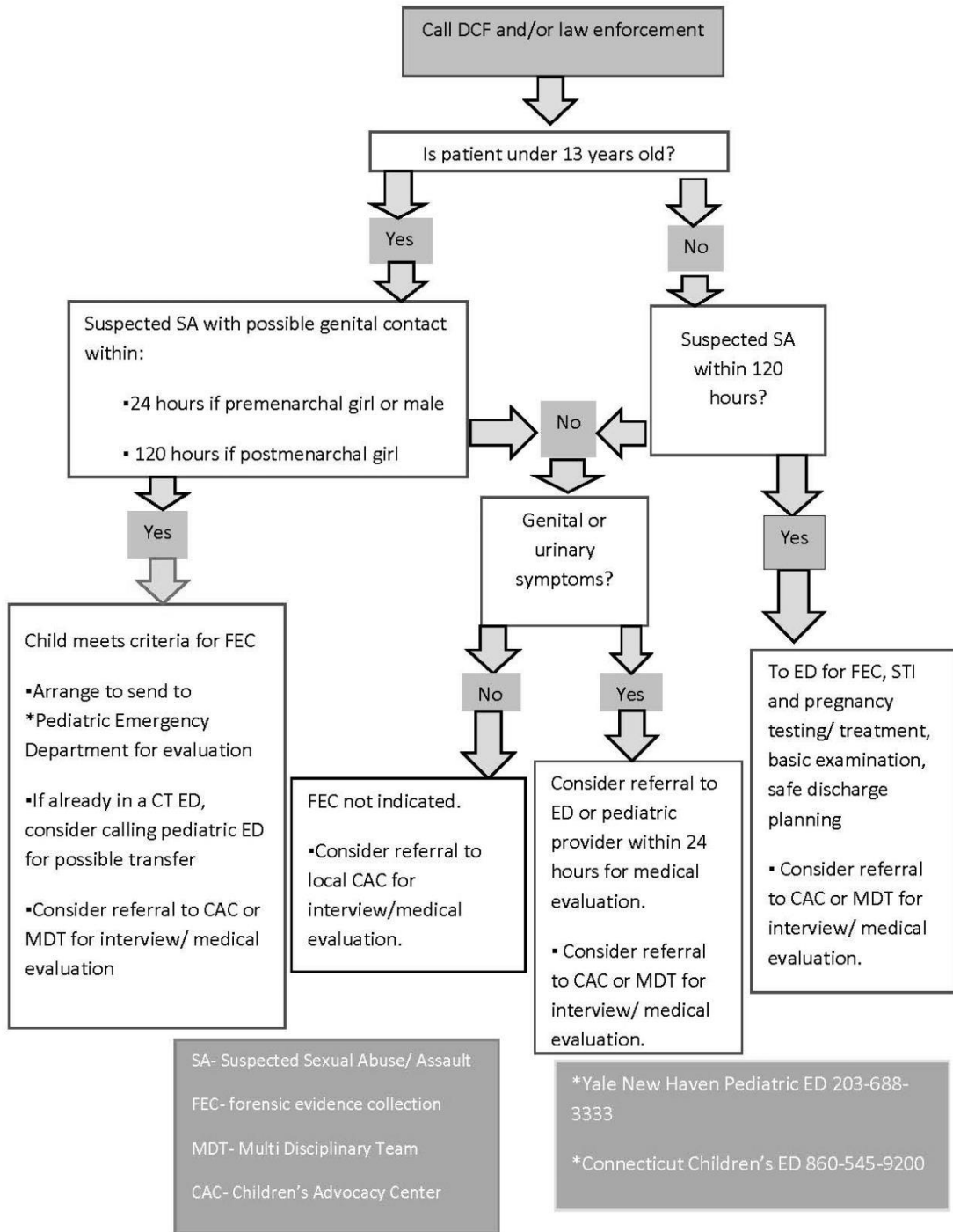
Consent for Examination and Evidence Collection

- **Under 13:** Consent for evidence collection (verbal will suffice) should be obtained from the parent/guardian of every child under the age of 13 (except as described below). Consent should also be obtained from every child under the age of 13 who is capable of doing so.
- No patient should be forced against her/his will to undergo a sexual assault examination and evidence collection.
- In the event that the parent/guardian refuses to consent to an examination of the child, and if it is believed that the child is in danger from her/his caretakers and is in need of immediate attention, the attending physician may take the child into custody at the hospital for a period of 96 hours [CGS § 17a-101(g)]. This allows health care personnel to provide immediate assessment, diagnosis and treatment, and allows child protective and law enforcement agencies to investigate any sexual assault/abuse, and protect the child from further danger.

Counseling and Support

- The Connecticut Alliance to End Sexual Violence (The Alliance) should be always called to ensure the presence of a support person.
- The Alliance has advocates specially trained to provide support for cases involving children. They may be reached at 1-888-999-5545.

Suspected Pediatric Sexual Abuse/Assault



References: Adams, JA et al. Guidelines for the care of children who may have been sexually abused, *Journal of pediatric and adolescent gynecology*, 29 (16), 81-87.

National Protocol for Sexual Abuse Medical Forensic Examinations, *Pediatric* April 2016 Department of Justice, Office of Violence Against Women Mackenzie B. Jenny C. The Use of Alternate Light Sources in the Clinical Evaluation of Child Abuse and Sexual Assault. *Pediatric Emergency Care* 2014; 30(3): 207-210.

Jenny C. Emergency Evaluation of Children when Sexual Assault is Suspected. *Pediatrics* 2011; 128(2): doi: 10.1542/peds.2011-1455

Appendix C

CT100B and CT400A Forms

CT100B:

- **Consent Form: Authorization and Release of Payment**
- **Page 1: Medical Report and History**
- **Page 1A: Medical Report and History (continued)**
- **Page 1B: Medical Report and History (continued)**
- **Page 2: Medical Report and History (final)**
- **Page 3: Physical Exam: Non – genital**
- **Page 4: Physical Exam: Non – genital (continued)**
- **Page 5: Physical Exam: Genital**
- **Page 6: Signature Page**
- **Page 7: Checklist**
- **Page 8: Discharge Instructions**

CT400A:

- **Consent Form**
- **Documentation**

**AUTHORIZATION FOR SEXUAL ASSAULT MEDICAL EXAMINATION
AND RELEASE OF PAYMENT INFORMATION**

I _____ consent to allow _____
(Name of Patient) (Name of Examiner)

and any assistant(s) to conduct a physical examination for the purpose of identifying and treating injury and collecting evidence to a sexual assault.

I. THE SEXUAL ASSAULT EXAMINATION AND EVIDENCE COLLECTION

This examination has been fully explained to me. I understand the nature of the examination and that the information gathered may be used in a court of law, if I choose to report this crime to law enforcement. I understand this examination may include clinical observation for the presence of injury and the collection of specimens for laboratory analysis, including testing for pregnancy and sexually transmitted infections, and that the examiner may provide me with medication(s) to prevent sexually transmitted infections or pregnancy. I understand that I can stop the examination at any time or withdraw my consent to any portion of the examination or to any evidence collection procedure(s) at any time.

II. REPORT TO LAW ENFORCEMENT NOT REQUIRED FOREXAMINATION

I understand that I am not required to report the sexual assault to law enforcement at this time or at any other time to have an exam and evidence collected, or to have the examination and medical care paid for by the Connecticut Office of Victim Services (OVS). If I do not immediately report the assault to law enforcement, I understand that the evidence collected will be held up to 5 years, during which time the evidence will be identified by a control number, not by my name. If I decide to report to law enforcement after 5 years following the assault, I understand that the evidence collected during the exam may no longer be available for use in prosecution.

III. AVAILABILITY OF CERTIFIED SEXUAL ASSAULT COUNSELOR/ADVOCATE

I understand that I have the right to speak to a certified sexual assault advocate and to have the sexual assault advocate present during the examination, if I choose. I understand that if the hospital has not called for a sexual assault advocate, I can request that one be contacted immediately. I understand that the services of the sexual assault advocate are confidential and free of charge.

IV. PAYMENT AND RELEASE OF PAYMENT

I understand that the costs of the sexual assault medical examination and evidence collection, including the cost for a pregnancy test, tests for sexually transmitted infections, and for any medication(s) to prevent sexually transmitted infections or pregnancy that I may be given, will be paid for by OVS. I understand that I am not required to report the sexual assault to law enforcement to have the examination paid for by OVS when evidence is collected. I understand that the hospital will not bill me or my insurance company (if any) for these costs. I authorize _____ (Name of Hospital) to send billing information to OVS to obtain payment. I also understand that in the event that I have physical injuries requiring medical treatment beyond the scope of the sexual assault examination that the hospital will bill me or my insurance company (if any) for the costs of any additional medical treatment. If I receive a bill that I have questions about, I can call OVS, at 1-888-286-7347, or an advocate with the Connecticut Alliance to End Sexual Violence at 1-888-999-5545.

I understand that I may be eligible for financial assistance for any unreimbursed medical costs from the Office of Victim Services. Call OVS at 1-888-286-7347 for more information.

Patient Signature Date

Parent/Guardian Signature (if applicable) Date

Control Number (if applicable): _____

Bar Code Number: CT - _____
(Located on side of Kit)

White — Patient File

Yellow — Patient

Pink — Billing

(2017)

CT1008A/1.6/17

**STATE OF CONNECTICUT
SEXUAL ASSAULT MEDICAL REPORT**

(02S 19a-112a) Revised June 2017

1. HEALTHCARE FACILITY: _____

a. Date and Time of Patient Arrival: _____
 _____ Month Day Year Time

2. MEDICAL HISTORY AS RELATED BY PATIENT

a. Chief Complaint: _____

b. Date and Time of Assault: _____
 _____ Month Day Year Time

c. Summary of Assault:



PATIENT LABEL (if handwritten, record name, MR # and DOB.)

_____ **Print Name**

 Signature _____ Date

**STATE OF CONNECTICUT
SEXUAL ASSAULT MEDICAL REPORT**

(025 19a-112a) Revised June 2017

Empty box for patient label information.

2. MEDICAL HISTORY AS RELATED BY PATIENT

c. Summary of Assault (cont'd):

Multiple horizontal lines for writing the summary of assault.

PATIENT LABEL (if handwritten, record name, MR # and DOB.)

Print Name

Signature

Date

PATIENT FILE — (All White Copies)
ENVELOPE ON KIT BOTTOM — (Yellow Copy of Page 1A)

1A

PAGE ____ OF ____

CT1008: MEDREP-1A.1 6/17

**STATE OF CONNECTICUT
SEXUAL ASSAULT MEDICAL REPORT**

(025-19a-112a) Revised June 2017

[Empty box for patient information]

2. MEDICAL HISTORY AS RELATED BY PATIENT

c. Summary of Assault (cont'd):

PATIENT LABEL (if handwritten, record name, MR # and DOB.)

[Lined area for medical history text]

Print Name

Signature _____ **Date** _____

2. MEDICAL HISTORY AS RELATED BY PATIENT (cont'd)

- a. Gender at Birth: F M
 Preferred Gender: F M
- b. Offender: F M Unsure

c. Number of Offenders: _____

d. Nature of Sexual Assault (check all that apply):

N/A <input type="checkbox"/>	Contact by Offender's				
	Penis	Hand	Mouth	Other	Unsure
Patient's Mouth					
Patient's Breasts					
Patient's Vagina					
Patient's Penis					
Patient's Anus					
Patient's Body Parts					
Specify Body Parts:					

N/A <input type="checkbox"/>	Penetration by Offender's				
	Penis	Hand	Mouth	Other	Unsure
Patient's Mouth					
Patient's Breasts					
Patient's Vagina					
Patient's Penis					
Patient's Anus					
Patient's Body Parts					
Specify Body Parts:					

N/A <input type="checkbox"/>	Ejaculation		
	Yes	No	Unsure
Patient's Mouth			
Patient's Breasts			
Patient's Vagina			
Patient's Penis			
Patient's Anus			
Patient's Body Parts			
Specify Body Parts:			

Did offender:	Yes	No	Unsure
Use lubricant?			
Use a condom?			
Insert foreign object?			

PATIENT LABEL (If handwritten, record name, MR # and DOB.)

Between the assault and the present, has the patient:		
	Yes	No
Urinated		
Defecated		
Wiped off		
Washed off		
Douched		
Bathed		
Showered		
Rinsed mouth		
Brushed teeth		
Eaten		
Drank		
Vomited		
Changed Clothes		
If clothes were changed, what was changed?		

Was patient menstruating at the time of assault?
 Yes No Unsure N/A

If yes, was tampon/napkin present?
 Yes No Unsure

Nature of physical assault, if applicable (specify, e.g., struck, bit, strangled, etc.): _____

Briefly describe any resulting physical injuries to patient:

Did patient bleed as a result of the physical injuries?
 Yes No Unsure

Describe any injuries to offender: _____

Did offender bleed as a result?
 Yes No Unsure

Print Name _____

Signature _____

Date _____

3. PAST MEDICAL HISTORY

a. Medical/Surgical History:

PATIENT LABEL (If handwritten, record name, MR # and DOB.)

Allergies: NKDA

Medications and Indications: No medications currently being taken:

Medical History: N/A:

Surgical History: N/A:

b. Gynecological History:

Date of last menstrual period: _____

Does patient use contraception? Yes: No: If yes, what type: _____

Is patient pregnant? Yes: No: Unsure:

If yes, duration of pregnancy: _____

Print Name

Signature

Date

4. PHYSICAL EXAMINATION
(Use only non-lubricated gloves)

a. Describe patient's outward appearance (e.g., torn clothing, missing shoe(s), messed/matted hair, etc.):

b. Document location, description and measurement of all injuries and abnormal findings. Describe any pattern of injury. Check box and use the back of pages 4 - 6 as needed for additional documentation.

General: _____

HEENT: _____

Neck: _____

Chest: _____

Back: _____

Breasts: _____

Heart/Lungs: _____

Abdomen: _____

Upper Extremities: _____

Lower Extremities: _____

Neurologic: _____

Skin: _____

Other: _____

c. Describe affect observed during examination (e.g., tearful, trembling, quiet, flat affect, etc.):

Diagram A



Documentation on back of page 4

PATIENT LABEL (If handwritten, record name, MR # and DOB.)

Diagram B



Diagram C

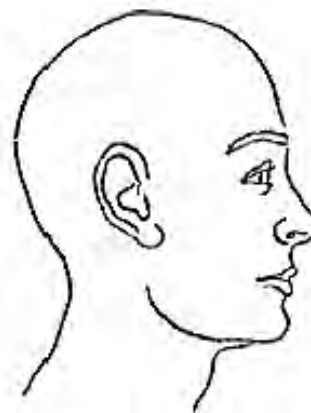
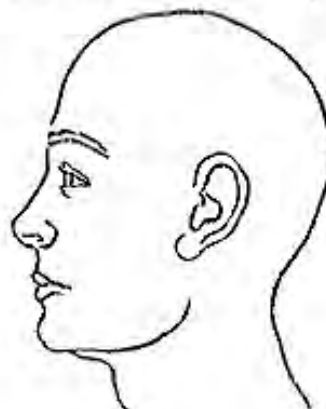


Diagram D



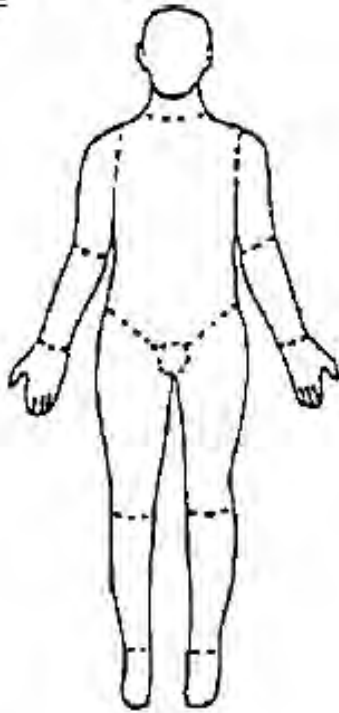
Print Name _____

Signature _____

Date _____

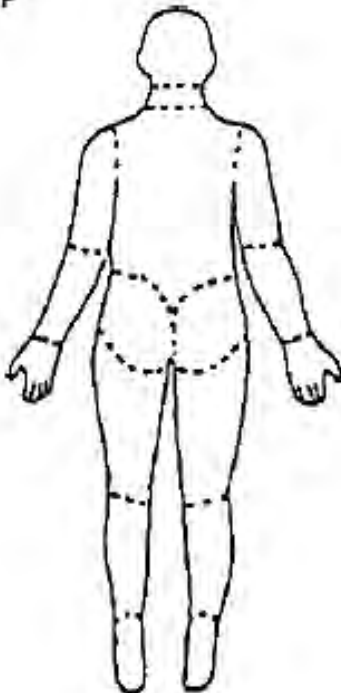
4. PHYSICAL EXAMINATION (cont'd)
(Use only non-lubricated gloves)

Diagram E



FRONT

Diagram F



BACK

Documentation on back of page 5

PATIENT FILE

PATIENT LABEL (if handwritten, record name, MR # and DOB.)

Diagram G



RIGHT SIDE

Diagram H



LEFT SIDE

Print Name _____

Signature _____

Date _____

5. GENTALIA EXAMINATION
(Use only non-lubricated gloves)

a. Colposcope used? Yes No

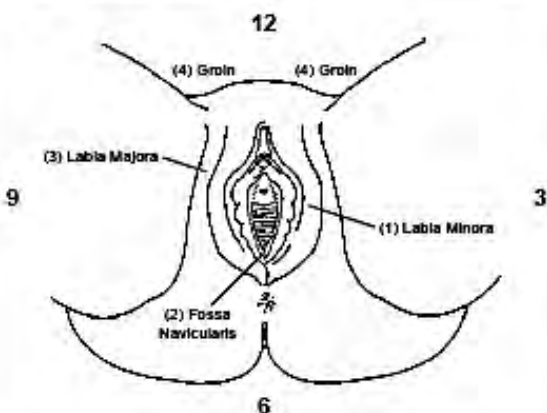
If yes, magnification: _____

Video or Photographs? Yes No

PATIENT LABEL (If handwritten, record name, MR # and DOB.)

b. FEMALE GENTALIA EXAMINATION:

Note any abnormalities and/or signs of trauma. Identify location of findings using the face of a clock (i.e. "1 cm laceration at 5 o'clock"). Also note any traces of lubricants or rectal soiling. Check box and use back of page as needed for additional documentation.



Labia Majora: _____

Labia Minora: _____

Introitus/Hymen: _____

Meatus: _____

Clitoral Hood: _____

Fossa Navicularis: _____

Vagina: _____

Cervix: _____

Posterior Fourchette: _____

Perineum: _____

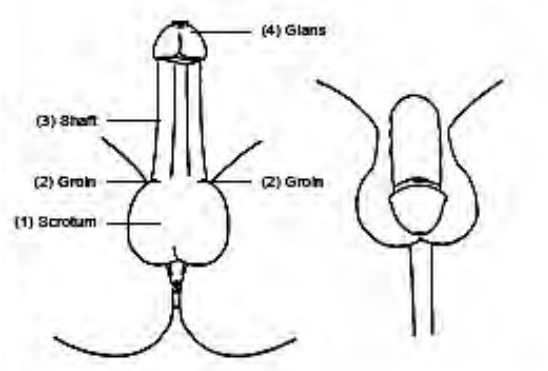
Anus: _____

Rectum: _____

Documentation on back of page 6

c. MALE GENTALIA EXAMINATION:

Note any abnormalities and/or signs of trauma. Also note any traces of lubricants or rectal soiling. Check box and use back of page as needed for additional documentation.



Penile Shaft: _____

Foreskin: _____

Scrotum: _____

Meatus: _____

Glans: _____

Testicles: _____

Perineum: _____

Anus: _____

Rectum: _____

Print Name _____

Signature _____

Date _____

6. LABORATORY SPECIMENS COLLECTED
(Note specific type of test performed)

	Pharynx	Cervix	Urethra	Rectum
GC Test:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chlamydia Test:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Yes	No
BV: _____			<input type="checkbox"/>	<input type="checkbox"/>
Trichomoniasis: _____			<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy Test: _____			<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B Test: _____			<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis C Test: _____			<input type="checkbox"/>	<input type="checkbox"/>
Syphilis: _____			<input type="checkbox"/>	<input type="checkbox"/>
Other: _____			<input type="checkbox"/>	<input type="checkbox"/>

7. TREATMENT
(Note specific medications and doses)

	Yes	No
GC: _____	<input type="checkbox"/>	<input type="checkbox"/>
Chlamydia: _____	<input type="checkbox"/>	<input type="checkbox"/>
BV: _____	<input type="checkbox"/>	<input type="checkbox"/>
Trichomoniasis _____	<input type="checkbox"/>	<input type="checkbox"/>
nPEP: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B Prophylaxis: _____	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy Prophylaxis: _____	<input type="checkbox"/>	<input type="checkbox"/>
Anti-emetic: _____	<input type="checkbox"/>	<input type="checkbox"/>
Laceration Repair: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus: _____	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

8. ADDITIONAL INFORMATION

PATIENT LABEL (If handwritten, record name, MR # and DOB.)

9. SIGNATURES

(Print name of interpreter, if applicable) (phone #)

(Print street address) (City) (State) (Zip)

(Print name of SAFE/RN)

(Signature of SAFE/RN) (Date)

(Print name of Physician or other Provider)

(Signature of Physician or other Provider) (Date)

10. EVIDENCE COLLECTION

a. Forensic Evidence/CT100B Kit completed? Yes No
Kit Completed by: _____

b. Toxicology/CT400A Kit completed? Yes No
Kit Completed by: _____

c. Photographs taken? Yes No

d. Evidence transfer:
 Photographs Toxicology/CT400A
 Forensic Evidence/CT100B
 Clothes

Stored by:

(Print name)

Given to law enforcement by:

(Print name)

(Signature) (Date)

Received by:

(Print name and badge # of police officer)

(Department/Unit)

(Signature) (Date)

Print Name

Signature Date

**STATE OF CONNECTICUT
SEXUAL ASSAULT DISCHARGE INSTRUCTIONS**

(CGS 19a-112a) Revised June 2017

1. YOU HAVE BEEN TESTED FOR:

	Yes	No
Gonorrhea: _____	<input type="checkbox"/>	<input type="checkbox"/>
Chlamydia: _____	<input type="checkbox"/>	<input type="checkbox"/>
Trichomonas: _____	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis: _____	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B: _____	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

These tests will usually tell if you had the infection or condition prior to your hospital visit. It is very important that you have a follow-up exam and tests within 2 weeks to be sure you did not contracted sexually transmitted infections (STI) from the assault.

2. YOU HAVE RECEIVED THE FOLLOWING:

a. Medications for:

	Yes	No
STI: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B: _____	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy Prophylaxis: _____	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/Vomiting: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus: _____	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

b. Treatment/Diagnosis: (Specify treatment and follow-up instructions)

Wound Care: _____
 X-Ray: _____
 Other: _____

3. FOLLOW-UP INSTRUCTIONS

a. Medical Follow-Up:

- 1) It is important that you take all medications and follow all instructions given to you.
- 2) You should refrain from sexual activities until your follow-up is completed.

Doctor: _____

Address: _____

Phone #: _____

You are responsible for making your follow-up appointment.

PATIENT LABEL (if handwritten, record name, MR # and DOB.)

**b. Sexual Assault Counseling/Advocacy Follow-Up
TOLL FREE STATEWIDE HOTLINES
English: 1-888-999-5545 Spanish: 1-888-568-8332**

A sexual assault advocate is available to provide free and confidential information, advocacy and counseling to you and your family 24 hours a day, 7 days a week.

Your local program: _____

4. IMPORTANT NAMES AND NUMBERS:

Health Care Facility: _____

Examiner: _____

Phone #: _____

Sexual Assault Counselor: (seen during visit)

Name: _____

Phone #: _____

Investigating Police Department: _____

Officer seen during visit: _____

Phone #: _____

Case # (if applicable): _____

Kit Control # (if applicable): _____

**Office of Victim Service's Victim Compensation Program
Monday - Friday 8:00am - 4:30pm
1-888-286-7347**

I have read and understand the above information.

(Signature of Patient/Patient's Representative) Date

Relationship to Patient

Discharge Instructions Completed by

am / pm

Date and Time of Discharge

Print Name

Signature Date

PLEASE BRING THIS FORM WITH YOU TO FOLLOW-UP VISITS

**STATE OF CONNECTICUT
SEXUAL ASSAULT CHECKLIST**

(025-19a-112a) Revised June 2017

PATIENT LABEL (if handwritten, record name, MR # and DOB.)

	YES	NO	COMMENTS
1. Connecticut Alliance to End Sexual Violence notified English: 1-888-999-5545 Spanish: 1-888-568-8332			
2. Law Enforcement notified			
3. Patient's clothing obtained			
4. History and physical examination done			
5. State of Connecticut Sexual Assault Medical Report completed			
6. Sexual Assault Evidence Collection Kit completed and sealed (if applicable) CT100B			
7. Toxicology Screen Evidence Collection Kit completed and sealed (if applicable) CT400A			
8. Additional evidence collected (e.g., photographs, etc.— specify)			
9. Hospital laboratory specimens collected			
10. Identification and chain of custody information on all Kits and bags completed (specify whether name or control number used.)			
11. "Moist Specimen" sticker applied to CT100B Kit box (if applicable)			
12. Yellow copy of Medical Report (plus copies of any additional medical history pages) sealed in envelope attached to Kit bottom			
13. Clothing bag(s) and CT100B Kit given to Law Enforcement			
a. Clothes held as evidence (please list)			
b. Shoes held as evidence (please describe)			
c. Other held as evidence (please list)			
14. Toxicology Screen Evidence Collection Kit given to Police CT400A			
15. Prophylactic medications administered (e.g., pregnancy, anti-emetic, STI, Hepatitis B)			
16. Follow-up care referrals made			
17. YELLOW copy of Consent and Discharge form given to patient			
18. Information for Sexual Assault Victims and Their Families brochure given to patient			
19. Other (Specify)			
20. Protective Services notified — mandated reports made			
a. Children: Department of Children and Families Child Abuse and Neglect Hotline (1-800-842-2288) DFC-136 form completed			
b. Elderly: Department of Social Services Community resident (1-888-385-4225 business hours; 2-1-1 non-business hours) Long Term Care resident (1-888-385-4225 business hours; 2-1-1 non-business hours) W-875 form completed			
c. Adult (18-59) with Mental Retardation: Office of Protective and Advocacy for Persons with Disabilities Abuse Investigation Division Hotline: (1-860-418-6000) PA-6 form completed			

Checklist Completed By
(Please print name)

PATIENT FILE



CONSENT FOR TOXICOLOGY SCREEN

CT400A-TOX

CGS19a-112a

PATIENT LABEL (If handwritten, record name, MR number, and birth date).

To Examining Clinician:

Please review information in this form with patient, allowing ample time to discuss any questions the patient may have. **It is important that the patient understand all segments of this form prior to signing it.** If patient chooses to consent to toxicology screen:

- (1) Have patient sign and date the form in the space(s) indicated
- (2) Provide your signature and date in the space(s) indicated
- (3) Place the white copy of this form in patient's medical record and give the yellow copy to the patient.

To Patient:

Please read and review all information in this form with the clinician prior to signing it. Please discuss any questions you may have to ensure that you understand all of the information presented. If you choose to consent to toxicology screen, provide your signature and date in the space(s) indicated.

Report to Law Enforcement Not Required for Toxicology Screen

If I do not immediately report the assault to the police, I understand that the evidence collected will be held up to 5 years, during which time the evidence will be identified by a control number, not by my name. If I decide to report to law enforcement after 5 years following the assault, I understand that the evidence collected during the exam may no longer be available for use in prosecution.

I consent to and authorize the collection of blood and/or urine samples for the purpose of detecting the presence of drugs or other substances that may have caused impairment.

I understand that blood samples must be obtained within 48 hours of the suspected drugging incident and urine must be obtained within 120 hours (5 days) of the suspected drugging incident.

I understand that the toxicology screen may detect any substances, medications or drugs (both legal and illegal) that may be in my system from the weeks prior to this incident.

I understand that the results of the toxicology screen may be very important for the possible arrest and prosecution of the offender.

I have discussed the toxicology screen with the clinician and have had an opportunity to ask questions and discuss concerns.

Signature of Patient

Date/Time

Signature of Clinician

Date/Time

WHITE COPY - MEDICAL RECORDS

YELLOW COPY - PATIENT
CT400ATOX/CF 1 B/17



STATE OF CONNECTICUT TOXICOLOGY SCREEN EVIDENCE COLLECTION KIT INSTRUCTIONS

NOTES

- A) This Kit should be used only when medically indicated, the patient or accompanying person states the patient may have been drugged, or the patient suspects drug involvement due to lack of recollection of events.
- B) This Kit should be completed only with patient consent. To enable patient to give informed consent, discuss information on consent form with patient prior to obtaining patient's signature.
- C) If patient consents to toxicology screen, samples should be collected even if patient is undecided about reporting the assault to police. If reported, the results will go to law enforcement and/or prosecutor's office. If not reported, the Kit will be held under a control number for up to 5 years.
- D) Collect specimens as follows:
 - Collect blood if suspected drugging incident was within 48 hours.
 - Collect urine, in addition to blood, if suspected drugging incident was within 120 hours.

STEP 1 Remove all components from Kit.

STEP 2 Review enclosed consent form with patient and obtain patient's signature on form.

Blood Specimen Collection

Note: Blood specimen collection must be performed only by a physician, registered nurse, licensed phlebotomist, or trained facility technician.

STEP 3 Cleanse the blood collection site with the alcohol-free prep pad provided. Following normal hospital/clinic procedure, withdraw blood specimens from patient, allowing both tubes to fill to maximum volume (10 mL).

Note: Immediately after blood collection, assure proper mixing of anticoagulant powder by slowly and completely inverting the blood tube at least 5 times. **Do not shake vigorously!**

STEP 4 Fill out all information requested on 2 of the 3 Specimen Security Seals provided. Remove backing from the 2 Specimen Seals. Affix center of seals to the blood tube rubber stoppers and press ends of seals down sides of the blood tubes. Return blood tubes to specimen holder.

Urine Specimen Collection

STEP 5 Have patient provide mid-stream urine specimen in bottle provided. A minimum of 30 mL is desired.

STEP 6 After specimen is collected, replace cap and tighten to prevent leakage.

STEP 7 Fill out information requested on the remaining Specimen Security Seal. Affix center of seal to the bottle cap and press ends of seal down sides of bottle. Return urine bottle to specimen holder.

STEP 8 Complete label on zip lock bag. Place specimen holder inside the zip lock bag, then squeeze out excess air and close bag. Place specimen holder in Kit.

Note: **Do not remove liquid absorbing sheet from specimen bag.**

STEP 9 Close Kit lid and affix kit box Evidence Seal where indicated.

STEP 10 Fill out all information requested on Kit top under "Medical Personnel."

STEP 11 Transfer sealed Kit to appropriate police department. Maintain Chain of Custody.

Note: If officer is not present at this time, place sealed Kit in secure refrigerated storage area until transfer to Law Enforcement.

**STATE OF
CONNECTICUT
CT 400A
TOXICOLOGY SCREEN
EVIDENCE COLLECTION
KIT DOCUMENTATION**



PATIENT LABEL (if handwritten, record name, MR number, and birth date).

Date/Time of Assault: _____

Time Blood collected: _____ Time Urine collected: _____

Patient symptoms: Circle all that apply

Drowsiness

Dizziness

Light-headedness

Memory Loss

Disorientation

Fatigue

Nausea

Vomiting

Loss of Consciousness

Severe Intoxication

Impaired Motor Skills

Other:

1) Length of time unresponsive, if known: _____

2) Estimated time lapse between suspected drugging incident and sample collection: _____

3) Amount of alcohol ingested: _____

4) Number of times patient voided before collection of urine for toxicology: _____

5) Summary of case history: _____

6) Medications and/or drugs (legal or illegal) ingested and time frame: _____

Appendix D

Strangulation Assessment

**Recommendations for the Medical/Radiographic Evaluation
of
Acute Adult, Non-Fatal Strangulation**

The *Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations* gratefully acknowledges Alliance for HOPE International, Bill Smock, MD, and Sally Sturgeon, DNP, SANE-A, for allowing us to reproduce, in part or in whole, the RECOMMENDATIONS for the MEDICAL/RADIOGRAPHIC EVALUATION of ACUTE ADULT, NON-FATAL STRANGULATION. The documents were accessed through the online Resource Library hosted by the Training Institute on Strangulation Prevention.



RECOMMENDATIONS for the MEDICAL/RADIOGRAPHIC EVALUATION of ACUTE ADULT, NON-FATAL STRANGULATION

Prepared by Bill Smock, MD and Sally Sturgeon, DNP, SANE-A
Office of the Police Surgeon, Louisville Metro Police Department

Endorsed by the National Medical Advisory Committee: Bill Smock, MD, Chair; Cathy Baldwin, MD; William Green, MD;
Dean Howley, MD; Ralph Raviello, MD; Heather Rozzi, MD; Steve Slapczynski, MD; Ellen Telford, MD; Michael Weaver, MD



- GOALS:**
1. Evaluate carotid and vertebral arteries for injuries
 2. Evaluate bony/cartilaginous and soft tissue neck structures
 3. Evaluate brain for anoxic injury

Strangulation patient presents to the Emergency Department

History of and/or physical exam with ANY of the following:

- Loss of Consciousness (anoxic brain injury)
- Visual changes: "spots", "flashing light", "tunnel vision"
- Facial, intraoral or conjunctival petechial hemorrhage
- Ligature mark or neck contusions
- Soft tissue neck injury/swelling of the neck/cartoid tenderness
- Incontinence (bladder and/or bowel from anoxic injury)
- Neurological signs or symptoms (LOC, seizures, mental status changes, amnesia, visual changes, cortical blindness, movement disorders, stroke-like symptoms.)
- Dysphonia/Aphonia (hematoma, laryngeal fracture, soft tissue swelling, recurrent laryngeal nerve injury)
- Dyspnea (hematoma, laryngeal fractures, soft tissue swelling, phrenic nerve injury)
- Subcutaneous emphysema (tracheal/laryngeal rupture)

Recommended Radiographic Studies to Rule Out Life-Threatening Injuries* (including delayed presentations of up to 6 months)

- CT Angio of carotid/vertebral arteries (GOLD STANDARD for evaluation of vessels and bony/cartilaginous structures, less sensitive for soft tissue trauma) or
- CT neck with contrast (less sensitive than CT Angio for vessels, good for bony/cartilaginous structures) or
- MRA of neck (less sensitive than CT Angio for vessels, best for soft tissue trauma) or
- MRI of neck (less sensitive than CT Angio for vessels and bony/cartilaginous structures, best study for soft tissue trauma) or
- MRI/MRA of brain (most sensitive for anoxic brain injury, stroke symptoms and intercerebral petechial hemorrhage)
- Carotid Doppler Ultrasound (NOT RECOMMENDED: least sensitive study, unable to adequately evaluate vertebral arteries or proximal internal carotid)*. References on page 2

History of and/or physical exam with:

- No LOC (anoxic brain injury)
- No visual changes: "spots", "flashing light", "tunnel vision"
- No petechial hemorrhage
- No soft tissue trauma to the neck
- No dyspnea, dysphonia or odynophagia
- No neurological signs or symptoms (i.e. LOC, seizures, mental status changes, amnesia, visual changes, cortical blindness, movement disorder, stroke-like symptoms)
- And reliable home monitoring

Discharge home with detailed instructions to return to ED if: neurological signs/symptoms, dyspnea, dysphonia or odynophagia develops or worsens

(-) Continued ED/Hospital Observation (based on severity of symptoms and reliable home monitoring)

- (+)
- Consult Neurology/Neurosurgery/Trauma Surgery for admission
 - Consider ENT consult for laryngeal trauma with dysphonia



RECOMMENDATIONS for the MEDICAL/RADIOGRAPHIC EVALUATION of ACUTE ADULT, NON-FATAL STRANGULATION



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Appendix E

Mandatory Reporting Information and Forms

- **Abuse of Children – Reporting Information**
 - **DCF Form 136: Report for Suspected Child Abuse/Neglect**
- **Abuse of Elderly (non-nursing home) – Reporting Information**
 - **Form W – 675: Report for Protective Services**
- **Abuse of Elderly (nursing home) – Reporting Information**
 - **Form W – 410: Long-term Care Ombudsman Program**
- **Abuse of Developmentally Disabled Adults – Reporting Information**
 - **Form PA- 6: Report of Suspected Abuse**

Child Abuse and Neglect Careline

505 Hudson Street

Hartford, CT 06106

Careline Phone Number for Oral Report: 1-800-842-2288

FAX: 860-560-7073

REPORT OF SUSPECTED CHILD ABUSE OR NEGLECT

DCF-136
05/2015 (Rev.)



Careline
1-800-842-2288

Within forty-eight hours of making an oral report, a mandated reporter shall submit this form (DCF-136) to the relevant Area Office listed below. See the reverse side of this form for a summary of Connecticut law concerning the protection of children.

Please Print or Type

Child's Name	<input type="checkbox"/> M <input type="checkbox"/> F	Age Or DOB	Race:	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black/African American (not of Hispanic Origin)	<input type="checkbox"/> Hispanic <input type="checkbox"/> White (not of Hispanic origin) <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____
Child's Address					
Name Of Parents Or Other Person Responsible For Child's Care			Address		Phone Number
Name Of Careline Worker To Whom Oral Report Was Made			Date Of Oral Report	Date And Time Of Suspected Abuse/Neglect	
Name Of Suspected Perpetrator, If Known			Address And Phone Number, If Known		Relationship To Child
Nature And Extent Of Injury(ies), Maltreatment Or Neglect					
Describe The Circumstances Under Which The Injury(ies), Maltreatment Or Neglect Came To Be Known					
Describe The Reasons Such Persons(s) Are Suspected Of Causing Such Injuries, Maltreatment Of Neglect					
Information Concerning Any Previous Injury(ies), Maltreatment Or Neglect Of The Child Or His/Her Siblings					
Information Concerning Any Prior Cases(s) In Which The Person(s) Have Been Suspected Of Causing An Injury(ies), Maltreatment Or Neglect Of A Child					
List Names And Ages Of Siblings, If Known					
What Action, If Any, Has Been Taken To Treat, Provide Shelter Or Otherwise Assist The Child?					

REPORTER SECTION

Reporter's Name:	Reporter's Race	
Agency Name:	<input type="checkbox"/> American Indian or Alaskan Native	
Phone Number:	<input type="checkbox"/> Asian/Pacific Islander	
Agency Address:	<input type="checkbox"/> Black/African American (not of Hispanic Origin)	
City:	<input type="checkbox"/> Hispanic (any race)	
	<input type="checkbox"/> White (not of Hispanic origin)	
	<input type="checkbox"/> Prefer Not to Answer	
	<input type="checkbox"/> Other _____	
Reporter's Signature	Position	Date

WHITE COPY: TO DCF AREA OFFICE (see below)

IF YOU NEED ADDITIONAL SPACE, YOU MAY ATTACH MORE DOCUMENTATION

Bridgeport 100 Fairfield Avenue Bridgeport, CT 06604 203-384-5300 TDD: 203-384-5399 Fax: 203-384-5306	Danbury 131 West Street Danbury, CT 06810 203-207-5100 TDD: 203-748-8325 Fax: 203-207-5169	Hartford 250 Hamilton Street Hartford, CT 06106 860-418-8000 TDD: 800-315-4082 Fax: 860-418-8325	Manchester 364 West Middle Turnpike Manchester, CT 06040 860-533-3600 TDD: 800-315-4415 Fax: 860-533-3734	Norwalk 761 Main Avenue, I-Park Complex Norwalk, CT 06851 203-899-1400 TDD: 203-899-1491 Fax: 203-899-1463, 203-899-1464
Meriden One West Main Street Meriden CT 06451 203-238-8400 TDD: 203-238-8517 Fax: 203-238-6425	Middletown 2081 South Main Street Middletown, CT 06457 860-638-2100 TDD: 860-638-2195 Fax: 860-346-0098	Milford 38 Wellington Road Milford, CT 06461 203-306-5300 TDD: 203-306-5604 Fax: 203-306-5606	New Britain One Grove Street, 4th Floor New Britain, CT 06053 860-832-5200 TDD: 860-832-5370 Fax: 860-832-5491	New Haven One Long Wharf Drive New Haven, CT 06511 203-786-0500 TDD: 203-786-2599 Fax: 203-786-0660
Norwich Two Courthouse Square Norwich, CT 06360 860-886-2641 TDD: 860-885-2438 Fax: 860-887-3683	Torrington 62 Commercial Blvd Torrington, CT 06790 860-496-5700 TDD: 860-496-5798 Fax: 860-496-5834	Waterbury 395 West Main Street Waterbury, CT 06702 203-759-7000 TDD: 203-465-7329 Fax: 203-759-7295	Willimantic 322 Main Street Willimantic, CT 06226 860-450-2000 TDD: 860-456-6603 Fax: 860-450-1051	Special Investigations Unit 505 Hudson Street, 7th Floor Hartford, CT 06106 860-550-6696 FAX: 860-723-7237

SUMMARY OF LEGAL REQUIREMENTS CONCERNING CHILD ABUSE/ NEGLECT

PUBLIC POLICY OF THE STATE OF CONNECTICUT (C.G.S. §17a-101)

To protect children whose health and welfare may be adversely affected through injury and neglect; to strengthen the family and to make the home safe for children by enhancing the parental capacity for good child care; to provide a temporary or permanent nurturing and safe environment for children when necessary; and for these purposes to require the reporting of suspected child abuse or neglect, investigation of such reports by a social agency, and provision of services, where needed, to such child and family.

WHO IS MANDATED TO REPORT CHILD ABUSE/NEGLECT?

Child Advocate and OCA Employees	Mental Health Professionals
Chiropractors	Optometrists
Coaches and Directors of a Private Youth Sports, Organization or Team	Persons Paid to Care for Children
Coaches and Athletic Directors of Youth Athletics	Persons who Provide Services to and have Regular Contact with Students
Dental Hygienists	Pharmacists
Dentists	Physical Therapists
Department of Children and Families Employees	Physician Assistants
Domestic Violence Counselors	Podiatrists
Office of Early Childhood Employees and Department of Public Health Employees who are Responsible for Licensing Day Cares and Camps	Police Officers
Family Relations Counselors (Judicial Dept.)	Probation Officers (Juvenile or Adult)
Family Rel. Counselor Trainees (Judicial Dept.)	Psychologists
Family Services Supervisors (Judicial Dept.)	Public or Private Institution of Higher Education Administrators, Faculty, Staff, Athletic Directors, Athletic Coaches and Athletic Trainers
Licensed Foster Parents	Registered Nurses
Licensed Marital and Family Therapists	School Administrators
Licensed or Unlicensed Interns at Any Hospital	School Coaches
Licensed or Unlicensed Resident Physicians	School Guidance Counselors
Licensed Physicians	School Paraprofessionals
Licensed Practical Nurses	School Superintendents
Licensed Professional Counselors	School Teachers
Licensed Surgeons	Sexual Assault Counselors
Licensed/Certified Alcohol and Drug Counselors	Social Workers
Licensed/Certified Emergency Medical Services Providers	Substitute Teachers
Medical Examiners	
Members of the Clergy	

DO THOSE MANDATED TO REPORT INCUR LIABILITY?

No. Any person, institution or agency which, in good faith, makes or does not make a report, shall be immune from any civil or criminal liability provided such person did not perpetrate or cause such abuse or neglect.

IS THERE A PENALTY FOR NOT REPORTING?

Yes. Any person required to report who fails to do so may be prosecuted for a Class A misdemeanor and may be required to participate in an educational and training program. Any person who intentionally and unreasonably interferes with or prevents a report may be prosecuted for a Class D felony.

IS THERE A PENALTY FOR MAKING A FALSE REPORT?

Yes. Any person who knowingly makes a false report of child abuse or neglect may be fined not more than \$2,000 or imprisoned for not more than one year or both. The identity of such person shall be disclosed to the appropriate law enforcement agency and to the alleged perpetrator of the abuse.

WHAT ARE THE REPORTING REQUIREMENTS?

- An oral report shall be made by a mandated reporter by telephone or in person to the DCF Careline or to a law enforcement agency as soon as practicable, but not later than 12 hours after the mandated reporter has reasonable cause to suspect or believe that a child has been abused or neglected or placed in imminent risk of serious harm. If a law enforcement agency receives an oral report, it shall immediately notify Careline. Oral reports to the Careline shall be recorded.
- Within 48 hours of making an oral report, a mandated reporter shall submit a written report to the DCF Careline on the DCF-136, "Report of Suspected Child Abuse or Neglect."
- When a mandated reporter is a member of the staff of a public or private institution or facility that provides care for children or a public or private school, the reporter shall also submit a copy of the written report to the person in charge of such institution, school or facility or the person's designee.

DCF CHILD ABUSE AND NEGLECT CARELINE: 1-800-842-2288

STATUTORY REFERENCES: C.G.S.17a-28, §17a-101 *et seq.*; §46b-120

DEFINITIONS OF ABUSE AND NEGLECT

Abused Child: Any child who has a non-accidental physical injury, or injuries which are at variance with the history given of such injuries, or is in a condition which is the result of maltreatment such as, but not limited to, malnutrition, sexual molestation, deprivation of necessities, emotional maltreatment or cruel punishment.

Neglected Child: Any child who has been abandoned or is being denied proper care and attention, physically, educationally, emotionally, or morally or is being permitted to live under conditions, circumstances or associations injurious to his or her well-being.

Exception: The treatment of any child by an accredited Christian Science practitioner shall not by itself constitute neglect or maltreatment.

CHILD UNDER AGE 13 WITH VENEREAL DISEASE: A physician or facility must report to Careline upon the consultation, examination or treatment for venereal disease of any child who has not reached his or her 13th birthday.

DO PRIVATE CITIZENS HAVE A RESPONSIBILITY FOR REPORTING?

Yes. Any person having reasonable cause to suspect or believe that any child under the age of 18 is in danger of being abused or has been abused or neglected may cause a written or oral report to be made to the Careline or a law enforcement agency. Any person making the report in good faith is immune from any liability, civil or criminal. However, the person is subject to the penalty for making a false claim.

WHAT IS THE AUTHORITY AND RESPONSIBILITY OF THE DEPARTMENT OF CHILDREN AND FAMILIES (DCF)?

All child protective services in Connecticut are the responsibility of the Department of Children and Families.

Upon the receipt of a report of child abuse or neglect, the Careline shall cause the report to be classified, evaluated immediately and forwarded to the appropriate Area Office for the commencement of an investigation or for the provision of services within timelines specified by statute and policy.

If an investigation produces evidence of child abuse or neglect, DCF shall take such measures as it deems necessary to protect the child, and any other children similarly situated, including, but not limited to, immediate notification to the appropriate law enforcement agency, and the removal of the child from his or her home with or without the parents' consent consistent with state law.

If DCF has probable cause to believe that the child or any other child in the household is at imminent risk of physical harm from the surroundings, and that immediate removal from such surroundings is necessary to ensure the child's safety, the Commissioner or designee shall authorize any employee of DCF or any law enforcement officer to remove the child and any other child similarly situated from such surroundings without the consent of the child's parent or guardian. The removal of a child shall not exceed 96 hours. If the child is not returned home within such 96-hour period, with or without protective services, DCF shall file a motion for temporary custody with the Superior Court for Juvenile Matters.

WHAT MEANS ARE AVAILABLE FOR REMOVING A CHILD FROM HIS OR HER HOME?

- 96-Hour hold by the Commissioner of DCF or designee (see above).
- 96-Hour hold by a physician – Any physician examining a child with respect to whom abuse or neglect is suspected shall have the right to keep such child in the custody of a hospital for no longer than 96 hours in order to perform diagnostic tests and procedures necessary to the detection of child abuse or neglect and to provide necessary medical care with or without the consent of such child's parents or guardian or other person responsible for the child's care, provided the physician has made reasonable attempts to (1) advise such child's parents or guardian or other person responsible for the child's care that the physician suspects the child has been abused or neglected, and (2) obtain consent of such child's parents or guardian or other person responsible for the child's care. In addition, such physician may take or cause to be taken photographs of the area of trauma visible on a child who is the subject of such report without the consent of such child's parent's or guardian or other person responsible for the child's care. All such photographs or copies thereof shall be sent to the local police department and the Department of Children and Families.
- Bench order of temporary custody – Whenever any person is arrested and charged with an offense under Section 53-20 or 53-21 or under Part V, VI, or VII of Chapter 952, as amended, the victim of which offense was a minor residing with the defendant, any judge of the Superior Court may, if it appears that the child's condition or circumstances surrounding the case so require, issue an order to the Commissioner of the Department of Children and Families to assume immediate custody of such child and, if the circumstances so require, any other children residing with the defendant and to proceed thereon as in other cases.

WHAT IS THE CENTRAL REGISTRY OF PERPETRATORS OF ABUSE OR NEGLECT?

The Department of Children and Families maintains a registry of persons who have been substantiated as responsible for child abuse or neglect and pose a risk to the health safety or well-being of children. The Central Registry is available on a 24-hour daily basis to prevent or discover child abuse of children.

Protective Services for the Elderly

55 Farmington Avenue

Hartford, CT 06105-3730

In CT: Phone for Oral Report (during business hours): 1-888-385-4225

In CT: Phone for Oral Report (after business hours, on weekends and
holidays): Infoline - 211

Out of State: Call Infoline at 1-800-203-1234

FAX: 860-424-5091



W-675
(Rev 6/15)

STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
Report Form For Protective Services For The Elderly

**To Refer a Connecticut
Protective Service Case Call:
1-888-385-4225 Toll Free**

Call the Protective Services for the Elderly at the Department of Social Services during business hours at the toll-free line: 1-888-385-4225 or Info-line at 211 (**after business hours, weekends or state holidays**) if you have any reason to believe or suspect that the elderly person cited below is being abused, neglected, exploited or abandoned. You may complete this form and forward it to the DSS Central Office via Fax 860-424-5091 or mail to **55 Farmington Avenue, Hartford, CT 06105**.

Pursuant to Sec. 17b-451 of the Connecticut General Statutes, certain individuals are mandated to report suspected abuse, neglect, exploitation, or abandonment. If you are making a written referral, complete this form giving as much information as you have available to you.

I. INDIVIDUAL BEING REFERRED (Person in need of protection)			
(Last Name)	(First)	(M.I.)	Age: _____
Date of Birth: _____			
ADDRESS (No. & Street)		(City or Town & Zip Code)	Phone (include area code): () - _____
SOCIAL SECURITY NUMBER: _____		LANGUAGE SPOKEN: _____	
RELEVANT PERSONS: In-Home or Not in Home (attach additional sheets, if needed)			
NAME	RELATIONSHIP	CURRENT ADDRESS	
II. REASON FOR REFERRAL (Check all appropriate categories, not mutually exclusive)			
<input type="checkbox"/> Abuse <input type="checkbox"/> Neglect <input type="checkbox"/> Exploitation <input type="checkbox"/> Abandonment			
Date of Alleged Incident (If Known) _____			
Give Details (attach additional sheets, if needed): _____			
Name of Suspected Perpetrator (If Known)	Relative (Specify)	Other (Specify)	
Is State or local police involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	Official's Name, Agency, Address, and Phone (include area code):		
Individual has Physical Problems? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Give details of physical problems/limitation: _____			
Is individual on any public assistance programs? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" (Specify):			
<input type="checkbox"/> Title XIX (Medicaid) <input type="checkbox"/> SNAP <input type="checkbox"/> Town <input type="checkbox"/> SSI / SSA <input type="checkbox"/> Medicare			
Other (Specify) _____			
III. REFERRAL SOURCE:			
NAME:		ADDRESS:	
Does referral source wish to be: <input type="checkbox"/> Anonymous		Relationship to Elderly Person:	Phone (include area code):
<input type="checkbox"/> Identified <input type="checkbox"/> Does Not Want to be Identified			() - _____
Signature _____		Printed Name _____	Date _____
Persons who are deaf or hard of hearing and have a TTD/TTY device can contact DSS at 1-800-842-4524. Persons, who are blind or visually impaired, can contact DSS at 1-860-424-5040.			

Protective Services for the Elderly – Long Term Care

55 Farmington Avenue

Hartford, CT 06105-3730

FAX: 860-424-5091

To: Mandatory Reporters for Residents of Nursing Homes Long Term Care Facilities

From: Dorian Long Program Administration Manager, Social Work Services

Date: September 24, 2015

Re: Review of Procedures and Mandated Reporting Form (W-410)

This memo is to update procedures and requirements regarding Connecticut General Statutes Sec.'s 17b-407 through 17b-408, which requires that suspected abuse, neglect, exploitation or abandonment of a resident in a long-term care facility be reported to the Commissioner of the Department of Social Services (effective 7/1/99).

The statute requires any mandatory reporter who has reasonable cause to suspect or believe that a long-term care resident has been abused, neglected, exploited or abandoned, report this information, or cause a report to be made, to the Social Work Division of the Department of Social Services within 72 hours of the incident. The following are definitions from the Connecticut State Statutes, Sec. 17b-450 that pertain to this reporting requirement:

Mandatory Reporters include "...Any physician or surgeon licensed under the provisions of chapter 370, any resident physician or intern in any hospital in this state, whether or not so licensed, and any registered nurse, licensed practical nurse, medical examiner, dentist, optometrist, chiropractor, podiatrist, social worker, clergyman, police officer, pharmacist, physical therapist, long-term care facility administrator, nurse's aide or orderly in a long-term care facility, any person paid for caring for a patient in a long-term care facility, any staff person employed by a long-term care facility and any person who is a sexual assault counselor or a domestic violence counselor ."

Abuse "...includes, but is not limited to, the willful infliction of physical pain, injury or mental anguish, or the willful deprivation by a caregiver of services which are necessary to maintain physical or mental health."

Neglect" refers to the failure or inability of an elderly person to provide for him or herself the services which are necessary to maintain physical and mental health or the failure to provide or arrange for provision of such necessary services by a caregiver."

Exploitation "...refers to the act or process of taking advantage of an elderly person by another person or caregiver whether for monetary, personal, or other benefit, gain or profit."

Abandonment "...refers to the desertion or willful forsaking of an elderly person by a caregiver or foregoing of duties or the withdrawal or neglect of duties and obligations owed an elderly person by a caregiver or other person."

We receive numerous reports of resident-to-resident altercations. Incidents between residents need only be reported when the facility has made a determination that the resident who is the alleged "abuser" has

the capability to take such action "intentionally, knowingly or recklessly" or, in the case of neglect, a person is acting with "criminal negligence," as described in the CGS Penal Code Sec. 53a-3 Definitions:

A person acts "intentionally" with respect to a result or to conduct described by a statute defining an offense when his (her) conscious objective is to cause such result or to engage in such conduct.

A person acts “knowingly” with respect to conduct or to a circumstance described by a statute defining an offense when he (she) is aware that his conduct is of such nature or that such circumstance exists.

A person acts “recklessly” with respect to a result or to a circumstance described by a statute defining an offense when he (she) is aware of and consciously disregards a substantial and unjustifiable risk that such result will occur or that such circumstance exists. The risk must be of such nature and degree that disregarding it constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation.

A person acts with “criminal negligence” with respect to or as a result of failing to perceive a substantial and unjustifiable risk that could occur. The risk must be of such nature and degree that the failure to perceive it constitutes a gross deviation from the standard of care that a reasonable person would observe in the situation.

Incidents meeting this legal standard, as a potential crime, must be reported to the police.

The determination of a resident’s capability to form intent should be made consistent with normal assessments of a resident’s condition and capabilities. Incidents among residents, which do not constitute abuse, should be addressed through facility assessment and care planning and incident reports to the State of Connecticut Department of Public Health as required by federal and state law.

As a reminder, the Office of the Long Term Care Ombudsman should continue to receive complaints directly from residents, family members or others acting on behalf of the resident. If a resident complains of “rough handling,” the facility is to ensure that resident is aware of the advocacy services provided by the Ombudsman. The facility should assist the resident in accessing the services of the Ombudsman.

Reports should be filed using the W-410 (Mandated Reporter Form) that is attached. This memo in no way impacts your reporting obligations to the Connecticut Department of Public Health.

If you have questions regarding the content of this memo, please call the Social Work Division at 1-888-385-4225. As a reminder, the fax number to send reports to is 860-424-5091. Telephone reports are not acceptable. Thank you.

Attachment

cc: Connecticut Department of Public Health

State LTC Ombudsman Form W-410 (Revised 5/06)	STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES SOCIAL WORK DIVISION	55 Farmington Avenue, Hartford, CT 06105-3730 Phone: 1-888-385-4225 Fax: 860-424-5091
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MANDATED REPORTER FORM FOR LONG TERM CARE FACILITIES

Resident in Need of Protection Being Referred		
Last Name:	First Name:	M.I.:
Date of Birth: ____/____/____	S.S. #: ____/____/____	Age:
Long Term Care Facility		
Name of Long Term Care Facility: _____		
Facility Address: _____		
Contact Person: _____		
Telephone: () _____ Fax: () _____		
Report of Suspected:		
<input type="checkbox"/> Abuse <input type="checkbox"/> Neglect <input type="checkbox"/> Exploitation <input type="checkbox"/> Abandonment		
Date of incident (if known): _____		
Relationship of the alleged perpetrator to the resident (i.e. family, facility staff, other resident, etc.): _____		

Who Has Been Notified/Involved?:		
<input type="checkbox"/> CT Department of Social Services <input type="checkbox"/> CT Department of Public Health <input type="checkbox"/> State or Local Police		
If this is a resident/family complaint, have you offered to contact the office of the Long Term Care Ombudsman program on their behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please provide information regarding the nature and extent of the situation and any other details which might be helpful in investigating the case and protecting the resident.		

Investigation pending and summary to follow. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Referral/Reporter Information:		
Name: _____		
Address: _____		
Telephone: () _____ Fax: () _____		
Relationship to the Resident: _____ Date of Report: _____		
Does the Reporter Wish to be: <input type="checkbox"/> Anonymous <input type="checkbox"/> Identified		

Note: Incidents between residents need only be reported when the facility has determined that the resident has the capability to act intentionally, knowingly or recklessly, in accordance with definitions contained in Penal Code 531.3.

TELEPHONE REPORTS ARE NOT ACCEPTABLE

Office of Protection and Advocacy for Persons with Disabilities

Abuse Investigation Unit

60B Weston Street

Hartford, CT 06120-1551

Fax: 860-297-4384

REPORT OF SUSPECTED ABUSE OF AN ADULT WITH INTELLECTUAL DISABILITY

PA-6 Rev. 8/2011

TELEPHONE NUMBERS

297-4355 (Hartford Area)

566-2102 (TDD Only)

1-800-842-7303 (Toll free Voice and TDD)

**STATE OF CONNECTICUT
OFFICE OF PROTECTION AND ADVOCACY
FOR PERSONS WITH DISABILITIES
60-B Weston Street
Hartford, CT 06120-1551**

See next page for summary of Connecticut law concerning protection of adults with intellectual disability from abuse. In cases of suspected abuse an **ORAL REPORT SHOULD BE MADE IMMEDIATELY TO THE ABUSE INVESTIGATION DIVISION** in the Office of Protection and Advocacy. Written reports must be submitted within (5) calendar days of the oral report.

Reporter: Send original to the above address. You may make a copy for your records

Individual Being Referred (alleged victim of abuse or neglect)

(Last Name)	(First Name)	(M.I.)	Date of Birth Mo./Day/Year	Age
Address (No. & Street)	(City or Town)		Telephone Number	
Parents, Guardian or Caretaker Name (s)	Address (If different)			
Suspected Perpetrator if known Name (s)	Address			
Date (s) of suspected abuse or neglect	Oral report made to (Protection and Advocacy Investigator)		Date of report	

Reasons for Believing Alleged Victim is a person with an intellectual disability

Information supporting alleged victim's inability to substantially protect himself/herself from abuse or neglect

Nature of extent of suspected abuse or neglect and supporting information (attach additional sheets if necessary)

<u>Referral Source</u>	Does reporter wish to be: Notified of Action? Y N	Does reporter wish to Remain Anonymous? Y N
Reporters name/agency	Address	Telephone Number
Reporters Signature	Title, Position or Relationship	Date

**SUMMARY OF CONNECTICUT LAW CONCERNING PROTECTION OF
ADULTS WITH INTELLECTUAL DISABILITY FROM ABUSE**

Who Is Mandated To Report Abuse Of Adults With Intellectual Disability?

Any physician or surgeon licensed under the provisions of chapter 370, any resident physician or intern in any hospital in this state, whether or not so licensed, any registered nurse, any person paid for caring for persons in any facility and any licensed practical nurse, medical examiner, dental hygienist, dentist, occupational therapist, optometrist, chiropractor, psychologist, podiatrist, social worker, school teacher, school principal, school guidance counselor, school paraprofessional, mental health professional, physician assistant, licensed or certified substance abuse counselor, licensed marital and family therapist, speech and language pathologist, clergyman, police officer, pharmacist, physical therapist, licensed professional counselor or sexual assault counselor or battered women's counselor, as defined in section 52-146k.

Do Those Mandated To Report Incur Liability?

No. Any person, institution or agency reporting in good faith is immune from any liability, civil or criminal.

Is There A Penalty For Not Reporting?

Yes. A person required to report who fails to do so shall be fined no more than \$500.00.

What Is The Reporting Procedure?

1. An oral report must be made as soon as possible within seventy-two (72) hours to the Office of Protection and Advocacy, Abuse Investigation Division. In cases where the allegation results in death an oral report must be made within twenty-four (24) hours.

2. A written report must follow within five (5) additional calendar days of the oral report

3. All information as noted on the front of this form, if known by the reporter, must be reported.

What Must Be Reported?

1. Suspected or known abuse or neglect of adults with intellectual disability between the ages of 18 and 59 (in cases where the allegation results in death all persons over 18) inclusive, must be reported to the Office of Protection and Advocacy, Abuse Investigation Division. Abuse is defined as the willful infliction of physical pain or injury or the willful deprivation by a caretaker of services which are necessary to the person's health or safety. Neglect is defined as a situation where a person with intellectual disability is not able to provide for him/her the services which are necessary to maintain his/her physical and mental health or is not receiving such services from the caretaker.

2. If the person with intellectual disability is 17 years old or younger, a report must be made to the Department of Children and Families on a form supplied by them.

3. If the person with intellectual disability is not deceased and is 60 years old or older, a report must be made to the Department of Social Services, on a form supplied by them.

4. If the person with intellectual disability is between the ages of 18 and 59 inclusive, and lives in a nursing home, both the Office of Protection and Advocacy Abuse Investigation Division and The Department of Social Services Ombudsman Office must be contacted and two separate forms filed.

Do Private Citizens Have A Responsibility For Reporting?

A separate section of the law indicates that any person, in addition to those specifically mandated, having reasonable cause to believe that a person with intellectual disability is being or has been abused or neglected, may make written report to the Office of Protection and Advocacy.

What Is The Authority and Responsibility Of The Office of Protection and Advocacy?

1. The Office of Protection and Advocacy is responsible for the investigation of allegations of abuse of adults with intellectual disability between the ages of 18 and 59 inclusive (18 and over for allegations resulting in death.)

2. If it is determined that an adult with intellectual disability has been abused or neglected and/or is in need of protective services, the case shall be referred to the Department of Developmental Services for development and implementation of a plan of protective services. State or local police involvement will be requested if necessary.

3. If it is determined that a caretaker or other person has abused a person with intellectual disability such information shall be referred to the appropriate office of the State's Attorney, which shall conduct further investigation as may be deemed necessary and shall determine whether criminal proceedings should be initiated against such caretaker or other person in accordance with applicable state law.




Dannel P. Malloy
Governor

State of Connecticut
Department of Developmental Services

DDS

Jordan A. Scheff
Acting Commissioner

To: All DDS staff and DDS Qualified Provider staff
From: Kendres Lally, DDS Director of Investigations 
Date: March 30, 2017
Re: Office of Protection and Advocacy for Persons with Disabilities' Abuse Investigation Division Relocated

Effective March 17, 2017, the state's Office of Protection and Advocacy for Persons with Disabilities' Abuse Investigation Division has moved to the Department of Developmental Services (DDS) Central Office in Hartford. All functions currently performed by the Abuse Investigation Division (AID) remain in operation and reports of suspected abuse or neglect involving persons with intellectual disability ages 18 through 59, inclusive, should continue to be reported to the AID consistent with Connecticut law.

However, please note that the toll free telephone number for reporting allegations has been changed.

The new number to call in order to make a referral for investigation is 1-844-878-8923

The Abuse Investigation Division also is requesting to be notified of any deaths of persons with intellectual disability, including on weekends and holidays, at this same toll free number. AID asks that callers leave as many details as possible pertaining to the death, including the caller's name and a number at which the caller can be reached, so that AID staff can follow up in a timely manner.

Also, please note that effective immediately, any correspondence for the AID should be mailed to:

**Protection and Advocacy Abuse Investigation Division
Department of Developmental Services, Central Office
460 Capitol Avenue, 3rd floor
Hartford, CT 06106**

Phone: 860 418-6000 ♦ TDD 860 418-6079 ♦ Fax: 860 418-6001
460 Capitol Avenue ♦ Hartford, Connecticut 06106
www.ct.gov/dds ♦ e-mail: ddsct.co@ct.gov
An Affirmative Action/Equal Opportunity Employer

Department of Developmental Services Regional Abuse and Neglect Reporting Protocol

State of Connecticut DDS Regional Abuse and Neglect Reporting Protocol

Every DDS and Qualified Provider employee or volunteer is mandated by Connecticut General Statute 46-11a to report suspected abuse or neglect of any individual with an intellectual disability.

If there is reasonable cause to believe that abuse or neglect has occurred, a mandated reporter **MUST** immediately (1) intervene to stop the abuse/neglect and protect the victim and (2) report it to the appropriate authorized reporting agency.

Ensure that the report is made directly to someone, since voicemails do not fulfill the responsibility of a mandated reporter.

AUTHORIZED AGENCIES:

AID (victim age 18-59*)
Abuse Investigation Division (formerly known as OPA or P&A)
1-844-878-8923

<p>DSS (victim over age 59) Department of Social Services Centralized Intake 1-888-385-4225 & DDS A&N Liaison</p>	<p>DCF (victim under age 18) Department of Children and Families Care Line 1-800-842-2288 & DDS A&N Liaison</p>
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DDS - Department of Developmental Services

<p>North Region: Paula Zeiner, A&N Liaison 155 Founders Plaza 255 Pitkin Street East Hartford, CT 06108 Phone: 860.263.2469 Fax: 860.263.2514 Paula.Zeiner@ct.gov</p> <p>Assistant: Kathleen Davis 860.263.2583 Kathleen.Davis@ct.gov</p>	<p>South Region: Tawnia Pacheco, A&N Liaison 35 Thorpe Avenue, 3rd Floor Wallingford, CT 06492 Phone: 203.294.5077 Fax: 860.622.2712 Tawnia.A.Pacheco@ct.gov</p> <p>Assistant: Kenerick Brown 203.294.5151 Kenerick.Brown@ct.gov</p>	<p>West Region: Vacant, A&N Liaison 55 West Main Street, 3rd Floor Waterbury, CT 06702 Phone: 203.805.7456 Fax: 860.622.2677</p> <p>Assistant: Damaris Hueras 203.805.7463 Dararis.Huertas@ct.gov</p>
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Southbury Training School (STS):
 Cyndi Miller, A&N Liaison, Lead Investigator
 STS Human Rights Office Southbury, CT 06488
 Phone: 203.586.2255 Fax: 203.586.2142 Cyndi.Miller@ct.gov

If the allegation is against a medically licensed facility or professional, notify the appropriate authorized agency(s) and then the AID or DDS will notify the Department of Public Health (**DPH**) to investigate.

*Report anything that the AID does not take (which includes, but is not limited to, individuals who are over or under age, allegations of verbal abuse, psychological abuse, financial exploitation and incidents of non-ingested food consistency violations) to the DDS Abuse & Neglect Liaison by completing a DDS intake form or contacting the Liaison directly.

For additional information or questions, please contact the Regional DDS Abuse & Neglect Liaison.

(PDF Version)
 version 11.15.17 tap

State of Connecticut DDS
 Abuse & Neglect Definitions
 (per DDS Policy I.F.PO.001)

Abuse & Neglect Definitions

Abuse: The willful infliction by a caregiver of physical pain or injury, or the willful deprivation of services necessary to the physical safety of an individual.

Financial Exploitation: The theft or misappropriation of property and/or monetary resources, which are intended to be used for or by an individual.

Neglect: The failure by a caregiver, through action or inaction, to provide an individual with the services necessary to maintain his or her physical and mental health and safety, including incidents of inappropriate or unwanted individual to individual sexual contact.

Neglect also includes the failure of a caregiver to respond to incidents of inappropriate or unwanted sexual contact between individuals who receive services from the department.

Neglect is also a situation in which an individual lives alone and is not able to provide for him/herself the services which are necessary to maintain his physical health, mental health or safety.

Programmatic Neglect: Failure to provide oversight in developing or implementing an individual's program, and/or ensuring staff training which ensures an individual's well-being and safety.

Psychological Abuse: Acts that inflict emotional harm, invoke fear and/or humiliate, intimidate, degrade, demean or otherwise negatively impact the mental health or safety of an individual.

Sexual Abuse: Any sexual contact or encouragement of sexual activity between a family member, paid staff or a volunteer and an individual, regardless of consent.

Verbal Abuse: The use of offensive and/or intimidating language that can provoke or upset an individual.

*Please note that the definitions for the purposes of the DDS Abuse & Neglect Registry are slightly

different. Contact your Liaison if you need that information.

version 11/15/17 tap

[No Excuse for Abuse Brochure \(PDF, 2 MB\)](#)

Content Last Modified on 3/15/2018 10:57:25 AM

Appendix F

The Connecticut Alliance to End Sexual Violence

- **Advocacy Services**
- **Program Map**
- **Program Contact Information**

Advocacy – The Connecticut Alliance to End Sexual Violence

- There are 9 sexual assault crisis programs in the state of CT. Each center provides the same core services:
 - o 24-hour toll free confidential hotline
 - o Certified sexual assault victim advocates
 - o Medical, police, and court accompaniment and advocacy
 - o Support groups
 - o Spanish-speaking & male advocates upon request
 - o Information and referral
 - o Community education
 - o Short term supportive counseling
- To contact the appropriate program please consult the program map and center information on the next two pages. To visit our website, go to:
<http://endsexualviolencect.org/>
- You can also call The Alliance's hotline at 1-888-999-5545 from your hospital's landline and you'll be connected to your local center.

CONNECTICUT ALLIANCE TO END SEXUAL VIOLENCE



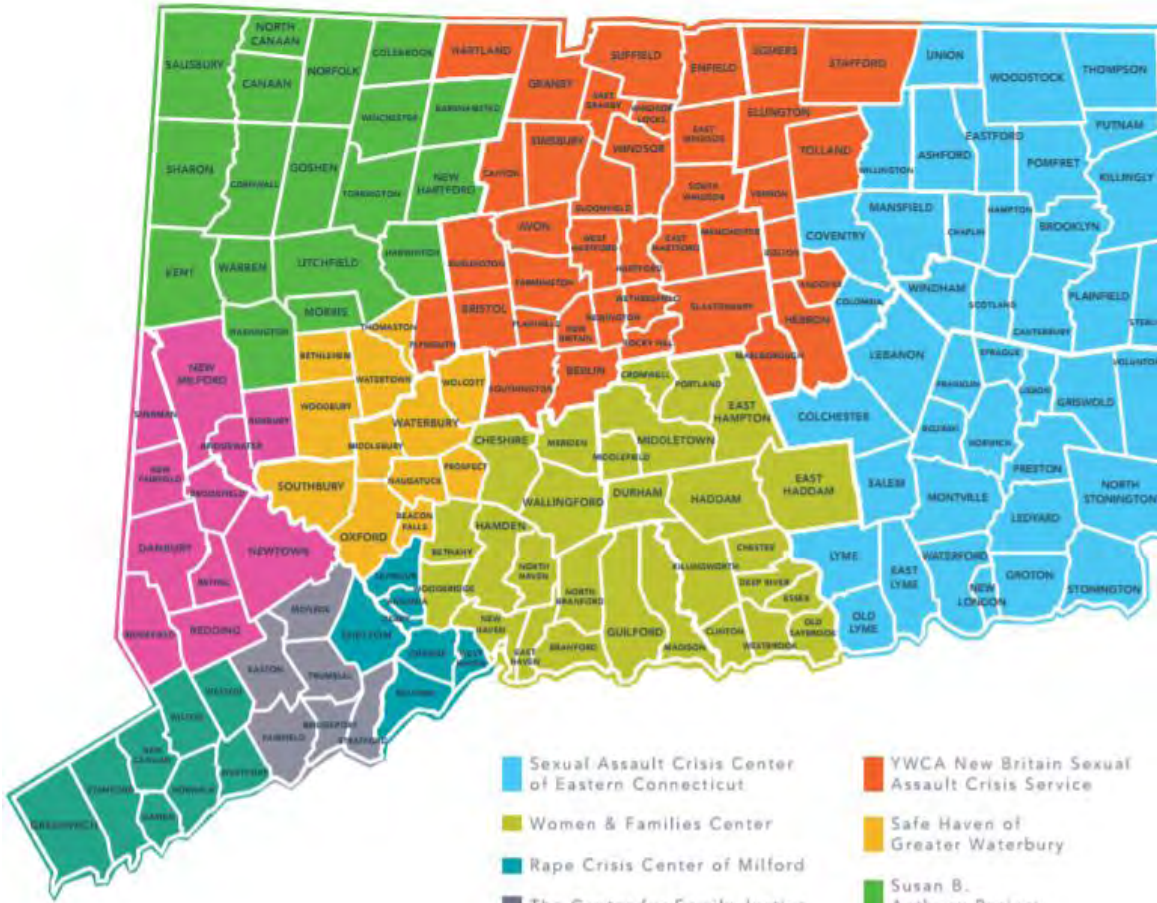
Support. Advocate. Prevent.

formerly CONNSACS

24-Hour, Toll-Free Hotlines:

1-888-999-5545 (English) | 1-888-568-8332 (Español)

Connecticut Alliance to End Sexual Violence is a statewide coalition of individual sexual assault crisis programs whose mission is to end sexual violence and to ensure high-quality, comprehensive, culturally competent sexual assault victim services.



All services are free and confidential.

The sexual assault crisis programs provide:

- certified sexual assault victim advocates
- 24/7 hotline services in English and Spanish
- short-term counseling for individuals and groups
- information and referrals to other social and legal services
- accompaniment and support in hospitals, police departments and courts



The Center for Family Justice
 Bridgeport Office: 203-334-6154
Hotline: 203-333-2233
 President and CEO: Deb Greenwood
 Program Director: Amanda Posila



Women's Center of Greater Danbury
 Danbury Office: 203-731-5200
Hotline: 203-731-5204
 President and CEO: Patricia Zachman
 Chief Operating Officer: Suzanne Adam



Susan B. Anthony Project
 Torrington Office: 860-489-3798
Hotline: 860-482-7133
 Executive Director: Jeanne Fusco
 Program Director: Michelle Marone-Pillsbury



Safe Haven of Greater Waterbury
 Waterbury Office: 203-575-0388
Hotline: 203-753-3613
 Executive Director: Lee Schlesinger
 Program Director: Melissa Malagutti



Rape Crisis Center of Milford
 Milford Office: 203-874-8712
Hotline: 203-878-1212
 Executive Director: Antonio Vitti
 Director of Victim Services: Peggy Pisano



**The Center for Sexual Assault Crisis
 Counseling and Education**
 Stamford Office: 203-348-9346
Hotline: 203-329-2929
 Executive Director: Iyonne Zucco



**Sexual Assault Crisis Center of
 Eastern Connecticut**
 Willimantic Office: 860-456-3595
Hotline: 860-456-2789
 New London Office: 860-442-0604
Hotline: 860-437-7766
 Executive Director: Georgette Katin
 Associate Director: Marla Busineau



Women & Families Center
 Meriden Office: 203-235-9297
 Middletown Office: 860-344-1474
 New Haven Office: 203-389-5010
Hotline: 203-235-4444
 Executive Director: Robyn Jay-Bage
 Program Director: Carlissa Conway



**YWCA New Britain
 Sexual Assault Crisis Service**
 New Britain Office: 860-225-4681
Hotline: 860-223-1787
 Hartford Office: 860-225-4681
Hotline: 860-547-1022
 Executive Director: Robin Sharp
 Program Director: Caitlin Reese

**CONNECTICUT ALLIANCE
 TO END SEXUAL VIOLENCE**
 Support. Advocate. Prevent.
 formerly CONNSAAG



24-Hour, Toll-Free Hotlines:
 1-888-999-5545 (English)
 1-888-568-8332 (Español)

www.endsexualviolencect.org
 96 Pitkin Street, East Hartford CT 06108
 Office: 860-282-9881 | Fax: 860-291-9335

Appendix G

Intimate Partner Violence

- **Special Concerns Regarding Intimate Partner Sexual Violence**
- **Intimate Partner Violence/Domestic Violence Victims**
- **General Information and Initial Response**
- **Counseling and Support**
- **Program Map**

Special Concerns Regarding Intimate Partner Sexual Violence (IPSV)

- Intimate Partner Sexual Violence (IPSV) takes place within the context of domestic violence. An IPSV patient is or has been in a relationship in which sexual violence is part of a larger pattern of domination and control, with or without additional physical violence.¹
- Intimate Partner Violence (IPV) is a pattern of behaviors, not a single event or an isolated incident. Patient may have experienced sexual assault or other physical violence at the hands of their offender on previous occasions.
- IPSV patients may be accompanied by their current or former partner or spouse. It is best to request the current or former partner or spouse to leave the room to conduct further assessment. Health care providers may cite hospital policy to allow further assessment to take place.
- Patients who have been sexually assaulted by a current or former partner or spouse will likely not want the relationship to end, but for the violence to stop.
- IPSV patients with children who are permitted no money or employment of their own may feel there is no escape.
- Patients experiencing intimate partner sexual violence are socialized to see rape as involving non-consensual sex between two strangers. Patients may be reluctant to define a partner as a “rapist.”²
- Sensitively asking questions specifically about IPSV is critical because the patient is unlikely to volunteer this information on their own.³

Intimate Partner Violence/Domestic Violence Victims General Information

- Intimate Partner Sexual Violence (IPSV) takes place within the context of domestic violence. An IPSV patient is or has been in a relationship with their offender and the sexual violence is part of a larger pattern of domination and control, with or without additional physical violence.⁴
- IPSV patients include teens to elderly people (including same-sex partners) who are married, dating, or living together. Abuse by ex-spouses or former partners is also considered IPSV.

¹ IPSV Support Group: A Guide to Psychoeducational Support Groups for Survivors of Intimate Partner Sexual Violence, Washington Coalition of Sexual Assault Programs.

² Connections: A Biannual Publication of Washington Coalition of Sexual Assault Programs, Summer 2008.

³ Marital Rape: New Research and Directions, February 2006.

⁴ Ibid, Footnote 1.

- IPSV patients may have experienced multiple rapes. Although IPSV can be a one-time event, IPSV survivors suffer the highest frequency of multiple rapes.⁵
- IPSV patient generally experience higher rates of severe injury.⁶
- IPSV patients may experience deep shame of having continued the relationship, isolation, and ambivalence over their feelings for the offender, who may also be a partner, spouse, first love, or parent to her/his children.

Initial Response

- IPSV patients generally are less likely to report sexual assaults or to seek medical care following a sexual assault due to societal views of what is or is not a sexual assault and the relationship between the patient and the offender.
- Many IPSV patients will not consider what took place as, “rape.” A response should include open ended questions and be designed to facilitate disclosure using such words as sexual activity, intimate experience, and so forth.
- IPSV patients may be more likely to have post-traumatic stress disorder symptoms, more pregnancies resulting from rape, and more sexually transmitted diseases.⁷
- Victims of IPSV have higher levels of anal and oral rape—partner perpetrators commonly use these forms of assault to humiliate, punish and take “full” ownership of their partners.⁸

Counseling and Support

- Call sexual assault crisis services as soon as possible and if possible alert them that the patient is experiencing IPSV to enhance the effectiveness of the counselor’s response.
- The Alliance may be reached at 1-888-999-5545.
- An IPSV patient may have profound shame regarding continuing the relationship after being sexually abused by a partner on multiple prior occasions.

⁵ Connections: A Biannual Publication of Washington Coalition of Sexual Assault Programs, Summer 2008.

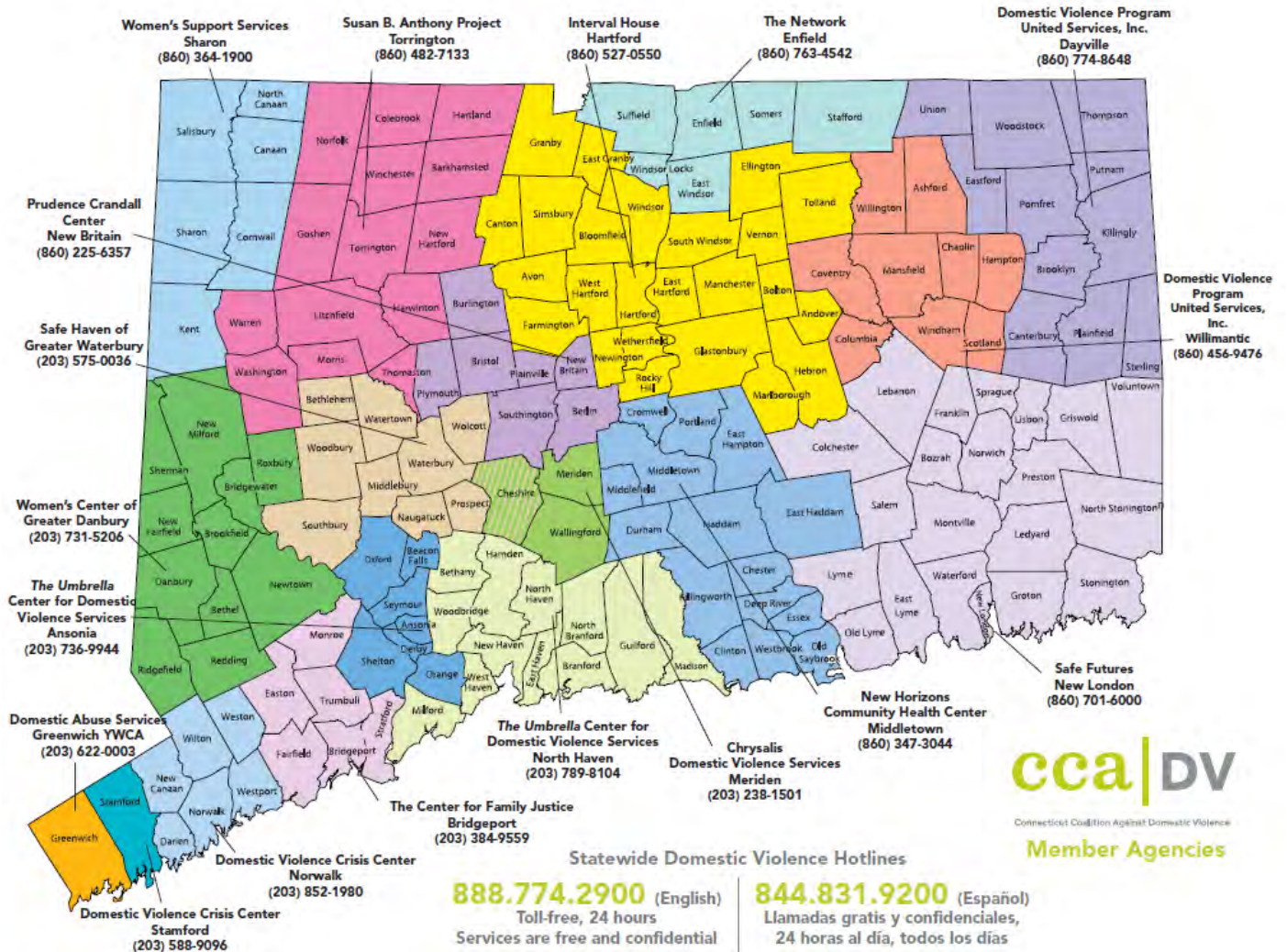
⁶ IPSV Support Group: A Guide to Psychoeducational Support Groups for Survivors of Intimate Partner Sexual Violence, Washington Coalition of Sexual Assault Programs.

⁷ U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, January 2007.

⁸ Connections: A Biannual Publication of Washington Coalition of Sexual Assault Programs, Summer 2008.

Connecticut Coalition Against Domestic Violence (CCADV)

CCADV member organizations are Connecticut's 18 domestic violence service organizations that provide critical support to victims of domestic violence. To contact a domestic violence advocate and for emergency shelter, counseling and other services, call the toll free domestic violence hotline at 888-774-2900 (English) or 844-831-9200 (Español). You may also call the direct hotline number of your local program, which is listed below. To visit our website, go to: <http://www.ctcadv.org/>



Appendix H

Office of Victim Services



Programs	Descriptions
Victim Compensation	Financial help for victims of violent crimes, their family members, and other persons for certain crime expenses that was not paid or eligible to be paid by financial resources, such as insurance.
Victim Notification	Confidential notification programs about the status of a criminal court case, inmate requests for a change in their court sentence, registration with the Sex Offender Registry, custody status with the Department of Correction, parole and pardon requests with the Board of Pardons and Paroles, and when an order of protection is issued, changed, or ends.
Victim Advocacy	<p>Court-based victim services advocates provide support to victims of violent crimes and their family members during court proceedings and give information on crime victims' rights and the criminal justice process.</p> <p>Victim services advocates at the Board of Pardons and Paroles provide support and information to victims of violent crimes and their family members during the pardons and paroles process.</p> <p>Civil court-based victim services advocates provide support and information on</p>

Programs	Descriptions
	applying for a civil protection order.
OVS Helpline	There is a toll-free, nationwide Helpline for information on crime victim rights, referrals to state and community agencies, and information on victim notification and the criminal justice process.
Sexual Assault Forensic Examiners Program	Sexual assault forensic examiners provide compassionate care and medical-forensic examination services to sexual assault victims that go to a participating health care facility within 120 hours of the assault.
Victim Resources	A list of community and state agencies that provide crisis intervention, counseling, 24-hour hotlines, and other services to crime victims.
State Law on OVS Services	Connecticut General Statutes, Chapter 968, Victim Services. The state law that directs the work of OVS.
Training and Outreach	Training to criminal justice and victim service professionals, students at high schools, colleges, and universities, and the public on victim rights and services provided by OVS.

For more information about services and programs through the Office of Victim Services, go to: <http://www.jud.ct.gov/crimevictim/>

Appendix I

Billing

- **Forensic Kit Billing Information**
- **Letter Bill Not Eligible for Reimbursement**
- **UB for Billing**



Sexual Assault Forensic Evidence Kit Billing

C.G.S. §19a-112a

GENERAL INFORMATION

- State law prohibits health care facilities from billing sexual assault victims directly or indirectly for the cost of gathering sexual assault evidence, [CGS §19a-112a (e)] (See Appendix A).
- Health care facilities are required by law to bill costs of gathering sexual assault evidence to the CT Judicial Branch, Office of Victim Services (OVS), and Forensic Kit Billing. [CGS §19a-112a (e)]
- Reimbursable costs associated with the sexual assault medical examination and evidence collection, including the cost of the emergency room charge, emergency department physician charge, cost of testing for pregnancy and sexually transmitted diseases and the cost of prophylactic treatment as provided in the protocol.
- The Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations will establish a payment amount to represent the cost of gathering evidence, and shall notify health care facilities of that amount and of any changes in that amount.
- Currently the rate is set at \$900 for eligible costs (see reimbursable costs above) when evidence kit is done and is payable to the healthcare facility where evidence is collected. Physicians who bill separately from the hospital are required to make suitable arrangements with the hospitals for reimbursement of their costs.

DEVELOPMENT OF INTERNAL PROCEDURES

- Each health care facility that provides for the collection of sexual assault evidence should develop internal procedures for the processing of bills which are subject to the above billing requirements.
- A method for identifying subject bills from the registration process to the billing process, to assure victims of sexual assault are not billed for visits related to sexual assault.
- A method for documenting on the bills that evidence was gathered during exam.
- A method for ensuring that the CT Judicial Branch, Office of Victim Services, Forensic Kit Billing is designated as the primary payer on subject bills.
- The designation of at least one person in the billing department to be informed about billing requirements and to communicate with other departments and/or CT Judicial Branch, Office of Victim Services, Forensic Kit Billing regarding such billing.
- A method for ensuring that the CT Judicial Branch, Office of Victim Services, Forensic Kit Billing is removed as guarantor for all billing procedures after the initial submission to the CT Judicial Branch, Office of Victim Services for purpose of CGS §19a-112a.

BILL SUBMISSION REQUIREMENTS

Health care facilities should submit a UB and itemized billing statement for the examination of a sexual assault patient whenever an evidence kit is used.

A notation on the UB that indicates that that bill qualifies for payment, e.g.:

- "CT 100 kit used" to indicate kit was used.
- State of CT Sexual Assault Checklist documenting kit was used.
- Documentation from medical records indicating kit was used.

- Itemized billing statement which lists the medications administered.
- UB should have at least one of the below diagnosis codes for sexual assault:
- Z04.4 (1)(2), T74.21 (XA)(XD)(XS), T74.22 (XA)(XD)(XS), T62.21 (XA)(XD)(XS), T76.22 (XA)(XD)(XS).

The billing and supporting documents should be submitted to:

Office of Victim Services
Attn: Forensic Kit Billing
225 Spring Street
Wethersfield, CT 06109



CONNECTICUT JUDICIAL BRANCH
OFFICE OF VICTIM SERVICES
225 Spring Street, Wethersfield, Connecticut 06109

Administrative Unit
Telephone: 860-263-2760
Toll-Free: 1-888-286-7347
Fax: 860-263-2777
TDD: 860-263-2779

Date

Provider Name

Attn:

Address

Address

Patient Name:

Control Number:

Date of Service:

Dear:

Connecticut law (§19a-112a(e)), requires that you bill the Office of Victim Services (OVS) in the Judicial Department directly when you perform a forensic examination for a victim of sexual assault using an evidence collection kit. You may not bill the patient or the patient's insurer for the examination and related testing and prophylactic treatment. The maximum payment OVS will make is \$900 per examination. You may not balance bill the victim or the insurer.

The Office of Victim Services Forensic Kit Billing has reviewed the claim submitted for evidence kit reimbursement.

After a review of the billing, OVS has determined that the bill is not eligible for reimbursement at this time for the following reason:

- <insert reason>

Patients who are victims of crime may be eligible for compensation for resulting medical expenses through the Office of Victim Services' Compensation Program (1-800-822-8428).

If you have any questions, please contact our office at 860-263-2760.

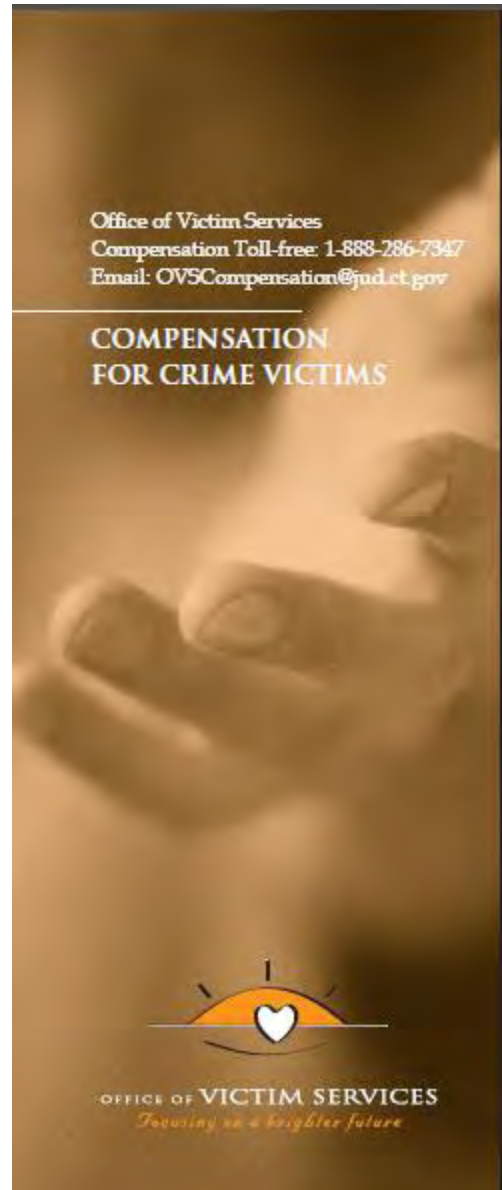
Sincerely,

Anna Fidyk
Accountant

1												2		3 PATIENT CONTROL NO.				4 TYPE OF BILL																																					
5 FED. TAX NO.				6 STATEMENT COVERED PERIOD FROM				7 COV. D.	8 N-C.D.	9 O-I.D.	10 L.R.D.	11																																											
12 PATIENT NAME												13 PATIENT ADDRESS																																											
14 BIRTHDATE		15 SEX	16 MB	17 DATE ADMISSION			18 HR	19 TIME	20 SEC	21 D HR	22 STAT	23 MEDICAL RECORD NO.			24			25	26	27	28	29	30	31																															
32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE DATE		37 OCCURRENCE DATE		38	39	40	41	42	43	44	45	46	47	48	49																																
42 REV. CD.												43 DESCRIPTION												44 HCPCS / RATES	45 SERVL DATE	46 SERVL UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49																										
50 PAYER												51 PROVIDER NO.				52 REL. # PO	53 ADD. # BIL	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56																																	
DUE FROM PATIENT												57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
58 INSURED'S NAME												59 P. REL.	60 CERT. - SSN - HIC - ID NO.				61 GROUP NAME				62 INSURANCE GROUP NO.																																		
63 TREATMENT AUTHORIZATION CODES				64 ECG	65 EMPLOYER NAME				66 EMPLOYER LOCATION																																														
67 PRIN. DIAG. CD.		68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 CODE	77 ADM. DIAG. CD.	78 E-CODE	79																																										
79 PC		80 PRINCIPAL PROCEDURE CODE		81 OTHER PROCEDURE CODE		82 OTHER PROCEDURE CODE		83 OTHER PROCEDURE CODE		84 OTHER PROCEDURE CODE		85 OTHER PROCEDURE CODE		86 ATTENDING PHYS. ID																																									
84 REMARKS												87 OTHER PHYS. ID				88 OTHER PHYS. ID				89 OTHER PHYS. ID				90 PROVIDER REPRESENTATIVE				91 DATE																											

Appendix J

Compensation



The Office of Victim Services (OVS) Victim Compensation Program offers financial help to crime victims, their family members, and other persons who have financial loss because of a crime.

HOW CAN I GET AN APPLICATION FOR VICTIM COMPENSATION?

To receive an application or for more information, call the Victim Compensation Program at 1-888-286-7347, email at OVSCompensation@jud.ct.gov or go to the OVS Web site at www.jud.ct.gov/crimevictim/.

WHO CAN RECEIVE VICTIM COMPENSATION?

- A victim who suffered a physical injury;
- A victim who suffered emotional injury from a threat of either physical injury or death and received treatment. Crimes include, for example, robbery, kidnapping, child pornography, unlawful sharing of an intimate image, voyeurism (being watched, photographed, or recorded without your knowledge and permission), stalking, sexual assault, and human trafficking;
- A child who witnesses domestic violence;
- A dependent and the legal designated decision maker of a homicide victim;

- A relative* of a sexual assault, domestic violence, child abuse, or homicide victim;
- A person who paid some or all of the funeral expenses;
- A person who provided care to a personal injury victim;
- A person who paid some or all of the crime scene clean-up expenses; or
- A person who has a disability and owns or keeps a service animal that was injured or killed during a crime.

* A relative is "a person's spouse, parent, grandparent, stepparent, aunt, uncle, niece, nephew, child, including a natural born child, stepchild and adopted child, grandchild, brother, sister, half-brother or half-sister, or a parent of a person's spouse." Section 54-201(4) of the Connecticut General Statutes, revised 2017.

WHAT ARE THE ELIGIBILITY REQUIREMENTS?

- You were injured during a crime or injured while helping police during a crime;
- The crime happened in Connecticut; or
 - You live in Connecticut and the crime happened in a country that does not have a victim compensation program that you are eligible for and you were a victim of international terrorism or a victim of a crime that would be eligible for victim compensation in Connecticut;

ELIGIBILITY REQUIREMENTS (CONTINUED)

- The crime was reported to the police within 5 days or within 5 days of when a report could reasonably be made; or
 - You are a victim of sexual assault, child abuse, or human trafficking and told certain medical providers, mental health providers, school personnel, or advocates about the crime; you went to a health care facility to have a sexual assault exam and evidence collection done; or a judge gave you a restraining order or a civil protection order; or
 - You are a victim of domestic violence and told a domestic violence or sexual assault counselor about the crime or a judge gave you a restraining order or a civil protection order.
- You did not cause the crime or do anything illegal;
- You are filing the application within 2 years of the date of the personal or emotional injury or death (a waiver form is available);
- You are cooperating with the police investigation; and
- You are cooperating with the Victim Compensation Program.

WHAT IS COVERED?

Only expenses and losses related to the crime that are not covered by insurance or other financial sources will be considered.

Physical Injury (up to \$15,000)

- Medical, dental, counseling, and prescription expenses;
- Counseling for relatives of sexual assault, domestic violence, and child abuse victims;
- Cosmetic and plastic surgery;
- Medical-related special needs, such as medical equipment (wheelchair) and changes to a home (ramp) or vehicle;
- Lost wages because of crime-related injuries or care to a victim;
- Lost wages and travel expenses for you and your relatives to attend adult court proceedings;
- Crime scene clean-up (up to \$1,000) to any person who paid some or all of the expenses.

Emotional Injury (up to \$5,000)

- Medical, dental, counseling, and prescription expenses.

Survivor Benefits (up to \$25,000)

- Funeral (up to \$5,000) to any person who paid some or all of the expenses;
- Loss of support for dependents and legal designated decision makers;

Survivor Benefits (CONTINUED)

- Lost wages and travel expenses for relatives and dependents to attend adult court proceedings;
- Counseling for relatives and legal designated decision makers;
- Crime scene clean-up (up to \$1,000) to any person who paid some or all of the expenses.

WHAT IS NOT COVERED?

- Property loss or damage;
- Pain and suffering;
- Household living expenses;
- Mileage to doctor appointments;
- Attorney fees. (If an attorney files an application for you, the Victim Compensation Program allows attorney fees up to 15% of the compensation ordered.)

IF MY CLAIM IS FOUND ELIGIBLE FOR VICTIM COMPENSATION, WHO GETS THE PAYMENTS?

- Lost wages and eligible expenses that you paid because of the crime will be paid directly to you.
- If there is a balance owed for crime-related treatment, payment will be sent to provider(s).
- If you have an attorney representing you, payment will be sent to your attorney, who must pay the person(s) or provider(s) listed on the OVS determination letter. Your attorney may take up to 15% of the compensation ordered for attorney fees.

DO I HAVE TO PAY THE VICTIM COMPENSATION PROGRAM BACK?

- If you receive money from any other financial sources, including from state or municipal agencies, insurance, or workers' compensation because of the crime, OVS is entitled to 2/3 of the amount the Victim Compensation Program paid.

For example, if you received \$15,000 in victim compensation and you receive a \$40,000 insurance or civil court settlement for the same expenses paid by the Victim Compensation Program, the Victim Compensation Program is entitled to receive \$10,000 from your settlement.

- If the court orders the offender to pay you restitution for expenses that were paid by the Victim Compensation Program, the Victim Compensation Program is entitled to receive full reimbursement, unless the court orders differently.

If you file a victim compensation application, it is important that you tell OVS if your contact information changes. If we cannot reach you, you may miss important deadlines set by state law or your claim may be closed.

Appendix K

Connecticut General Statutes

- **Sec. 19a-112a. Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations. Protocol. Sexual assault evidence collection kit. Preservation of evidence. Costs. Training and sexual assault examiner programs**
- **Sec. 19a-112e. Provision of emergency treatment to a victim of sexual assault. Standard of care**
- **Sec. 19a-112g. Sexual assault forensic examiners. Responsibilities**
- **Public Act 17-31. An Act Concerning Strengthening Laws Concerning Domestic Violence**

Sec. 19a-112a. Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations. Protocol. Sexual assault evidence collection kit. Preservation of evidence. Costs. Training and sexual assault examiner programs.

(a) There is created a Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations composed of fourteen members as follows: The Chief State's Attorney or a designee; the executive director of the Permanent Commission on the Status of Women or a designee; the Commissioner of Children and Families or a designee; one member from the Division of State Police and one member from the Division of Scientific Services appointed by the Commissioner of Emergency Services and Public Protection; one member from Connecticut Sexual Assault Crisis Services, Inc. appointed by its board of directors; one member from the Connecticut Hospital Association appointed by the president of the association; one emergency physician appointed by the president of the Connecticut College of Emergency Physicians; one obstetrician-gynecologist and one pediatrician appointed by the president of the Connecticut State Medical Society; one nurse appointed by the president of the Connecticut Nurses' Association; one emergency nurse appointed by the president of the Emergency Nurses' Association of Connecticut; one police chief appointed by the president of the Connecticut Police Chiefs Association; and one member of the Office of Victim Services within the Judicial Department. The Chief State's Attorney or a designee shall be chairman of the commission. The commission shall be within the Division of Criminal Justice for administrative purposes only.

(b) (1) For the purposes of this section, "protocol" means the state of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual Assault, including the Interim Sexual Assault Toxicology Screen Protocol, as revised from time to time and as incorporated in regulations adopted in accordance with subdivision (2) of this subsection, pertaining to the collection of evidence in any sexual assault investigation.

(2) The commission shall recommend the protocol to the Chief State's Attorney for adoption as regulations in accordance with the provisions of chapter 54. Such protocol shall include nonoccupational post-exposure prophylaxis for human immunodeficiency virus (nPEP), as recommended by the National Centers for Disease Control. The commission shall annually review the protocol and may annually recommend changes to the protocol for adoption as regulations.

(c) The commission shall design a sexual assault evidence collection kit and may annually recommend changes in the kit to the Chief State's Attorney. Each kit shall include instructions on the proper use of the kit, standardized reporting forms, standardized tests which shall be performed if the victim so consents and standardized receptacles for the collection and preservation of evidence. The commission shall provide the kits to all health care facilities in the state at which evidence collection examinations are performed at no cost to such health care facilities.

(d) Each health care facility in the state which provides for the collection of sexual assault evidence shall follow the protocol as described in subsection (b) of this section and, with the consent of the victim, shall collect sexual assault evidence. After the collection of any evidence, the health care facility shall contact a police department to receive the evidence. Not later than ten days after the collection of the evidence, the police department shall transfer the evidence in a manner that maintains the integrity of

the evidence, to the Division of Scientific Services within the Department of Emergency Services and Public Protection or the Federal Bureau of Investigation laboratory. If the evidence is transferred to the division, the division shall analyze the evidence not later than sixty days after the collection of the evidence or, if the victim chose to remain anonymous and not report the sexual assault to the police department at the time of collection, shall hold the evidence for at least five years after the collection of the evidence. If a victim reports the sexual assault to the police department after the collection of the evidence, such police department shall notify the division that a report has been filed not later than five days after filing such report and the division shall analyze the evidence not later than sixty days after receiving such notification. The division shall hold any evidence received and analyzed pursuant to this subsection until the conclusion of any criminal proceedings. The failure of a police department to transfer the evidence not later than ten days after the collection of the evidence, or the division to analyze the evidence not later than sixty days after the collection of the evidence or after receiving a notification from a police department, shall not affect the admissibility of the evidence in any suit, action or proceeding if the evidence is otherwise admissible.

(e) (1) No costs incurred by a health care facility for the examination of a victim of sexual assault, when such examination is performed for the purpose of gathering evidence as prescribed in the protocol, including the costs of testing for pregnancy and sexually transmitted diseases and the costs of prophylactic treatment as provided in the protocol, and no costs incurred for a medical forensic assessment interview conducted by a health care facility or provider or by an examiner working in conjunction with a multidisciplinary team established pursuant to section 17a-106a or with a child advocacy center, shall be charged directly or indirectly to such victim. Any such costs shall be charged to the Forensic Sex Evidence Exams account in the Judicial Department.

(2) No costs incurred by a health care facility for any toxicology screening of a victim of sexual assault, when such screening is performed as prescribed in the protocol, shall be charged directly or indirectly to such victim. Any such costs shall be charged to the Division of Scientific Services within the Department of Emergency Services and Public Protection.

(f) The commission shall advise the Chief State's Attorney on the establishment of a mandatory training program for health care facility staff regarding the implementation of the regulations, the use of the evidence collection kit and procedures for handling evidence.

(g) The commission shall advise the Chief State's Attorney not later than July 1, 1997, on the development of a sexual assault examiner program and annually thereafter on the implementation and effectiveness of such program.

Sec. 19a-112e. Provision of emergency treatment to a victim of sexual assault. Standard of care. (a) As used in this section:

(1) "Emergency contraception" means one or more prescription drugs used separately or in combination administered to or self-administered by a patient to prevent

pregnancy, within a medically recommended amount of time after sexual intercourse and provided for that purpose, in accordance with professional standards of practice, and determined to be safe by the United States Food and Drug Administration.

(2) “Emergency treatment” means any medical examination or treatment provided in a licensed health care facility to a victim of sexual assault following an alleged sexual assault.

(3) “Medically and factually accurate and objective” means verified or supported by the weight of research conducted in compliance with accepted scientific methods and published in peer-reviewed journals, where applicable.

(4) “Victim of sexual assault” means any female person who alleges or is alleged to have suffered an injury as a result of a sexual offense.

(5) “Sexual offense” means a violation of subsection (a) of section 53a-70, section 53a-70a or 53a-70b, subsection (a) of section 53a-71, section 53a-72a or 53a-72b, subdivision (2) of subsection (a) of section 53a-86, subdivision (2) of subsection (a) of section 53a-87 or section 53a-90a, 53a-196a or 53a-196b.

(6) “Independent provider” means a physician licensed under chapter 370, a physician assistant licensed under chapter 370, an advanced practice registered nurse or registered nurse licensed under chapter 378, or a nurse-midwife licensed under chapter 377, all of whom are trained to conduct a forensic exam in accordance with the state of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual Assault, published by the Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations pursuant to section 19a-112a.

(b) The standard of care for each licensed health care facility that provides emergency treatment to a victim of sexual assault shall include promptly:

(1) Providing each victim of sexual assault with medically and factually accurate and objective information relating to emergency contraception;

(2) Informing such victim of sexual assault of the availability of emergency contraception, its use and efficacy; and

(3) Providing emergency contraception to such victim of sexual assault at the facility upon the request of such victim, except that a licensed health care facility shall not be required to provide emergency contraception to a victim of sexual assault who has been determined to be pregnant through the administration of a pregnancy test approved by the United States Food and Drug Administration.

(c) In order to comply with the standard of care requirements prescribed in subsection (b) of this section, a licensed health care facility may contract with one or more independent providers to: (1) Ensure compliance at the facility with the standard of care requirements prescribed in said subsection (b), and (2) conduct at the facility a forensic exam of the sexual assault victim in accordance with the state of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual Assault, published by the Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations pursuant to section 19a-112a.

(d) No licensed health care facility that provides emergency treatment to a victim of sexual assault shall determine such facility's protocol for complying with the standard of care requirements prescribed in subsection (b) of this section on any basis other than a pregnancy test approved by the United States Food and Drug Administration.

Sec. 19a-112g. Sexual assault forensic examiners. Responsibilities.

(a) As used in this section, "sexual assault forensic examiner" means a registered nurse or advanced practice registered nurse licensed pursuant to chapter 378 or a physician licensed pursuant to chapter 370.

(b) A sexual assault forensic examiner may provide immediate care and treatment to a victim of sexual assault who is a patient in an acute care hospital and may collect evidence pertaining to the investigation of any sexual assault in accordance with the State of Connecticut Technical Guidelines for Health Care Response to Victims of Sexual Assault, published by the Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations pursuant to section 19a-112a. Services provided by a sexual assault forensic examiner shall be: (1) In accordance with the hospital's policies and accreditation standards; and (2) pursuant to a written agreement entered into by the hospital, the Department of Public Health and the Office of Victim Services concerning the hospital's participation in the sexual assault forensic examiners program. Nothing in this section shall be construed as altering the scope of the practice of nursing as set forth in section 20-87a.

Public Act No. 17-31

Public Act 17-31. An Act Concerning Strengthening Laws Concerning Domestic Violence

Be it enacted by the Senate and House of Representatives in General Assembly

Sec. 3. Section 53a-64aa of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) A person is guilty of strangulation or suffocation in the first degree when such person commits strangulation or suffocation in the second degree as provided in section 53a-64bb, as amended by this act, and (1) in the commission of such offense, such person (A) uses or attempts to use a dangerous instrument, or (B) causes serious physical injury to such other person, or (2) such person has previously been convicted of a violation of this section or section 53a-64bb, as amended by this act.

(b) No person shall be found guilty of strangulation or suffocation in the first degree and unlawful restraint or assault upon the same incident, but such person may be charged and prosecuted for all three offenses upon the same information. For the purposes of this section, "unlawful restraint" means a violation of section 53a-95 or 53a-96, and "assault" means a violation of section 53a-59, 53a-59a, 53a-59b, 53a-59c, 53a-60, 53a-60a, 53a-60b, 53a-60c, 53a-61 or 53a-61a.

(c) Strangulation or suffocation in the first degree is a class C felony.

Sec. 4. Section 53a-64bb of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) A person is guilty of strangulation or suffocation in the second degree when such person restrains another person by the neck or throat or obstructs such other person's nose or mouth with the intent to impede the ability of such other person to breathe or restrict blood circulation of such other person and such person impedes the ability of such other person to breathe or restricts blood circulation of such other person.

(b) No person shall be found guilty of strangulation or suffocation in the second degree and unlawful restraint or assault upon the same incident, but such person may be charged and prosecuted for all three offenses upon the same information. For the purposes of this section, "unlawful restraint" means a violation of section 53a-95 or 53a-96, and "assault" means a violation of section 53a-59, 53a-59a, 53a-59b, 53a-59c, 53a-60, 53a-60a, 53a-60b, 53a-60c, 53a-61 or 53a-61a.

(c) Strangulation or suffocation in the second degree is a class D felony.

Sec. 5. Section 53a-64cc of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) A person is guilty of strangulation or suffocation in the third degree when such person recklessly restrains another person by the neck or throat or obstructs such other person's nose or mouth and impedes the ability of such other person to breathe or restricts blood circulation of such other person.

(b) No person shall be found guilty of strangulation or suffocation in the third degree and unlawful restraint or assault upon the same incident, but such person may be charged and prosecuted for all three offenses upon the same information. For the purposes of this section, "unlawful restraint" means a violation of section 53a-95 or 53a-96, and "assault" means a violation of section 53a-59, 53a-59a, 53a-59b, 53a-59c, 53a-60, 53a-60a, 53a-60b, 53a-60c, 53a-61 or 53a-61a.

(c) Strangulation or suffocation in the third degree is a class A misdemeanor.