Recent Rape/Sexual Assault:
National Guidelines on Referral and Forensic Clinical Examination in Ireland

3rd edition 2014
Strategic Vision

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

The strategic vision will be realised by:

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

Working Philosophy

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

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

Mission Statement

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

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

The above were developed, through collaborative inter-agency input from all the different agencies, which together make up the Irish Sexual Assault Response Services.
Recent Rape/
Sexual Assault:
National Guidelines on
Referral and Forensic
Clinical Examination
in Ireland

3rd edition 2014

How to Access and Reference this Document

Acknowledgments and Thanks

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

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

This is the third edition of the ‘Recent Rape/Sexual Assault: National Guidelines on Referral and Forensic Clinical Examination in Ireland.’ The purpose of this document is to facilitate all aspects of a responsive and coordinated service for women and men over the age of 14 years who have been raped or sexually assaulted. This revised document includes a number of updates and relevant additions to the various sections, and as such this document replaces the 2nd edition entirely.

The interagency nature of these guidelines enables consistent provision of high quality care at all stages of the journey, regardless of the circumstances of the incident or the person’s involvement with criminal justice agencies. This document ensures that clearly defined referral pathways exist, so that women and men can access appropriate individualised care that is responsive to their needs. It is important to highlight that people respond to instances of sexual violence in different ways, and while this document provides guidance for compassionate and effective care, it does not represent the only medically or legally acceptable response. There may be circumstances where personal or clinical factors may mandate appropriate deviation from these guidelines.

This edition also introduces, for the first time, guidelines for collection and preservation of evidentially valuable forensic samples, in circumstances where the person has yet to decide to report to An Garda Síochána (Section 2: 21, p. 100). This is a welcome development for Irish SATUs which will bring us in line with international best practice. To date, if a man or woman presented to an agency (SATU, acute medical facility, Rape Crisis Centre or indeed An Garda Síochána) after an acute incident of sexual violence, the person had two options:

Option 1: To report the incident to An Garda Síochána, who would bring them to a SATU where they would receive comprehensive medical, psychological and forensic care, injuries would be documented and treated and appropriate forensic samples would be taken.

Option 2: Attend the SATU to avail of a health check and receive medical and psychological care, but without reporting the incident to An Garda Síochána. However, in the absence of An Garda Síochána, forensic samples could not be taken. If the patient chose this option, but subsequently changed their mind and reported the incident to An Garda Síochána, the opportunity to take time sensitive forensic samples may have passed, which could compromise potential prosecution.

These two options still exist, and indeed the majority of patients attending SATUs will continue to choose one of these options. However, undoubtedly, the person makes the decision whether or not to report an incident to An Garda Síochána at a time of immense personal stress, often while exhausted and terribly disturbed by events. As biological evidence deteriorates quickly, they may feel under pressure to make this decision with greater rapidity than they would like and the acute trauma of the events may have impacted on their ability to make an informed decision. Unfortunately, the person’s decision is taken at either end of a continuum of ‘all or nothing’ or ‘now or never’ with regard to reporting the incident and gathering time sensitive forensic evidence. This may lead them to a decision not to report the incident, which they may later regret. The new reporting option, which is available for persons over 18 years of age, allows for the collection and preservation of evidentially valuable forensic samples, in circumstances where the person has yet to decide to report to An Garda Síochána.

As a service, and group of interagency professionals, we continue to be irrepressibly ambitious for the future. We will remain involved with National and International programmes and strategies as they progress, to reduce sexual crime but also continue to focus on provision of the highest standard of responsive care to those who need it. Ongoing developments within the SATU services that have occurred in conjunction with revision of these Guidelines include development of a suite of Key Performance Indicators (KPIs) to assess and monitor various aspects of service provision, quality of care and interagency cooperation. These metrics are underpinned by the Mission, Vision and Philosophy of the services (Inside cover) and also the patient documentation template which is continuously under review. These developments are vital components of the interagency service.
that is provided. By the time the next revision of these Guidelines is launched we would hope to be further supported by technological developments including electronic patient records and data collection platforms.

In formulating the third edition of these guidelines, an evaluation of the second edition (2010) was carried out. This evaluation, combined with current best practice, provided the roadmap for updating this edition. Ongoing review and appropriate updating of these National SATU Guidelines will be a continued objective of this group. Please forward any feedback and suggestions for future editions to SATU@rotunda.ie with the subject heading: Guidelines feedback/suggestions.

References


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


USING THE GUIDELINES

Operational Definitions/Glossary of Terms/Abbreviation List

In devising this book of guidelines, the diversity of language used by each discipline/agency has been recognised. In order to facilitate the reader, the correct terminology which is used by the different professionals is reflected in the section relevant to that discipline. For further clarity, operational definitions, glossary of terms and an abbreviations list have also been included. (p. 202). When you first encounter an operational definition or term included in the glossary, the text is in italic print. The first time an abbreviation appears in the document it follows the full text in brackets e.g. Rape Crisis Centre (RCC).

Quick Reference Pages

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

- Response to a History of Rape/Sexual Assault (p. 13-14).
- Consideration for Referral of Younger Persons to Services (p. 15).
- Contact Details for SATUs and Psychological Support (p. 16).
- Flowchart - Storage of Evidence: Formally Reporting the Incident to An Garda Síochána (Section 2, p.110).

Discipline/Agency Guidelines Colour Coding

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

Boxes with Key Points

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

References

References used in a guideline are recorded directly after the relevant section of the particular guideline.
An Garda Síochána: Taking a Complaint of Rape or Sexual Assault

Physical & Psychological needs of the complainant are the priority

- Day/Date/Time/Place: Scene
- Name/DOB/Address: Nil by mouth
- Demeanour of complainant: Kit
- Injury/intoxication: Evidence Bags
- State of Clothing: Consider using an Early Evidence Kit

Contact SATU for Forensic Clinical Examination (p. 16)

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

Subject to statutory reporting requirements e.g. Children First Guidance\(^1\) or Withholding Information Act\(^2\)

RESPONSE TO A HISTORY OF RAPE/SEXUAL ASSAULT

GP or Emergency Department Response

Physical & Psychological needs of the patient are the priority

- Discuss contacting An Garda Síochána
- RCC personnel are available 24/7 to support the patient (p. 16)
- Discuss with the patient the relevance of contacting a SATU (p. 14)
- Depending on the circumstances (e.g. patient with serious injury), the Forensic Clinical Examiner can carry out the Forensic Clinical Examination at the referring hospital (p. 41)

If not involving a SATU:
- Examine patient, document findings and treat accordingly
  - Consider:
    - Emergency contraception (p. 89)
    - Chlamydia prophylaxis (p. 125)
    - Hepatitis B vaccine (p. 125)
    - HIV PEP (p. 127)
    - Check re: child protection and safety issues – home is safe, support of family/friends (p. 92)
    - Consider: Social Services referral and/or Primary Care Team referral, STI follow up (p. 130)

Subject to statutory reporting requirements e.g. Children First Guidance\(^1\) or Withholding Information Act\(^2\)
RESPONSE TO A HISTORY OF RAPE/SEXUAL ASSAULT

Psychological Support Response (Section 3 p. 113)

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

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

Subject to statutory reporting requirements e.g. Children First Guidance¹ or Withholding Information Act.²

SATU Response

Physical & Psychological needs of the patient are the priority

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

Option 1: Forensic Clinical Examination and care (Section 2, p. 56)

Option 2: Health check and care (Section 2, p. 87)

Option 3: Collection and Storage of Forensic Evidence without Immediate Reporting to of An Garda Síochána (Section 2:21 p. 100)

Subject to statutory reporting requirements e.g. Children First Guidance¹ or Withholding Information Act.²

References


CONSIDERATION FOR REFERRAL OF YOUNGER PERSONS TO SERVICES adapted

Obtain relevant details

For All Patients
- Counselling
- Facilitate appropriate supports if mental health concerns e.g. suicidal ideation, self harm
- Safe house placement
- Community resources linkage
- Follow-up for medical care/treatment as needed.

References
## Sexual Assault Treatment Units (SATUs)

<table>
<thead>
<tr>
<th>Location</th>
<th>Address</th>
<th>Email address</th>
<th>Tel. No.</th>
<th>Out of Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>CORK</td>
<td>South Infirmary, Victoria University Hospital (SIUH)</td>
<td><a href="mailto:satu@sivuh.ie">satu@sivuh.ie</a></td>
<td>021 4926297</td>
<td>Phone Hospital 0214926100 Nurse Manager on duty for Hospital</td>
</tr>
<tr>
<td>DONEGAL</td>
<td>Letterkenny General Hospital</td>
<td><a href="mailto:satu.letterkenny@hse.ie">satu.letterkenny@hse.ie</a></td>
<td>087 0681964</td>
<td>Phone Hospital 074 9125888 Nurse Manager on duty in the Emergency Dept.</td>
</tr>
<tr>
<td>DUBLIN</td>
<td>Rotunda Hospital</td>
<td><a href="mailto:SATU@rotunda.ie">SATU@rotunda.ie</a></td>
<td>01 817 1736</td>
<td>Phone Hospital 01 817 1700 ask for SATU</td>
</tr>
<tr>
<td>GALWAY</td>
<td>Hazeldour House</td>
<td><a href="mailto:satugalway.hsewest@hse.ie">satugalway.hsewest@hse.ie</a></td>
<td>091 765751</td>
<td>Phone 091757631 Nurse Manager on duty for Merlin Park Hospital</td>
</tr>
<tr>
<td>MULLINGAR</td>
<td>Midland Regional Hospital</td>
<td><a href="mailto:satu.mrhm@hse.ie">satu.mrhm@hse.ie</a></td>
<td>044 9394239</td>
<td>Phone Hospital 044 9340221 Ask for Nursing Admin to be bleeped</td>
</tr>
<tr>
<td>WATERFORD</td>
<td>University Hospital Waterford</td>
<td><a href="mailto:wh.satu@hse.ie">wh.satu@hse.ie</a></td>
<td>051 842157</td>
<td>Phone Hospital 051 848000 Nurse Manager on duty for Hospital</td>
</tr>
</tbody>
</table>

### Psychological Support Response (Section 3 p. 113)

**Dublin Rape Crisis Centre (RCC)**

24 hour National Helpline Number is:

1 800 778 888

Details of all RCCs available at:

www.rapecrisishelp.ie
Preservation of Forensic Evidence

NB. Medical stability always takes priority

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

For All Types Of Rape/Sexual Assault

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

Vaginal & Anal Rape/Sexual Assault

The person should not if possible:

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

If possible:

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

Oral Rape/Sexual Assault

The person should not if possible:

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

Clothing

The person should if possible:

- Change out of the clothes worn at the time of the rape/sexual assault as soon as possible.
- Place the items of clothing in separate paper bags (not plastic) and label immediately¹ (See section 1:7, p. 28).
- Underwear, worn after the incident, should also be collected and placed in a separate paper bag.²
Personnel if possible:

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

If clothing has to be cut:

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

Wounds and Blood/Saliva/ Semen Stains

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

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

- Do not talk, cough or sneeze over any specimens.¹⁻³
- Do not handle specimens, but if specimen must be handled then do so with gloved hands.
- If bullets are handled then use gloved hands – metal forceps should NOT be used.
- Package specimens individually in an appropriate bag and label immediately⁴ (See 1:6 p. 27, 1:7, p.28).

NB. The continuity of evidence should be maintained (See 1: 6 p. 27).

References


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AN GARDA SÍOCHÁNA

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1:9  Collection and Storage of Forensic Evidence Without Immediate Reporting to An Garda Síochána - See Section 2:21, p. 100.  27
Role of An Garda Síochána

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

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

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

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

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

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

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

If the Court does decide that an individual is guilty beyond reasonable doubt, then the Judge, when deciding the appropriate sentence for the convicted person, will request background information on the culprit from the Gardaí. To assist the Judge in making an informed decision regarding the sentence the Gardaí supply all known background information, both favourable and unfavourable, to the Court. The Judge will look for a Victim Impact Report regarding the effect that the criminal offence has had on the injured party.
The penal stage of the system is also independent of An Garda Síochána and Gardaí do not have an input as to where a prisoner is located or the category assigned to the prisoner. An Garda Síochána do provide information to Prison Governors on a particular prisoner’s background, especially where the prisoner is unknown to the prison authorities. An Garda Síochána is separate and autonomous from the other elements of the Criminal Justice System, but there is a high degree of goodwill and co-operation between the different agencies.

### See also

The Law in Relation to Sexual Offences in Ireland (See 7: p. 156).

Appendix 1: Sexual violence prevalence information (p. 166).

## 1:2 Initial Actions on Receipt of a Complaint

### An Garda Síochána:

Taking a Complaint of Rape or Sexual Assault

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<td><strong>Injury/intoxication</strong></td>
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<td><strong>State of Clothing</strong></td>
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**Contact SATU for Forensic Clinical Examination (p. 16)**

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

Subject to statutory reporting requirements e.g. Children First Guidance\(^1\) or Withholding Information Act.\(^2\)

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

- Chapter 23 of the Garda Síochána Code.
Disclosing a sexual offence is often difficult for a complainant. Gardaí should adopt a caring, sensitive and non-judgemental approach throughout the entire investigative process. Investigating Gardaí should bear in mind the emotional and physical pain the victim may be suffering (See 3:2, p. 115), while ensuring that all available evidence regarding the reported offence is obtained. On receipt of a complaint to a member of An Garda Síochána, where a Forensic Clinical Examination is required, the following steps should be followed:

- **Immediate medical assistance should be sought, if necessary.**
- The investigation process must be explained to the complainant.
- It should be established if the complainant consents to a Forensic Clinical Examination.
- Where the complainant is under 18 years of age, the consent of the parents/guardians is also required.
- Contact is made with a Sexual Assault Treatment Unit/Forensic Clinical Examiner to arrange a prompt Forensic Clinical Examination (p. 16).
- Use an Early Evidence Kit where necessary and appropriate, particularly where the forensic examination is expected to be delayed (See 1:5, p. 25).
- To prevent the cross-contamination of evidence (See 5:5, p.138); ensure any suspect(s) are not brought to any place that the complainant has been.
- Use an unmarked patrol car, where possible, in taking the complainant to the Sexual Assault Treatment Unit/Forensic Clinical Examiner.

**KEY POINTS: Sensitivity to Complainant**

- Explain procedures.
- Consent sought for Forensic Clinical Examination.
- Use unmarked patrol car where possible.
- Gardaí should dress in plain clothes if possible.
- Avoid areas where complainant may be identified if possible.
- Use Early Evidence Kit if indicated (See 1:5, p. 25).
- Change of clothing brought with complainant to SATU.
- Be aware and sensitive to the needs of the complainant.
1:3 Interviewing the Complainant

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

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

1:4 Specialist Victim Interviewers and Dedicated Interview Suites

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

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

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

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

Garda, HSE and Child & Family Agency (Tusla) personnel throughout the State have received extensive training as Specialist Victim Interviewers and must be employed where appropriate in the circumstances outlined above.
A number of dedicated interview suites have been developed throughout the country to be used for the video-recorded interviewing of such complainants. Pending their availability, these suites may also be employed for the taking of written statements from other victims of sexual crime as the setting may be more appropriate than most areas in Garda stations.

KEY POINTS: Taking a Statement

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

Specialist Victim Interviewers and Dedicated Interview Suites:
- For all complainants under the age of 14 years.
- For all persons with an intellectual disability.
- For other complainants of sexual crime over the age of 14 years, where appropriate.

Detailed Account Taken of:
- Events leading up to incident.
- Incident itself.
- The events following the incident.

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

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

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

The early evidence kit contains:

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

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

• It is designed to be used in cases where there is going to be a delay between the complaint of rape/sexual assault and the Forensic Clinical Examination.

• **It is to be used primarily in cases where:**
  
  A. Non-consensual oral sex is reported/suspected to have been an element of the sexual offending, (See Box: A overleaf) and/or
  
  B. Toxicological examination may be required as it is reported/suspected that the rape or sexual assault was drug/alcohol facilitated (e.g. where the complainant’s drink may have been ‘spiked’) (See Box: B overleaf).

### Early Evidence Kits

#### Box A: Oral Sex

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

- Gloves must be worn and swabs should be pre-labelled by the Garda with the victim’s name and the site that the sample was taken from.

- If the reported sexual assault occurred more than 24 hours prior to presentation, there is no need to take oral swabs, as semen does not persist in the mouth beyond this time (See 5:7, Table 16, p.141).

#### Box B: Drug/Alcohol Facilitated Rape/Sexual Assault

- If the complainant wishes to urinate and there is a delay getting a Forensic Clinical Examiner, a urine sample should be collected at this point.

- A large container is available in the Early Evidence Kit for the collection of urine. This can then be decanted into the smaller screw cap container provided.

- A Garda should witness the urine sample being taken and fill in the accompanying information form. Standing outside the cubicle is deemed adequate for witnessing.

- Urine samples collected from complainants of drug facilitated rape/sexual assault are analysed at Forensic Science Laboratory. A urine sample should be collected as soon as possible after the incident and up to 120 hours after the reported assault (See 5.8 on Toxicology, p.142).
**Procedure when using the Early Evidence Kit**

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

**KEY POINTS: Using Early Evidence Kit**

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

**Swab sites**

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

### 1:6 Continuity of Evidence

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

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

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

Each witness may be required to give evidence as to what was done with the item.
A Garda assumes the role of Exhibits Officer and all items should be handed over to the Exhibits Officer, who will prepare a chart showing all movements of the exhibits.

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

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

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

### 1:7 Collection of Clothing from the Complainant

- To avoid contamination, use gloves and other personal protection equipment (such as disposable coats) as required.
- The Garda who takes possession of the complainant’s clothing should have no prior contact with the suspect.
- The Garda should establish whether these clothes have been washed since the reported rape/sexual assault.
- Possession should be taken of the clothing the complainant was wearing during the reported rape/sexual assault, preferably before attending for a Forensic Clinical Examination to preserve evidence.
- Where the change of clothes has taken place prior to the Forensic Clinical Examination, the need to take possession of the new clothing, particularly underwear, may also be considered. Exhibit bags should be available for such an occurrence.
- Each garment/item should be placed in a separate exhibits bag.
- The exhibit bags should be sealed and clearly labelled by the Garda. Seal the bags by folding over the top of the bag and securing with staples or sellotape.
- If envelopes are used for smaller exhibits, these should not be sealed by licking.
- If the clothing is dry, pack items into separate sealed paper bags (Wet clothes - see Box 1 overleaf).
- Sanitary protection should be packed in paper bags supplied in the kit and then placed in the appropriate re-sealable plastic bag labelled “Panties/Sanitary Module”.
- Continuity of evidence (See 1.6, p. 27) should be maintained at all times.
1:8 Transfer and Storage of the Completed Kits (Sexual Offences Examination Kit and Toxicology Kit)

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

- Keep the medical form separate from the kits, do not put it in the tamper evident bags. The form must be submitted by the Gardaí when submitting the Kit/s to Forensic Science Ireland.

- On completion of the Forensic Clinical Examination, the samples taken should be packed and sealed in the new tamper evident bag provided for this purpose in all Sexual Offences Examination Kits.

- Toxicology Samples (i.e. alcohol/drug module): if taken, samples should be packaged in the new tamper evident bag provided for this purpose in all alcohol/drug modules.

- The person who packs and seals the used Sexual Offences Examination Kit and Toxicology Kit should fill in the label on the bags.

- The Garda should keep a record of the Serial Number on the tamper evident bag containing the Sexual Offences Examination Kit and on the Toxicology Kit tamper evident bag.

- The Sexual Offences and Toxicological Kits should be transported to Forensic Science Ireland, as soon as possible, by a member of An Garda Síochána, but in the interim the Kits should be kept in a fridge in a secure location.

- Continuity of evidence should be maintained at all times (See 1.6, p. 27).

KEY POINTS: Colds/Allergy/Hay Fever

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

Box 1: Wet or Heavily Blood Stained Clothing

- If the clothing is wet or heavily stained with wet blood pack items into separate paper bags, seal and submit to Forensic Science Laboratory immediately for drying.

- Inform the Forensic Science Laboratory when submitting exhibits that are wet or heavily bloodstained and that they require drying.
KEY POINTS: Transfer and Storage of the Kits

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

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

**See Section 2:21 p. 100**

Person Subsequently Reports the Incident to An Garda Síochána (See 2:35, p. 107).

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2 Sexual Assault Treatment Units: Introduction

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

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

2:1 Pre-requisites for All SATU Staff

- Have (or be in the process of undertaking) training in providing services and care for victims of sexual violence (relevant to the role to be undertaken).

- Have (or be in the process of undertaking) a local SATU induction programme, relevant to that particular SATU.

- Have a working knowledge of the most recent edition of the National SATU Guidelines and local SATU protocols/policies/guidance.

- Be committed to participating in an around the clock, on-call rota, as part of a coordinated SATU response.

- Be willing to respond within a defined timeframe i.e. within 3 hours from call to commencing the Forensic Clinical Examination. (KPI).\(^1\)

2.1.1 On-going Commitment to SATU:

- Attend relevant local liaison and update meetings etc.

- Participate, if applicable, in local/national Peer Review Meetings on a quarterly basis.

- Engage in supervision and avail of appropriate learning opportunities.

**Key Performance Indicator**

\(^1\) KPI: % of patients seen by a Forensic Clinical Examiner, within 3 hours of a request to SATU for a Forensic Clinical Examination (See Appendix 2: Record of Request for SATU Services, p.173).
• Address own health and wellness needs, mindful of this challenging area of care.

NB. The above lists are not definitive or exhaustive.

### 2:2 Forensic Clinical Examiner Role

The Forensic Clinical Examiner has many roles. A caring, non-judgemental approach is of the utmost importance when providing services for a victim of sexual crime. The Examiner should clearly convey that no one deserves to be raped and the patient is not responsible for the assault. The person should be reassured that he/she made the best choices possible, under the circumstances (See Box 2, p. 40). It is important to remember, that the person may not recollect the entire incident (See 3:2; p.115), or may be unable or unwilling to talk about some aspects of the incident.

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

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

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

An objective report of the history and examination findings is prepared and it may include an interpretation of the findings (See 2:20, p. 96, Appendix 3, p. 175). The report is best prepared as soon as possible, (KPIs)\(^{i,i} \) while the details remain fresh in the Forensic Clinical Examiner’s mind.

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**Key Performance Indicator**

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

2. **KPI:** % of patients seen by a Forensic Clinical Examiner, within 3 hours of a request to SATU for a Forensic Clinical Examination.
2:3 SATU Support Staff

The SATU Support Staff plays a key role in helping to co-ordinate responsive SATU care. This role is vital in prioritising the patient’s need for support and reassurance throughout their SATU attendance. Traditionally this role has been provided by registered nurses and midwives (‘assisting nurses’), but Units may choose to train and support other appropriately skilled staff members to provide this care. A local guideline/policy should outline specific responsibilities of the SATU Support Staff to ensure that the patient receives the highest standard of responsive care throughout their SATU attendance. In particular the following points should be considered:

Pre-examination

- Relevant personnel are informed that a case is commencing/ongoing e.g. Nursing/Midwifery Administration, Security Staff.
- Ensure that the RCC Psychological Support Worker has the opportunity to meet with the patient. \textbf{(KPI)}
- Follow the local anti-DNA contamination protocol at the section regarding SATU preparation before a case.
- Keep accurate relevant documentation including documenting delays. \textbf{(KPI)}

\textbf{Key Performance Indicator}

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

\textit{KPI}: % of patients seen by a Forensic Clinical Examiner, within 3 hours of a request to SATU for a Forensic Clinical Examination.
During the Examination

- Be with the patient, providing support and encouragement in a chaperone capacity.

- Answer questions or queries, if required.

- Assist the Forensic Clinical Examiner, with appropriate care provision within scope of practice. This may include documentation of weight, height & BMI, performing a urinary HCG (pregnancy) test, cleaning and dressing of wounds and administering prescribed medications according to professional guidance.8

- Prevent contamination of forensic samples (See 5:5 p. 138).

Post examination Care

- Offer the patient a shower and change of clothing.

- Facilitate the patient spending time with the Psychological Support Worker prior to discharge.

Following Completion of a Case

- Complete the SATU register and any relevant documentation.

- Best practice procedures followed for blood spillages, laundry, used instruments etc.

- Ensure the local anti-DNA contamination protocol re: actions on completion of a case are followed.

- Leave the SATU prepared and ready to receive the next patient.

- Inform appropriate personnel that the case is finished and the SATU is vacated.
All SATU Staff: Some Do and Don’ts. (See Box 2)

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

The Forensic Clinical Examiner is sometimes asked to evaluate a patient who has significant physical injury. Significant physical injury is rare, but may be more common in stranger attacks, rapes by an intimate partner\textsuperscript{9,10} and in male rape.\textsuperscript{11} In this circumstance, life threatening conditions must be dealt with as a priority, and the Forensic Clinical Examination can then be performed after stabilisation of the patient. Depending on the circumstances, the Forensic Clinical Examiner may carry out the Forensic Clinical Examination at the referring Hospital (See Box 3, overleaf). In these situations it is important to document the extent and reason for any delay (See consent re: unconscious patient: 2:5.3, p. 48).

**KEY POINTS:**

- Life threatening conditions must be dealt with as a priority.
- Forensic Clinical Examination performed after stabilisation of patient.
- The Forensic Clinical Examiner may carry out the examination at the referring Hospital.
- Document any delay and reason for the delay in performing Forensic Clinical Examination.
Box 3: Forensic Clinical Examination in locations other than a SATU

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

The following points should be noted

1. A liaison person should be identified by the Hospital or other facility where the Forensic Clinical Examination is to be carried out.

2. Both the Forensic Clinical Examiner and SATU Support Staff (‘Assisting Nurse’) should attend such cases.

3. Each SATU should have a defined list of items to be brought to a case. This list should include a set of patient documentation, Sexual Offences Examination Kit, equipment and disposable linen (if available).

4. Medications that may be required should also be brought – e.g. Emergency Contraception, Chlamydia prophylaxis, Hepatitis B immunisation and PEP (HIV).

5. Consideration needs to be given to potential sources of DNA contamination in the location of the Forensic Clinical Examination (e.g. Emergency Department).

6. Appropriate cleaning of the location prior to the examination and minimisation of staff throughput during the examination are important factors.

7. Forensic samples are taken and given directly to An Garda Síochána, to ensure the continuity of evidence from the moment of collection.

8. Patient information and appointment cards should be provided to facilitate ongoing patient care.

9. Appropriate follow up including RCC is organised.

10. Consent and the unconscious patient (See 2:5.3, p. 48).

References


Consent to Forensic Clinical Examination

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

Box 4: Consent

Consent is obtained when:

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

Remember

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

Consent is witnessed and signed by:

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

An outline of what should be explained to the patient prior to obtaining consent for Forensic Clinical Examination can be found in the National SATU Patient Documentation, 2nd edition. It is vital to ensure that the patient understands that personal details, details of the incident, examination findings as well as results of forensic samples will be recorded and may be disclosed to criminal justice agencies. Other details recorded in the Patient Documentation, including followup STI screening etc may also ultimately be disclosed, and patients should be advised of this.

Read and explain the consent form to the patient. At each section, a tick box is completed, to indicate if the patient is in agreement with each of the elements of the consent. The Forensic Clinical Examiner then obtains written informed consent for the Forensic Clinical Examination from the patient/parent or guardian. The consent is witnessed and signed by the attending Garda and the SATU Support Team Member.
Consent is also appropriately sought for:

- Any care/treatment given.
- Provision of a report to the GP regarding their attendance at the SATU.
- Future contact with the patient and methods of contact that they would prefer.

2:5.1 Special considerations re: Consent

Age

The age in relation to consent for a Forensic Clinical Examination is governed by different elements of the law (See table 1), all of which should be considered when obtaining consent for someone less than 18 years of age. The Childcare Act, 1991⁵ provides that due consideration must be taken of the wishes of the child as the child increases in age and understanding and the Children First Bill, 2014, regards the best interests of the child as a paramount consideration.⁶ If a parent or guardian is signing the consent, the young person, if appropriate, should also be encouraged to co-sign the consent form.

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

<table>
<thead>
<tr>
<th>Age</th>
<th>Legal consideration</th>
<th>Legal reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 yrs</td>
<td>“A minor who has attained 16yrs can consent to surgical, medical and dental treatment.”</td>
<td>Section 23: Non-Fatal Offences Against the Person Act (1997)⁷</td>
</tr>
</tbody>
</table>
| <18 yrs | A ‘child’ means a person under the age of 18 years other than a person who is or has been married.  
  The Child Care Act states that: “in so far as is practicable, give due consideration, having regard to their age and understanding, to the wishes of the child.”  
  Amendment to the Constitution of Ireland: “…….. in respect of any child who is capable of forming his or her own views, the views of the child shall be ascertained and given due weight having regard to the age and maturity of the child.” | Childcare Act (1991).⁵  
  Thirty-first Amendment of the Constitution (Children) Act 2012.⁹ |
### Table 1: Consent and Age Considerations

**NB.** Excerpts only – Each Act is available in full at [www.irishstatutebook.ie](http://www.irishstatutebook.ie)

**NB.** Some of the content below is still at Bill stage, status should be checked

<table>
<thead>
<tr>
<th>Age</th>
<th>Legal consideration</th>
<th>Legal reference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Withholding of Information Act</td>
<td>Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012.¹⁰</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
|       | “ offence if—                                                                                       
|       | (a) he or she knows or believes that an offence, that is a Schedule 1 offence, has been committed by another person against a child, and                                                                 |                                                                                                      |
|       | (b) he or she has information which he or she knows or believes might be of material assistance in securing the apprehension, prosecution or conviction of that other person for that offence, and fails without reasonable excuse to disclose that information as soon as it is practicable to do so to a member of the Garda Síochána.” |                                                                                                      |
|       | The Children First Bill states:                                                                                                                               | Children First Bill (2014).⁶                                                                      |
|       | “Mandated persons ¹¹ (1) …. where a mandated person knows, believes or has reasonable grounds to suspect, on the basis of information that he or she has received, acquired or becomes aware of in the course of his or her employment or profession as such a mandated person, that a child –                                                                 |
|       | (a) has been harmed                                                                                                                                             |                                                                                                      |
|       | (b) is being harmed, or                                                                                                                                            |                                                                                                      |
|       | (c) is at risk of being harmed, he or she shall, as soon as practicable, report that knowledge, belief or suspicion, as the case may be, to the Agency.”                                                                 |                                                                                                      |
|       | “The Agency (Child and Family Agency), in performing a function under this Act, regard the best interests of the child as the paramount consideration.”                                                                 |                                                                                                      |

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

### 2:5.2. Capacity

Capacity means the ability to understand the nature and consequences of a decision in the context of available choices, at the time the particular decision is to be made.¹² Some adults have a decision making ability which is permanently or temporarily limited so they may not have the capacity to make certain decisions.¹³
Assessment of Capacity

There is a presumption of capacity\(^2\),\(^{28}\) unless it is proven that this is not the case,\(^{28}\) for every person who has reached the age of majority, which is 18 years of age.\(^{14}\) All practical steps have to be taken to support a person in terms of decision-making capacity before it can be decided that he or she lacks capacity.\(^{29}\) Capacity should focus on the specific decision that needs to be made, at the specific time the decision is required.\(^2\) It does not matter if the capacity is temporary, or the person retains the capacity to make other decisions, or if the capacity fluctuates. The assessment of capacity is issue or task-specific.\(^2\),\(^{28}\),\(^{28}\),\(^{15}\) A person cannot be deemed to lack decision-making capacity simply because there is a risk that he or she might make an unwise decision.\(^{28}\) It is important to give those who may have difficulty making decisions the time and support they need to maximise their ability to make the decision for themselves.\(^2\) (See Box 5).

Box 5: To Demonstrate Capacity Individuals Should Be Able To:

- a. Understand in simple language what the Forensic Clinical Examination is, its purpose and nature and why it is being proposed.
- b. Understand the principal benefits, risks and alternatives.
- c. Understand in broad terms the consequences of not having a Forensic Clinical Examination and appropriate treatment.
- d. Retain the information for a sufficient period of time, in order to consider it and arrive at a decision.
- e. Communicate that decision whether by talking, writing, using sign language, assisted technology or any other means of communication?\(^2\),\(^{28}\) Adapted

Assisted Decision-Making

The philosophy of the Assisted Decision-Making (Capacity) Bill 2013,\(^{28}\) is to safeguard the person’s autonomy to the greatest extent possible. The Bill moves away from the more paternalistic focus on best interests. This is because international good practice advises that it is better to enable a person to take his or her own decisions than to have a third party decide what is best.\(^{28}\) The Forensic Clinical Examiner should work from a position of enabling the person’s decision making rather than purely from a best interests or their perceived best course of action viewpoint.

In situations where the person does not, regardless of assisted decision-making support, have the capacity then best interest decisions weigh up a range of factors (including the wishes or preferences, if known, of the person and the views of their families and carers) and decide what is on balance, the best for the person both now and in the future.\(^2\),\(^{28}\) ‘Best interests’ encompasses not only medical but also ‘emotional and all other welfare best interests.’\(^{16}\) The aim is to build up a picture of the person’s preferences so that the action taken will tally with what the person would have wanted, had she or he been able to say so.\(^{28}\)
### 2:5.3 Patient with Serious Injury/Unconscious Patient

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

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

Acting on the basis of good professional practice, the Forensic Clinical Examination should be undertaken if it is considered to be in the best interests of the patient. The rationale behind any decisions, the factors considered and the judgements made need to stand up to any future scrutiny. All steps taken and decisions made are clearly documented (See Box 6).

#### Patient Regains Capacity

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

---

**Box 6: Patient with Serious Injury / Unconscious**

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

- Prior to undertaking the Forensic Clinical Examination the Forensic Clinical Examiner speaks with and informs the patient’s family/significant others.*

- Elicits any beliefs and values the patient may hold prior to this so these can be taken into account.¹ ² ²⁸

*NB: A family member has no legal right to give or refuse consent on behalf of the adult patient.²

---

### 2:5.4 Intoxicated Patients

There may be a temporary loss of capacity in patients who are intoxicated due to alcohol or drugs. A guiding principle is that no action should be taken if the matter is not urgent, or if the person is likely to recover capacity shortly. Forensic Clinical Examination should therefore normally be deferred until the patient’s capacity has returned. Always record the clear and precise reasons for deferring a Forensic Clinical Examination. Time is crucial as regards the collection of forensic evidence and therefore
the Forensic Clinical Examination should take place as soon as capacity returns. The Gardaí may wish to use an Early Evidence Kit in the interim period (See 1:5, p. 25).

2:5.5 **Communication Difficulties and Informed Consent**

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

2:5.6 **Use of Interpreters**

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

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

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

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

 Guidance on good practice in the use of interpreters and Emergency Multilingual Aids can both be accessed from [www.hse.ie/ema](http://www.hse.ie/ema).
2:5.7 **Deaf/Hard of Hearing**

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

It is important that you write down your name and explain that you are here to help her/him. In order for the patient to give consent it may be necessary to use non traditional methods, for example, the use of anatomical pictures/sketches may help the patient identify the nature, details and circumstances of the sexual assault (See Box 7).

**Sign Language Interpreting Services**

To reinforce: **it is not appropriate** to ask family member/friends to interpret for patients. Using a sign language interpreter is the only effective communication method with someone whose first language is sign language (See 2:5.6; p.49).

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**Box 7: Communicating With Deaf/Hard of Hearing Patients**

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

For further information contact DeafHear.ie

www.deafhear.ie  Tel: 018175700
2:5.8 Blind or Vision Impaired Patients

Over 7,000 people use the services of the National Council for the Blind of Ireland (NCBI) every year and of this figure 95% have some degree of useful vision. If a person is vision impaired, their vision may be blurred, colours can become dulled and they may not see small details. The NCBI give information on a range of ways in which services for the blind or vision impaired patients can be more accessible (See Box 8).

Box 8: NCBI Services: Care for Blind or Vision Impaired

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

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

Blind or vision impaired patients should be supported through effective communication to understand the process and give their informed consent (See Box 9 also 2:5.2, p. 46).

Box 9: Supporting the Process of Informed Consent
Blind or Vision Impaired Patient:

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

2:5.9 Patients with Disabilities

The Irish Medical Council’s: Guide to Professional Conduct and Ethics states “Patients with disabilities are entitled to the same treatment options and respect for their autonomy as any other patient. Disability does not necessarily mean lack of capacity.”

Furthermore, Ireland is a signatory to The United Nations (UN) Convention on the Rights of Persons with Disabilities 2006. Article 12 of the Convention views equal recognition before the law as a fundamental right for people with disabilities.

The Assisted Decision-Making (Capacity) Bill 2013 has been framed to meet Ireland’s obligations under Article 12 of the Convention. As discussed above, the Bill proposes a model of supported decision-making aimed at enabling all persons to exercise their decision-making capacity.
Any decision you make on intervention or non-intervention in the case of a person with a disability requires their consent. Where necessary you should consider getting a second opinion before making decisions on complex issues.\(^4\)

### 2:5.10 Patients with Intellectual Disabilities

Each patient should be assessed as an individual regarding their capacity to understand and give their consent (See 2:5.2, p. 46). If a person with an intellectual disability lacks the capacity to give consent, you should consult their parents, guardians and/or carers. Many Intellectual Disability Services now have a Designated Person structure, with nominated Organisation Designated Persons and onsite Designated Contact Persons to manage abuse incidents/allegations. The SATU should set up service level agreements with the Intellectual Disability Services locally with regard to referral processes and activating the Organisation Designated Persons system. The benefits of using Garda Specialist Interviewer’s skills should also be considered (See 1.4 p. 24).

### 2:5.11 Patients with Mental Health Conditions/Disorders

Consent in relation to a patient with a mental health condition should be obtained in the same manner as all other patients that is - they give their consent freely, following adequate information which is given in the appropriate manner\(^4\) (See 2:5.2, p. 46). Where an adult patient is deemed to lack capacity to make the decision then steps should be made to find out whether any other person has legal authority to make decisions on the patient’s behalf.\(^4\)

In the case of a patient who is an inpatient through an Involuntary Admission Order to a Psychiatric Hospital, then the Consultant Psychiatrist responsible for the care and treatment of that patient assesses that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment.\(^29, 30\) Guidance on consent with regard to the Mental Health Act\(^29\) and the Mental Health Commission (MHC) reference guide\(^30\) should be accessible from within the SATU.

### 2:5.12 Ward of Court

A Ward of Court falls into two categories of “Wards”:

- The first comprises adults who have been brought into Wardship because of mental incapacity.
- The second is persons under 18 years of age who are taken into Wardship as minors.\(^31\)

**Ward of Court and Forensic Clinical Examination:**

The following approach has been recommended by the Wards of Court Office (May 2014):

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

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

Office of Ward of Court Contact Details

Office of Wards of Court
Phone: 01 888 6189/6140
Fax: 01 8724063
E-mail: Wards@courts.ie

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

2:5.13 Refusal of a Forensic Clinical Examination

Every adult with capacity is entitled to refuse medical treatment, and their refusal must be respected. A person cannot be deemed to lack decision-making capacity simply because there is a risk that he or she might make an unwise decision. If a patient chooses not to have a Forensic Clinical Examination, then they should do so with a clear understanding of the implications of the choice they are making. If the person does not report the incident to An Garda Síochána and have a Forensic Clinical Examination performed, they must understand that the case will not progress through the criminal justice system. The person can report the incident to An Garda Síochána at a future date if they change their mind; but they must be aware that any delay in reporting the incident may cause forensic evidence to be lost. Other options available e.g. Forensic Clinical Examination without involvement of An Garda Síochána and storage of evidence are fully explained (See 2:21, p.100). The Rape Crisis Centre personnel and SATU Staff are available to support the person with her/his decision making (Other possible scenarios: see Box 10).
Box 10: Possible Scenarios (See also Option 3, p. 100)

**Patient Wishes to Seek Advice from An Garda Síochána:**

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

**Action:**

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

**Patient Does Not wish An Garda Síochána Involvement:**

**Action:**

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

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

**References**

1. Faculty of Forensic and Legal Medicine. (FFLM) Consent from patients who may have been seriously assaulted. Academic Committee of the FFLM. July. 2011. Due updating July 14 checked 20th August 14, not yet updated [www.fflm.ac.uk/](http://www.fflm.ac.uk/)


Recent Rape/Sexual Assault: National Guidelines on Referral and Forensic Clinical Examination in Ireland. 3rd edition; 2014.


2:6 Forensic Clinical Examination

2:6.1 History Taking

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

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

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

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

To ensure accuracy:
- The history may be read back to the patient.

References


6 National Judicial Education Program: Legal Momentum USA. Medical Forensic Sexual Assault Examinations: What Are They, and What can They Tell the Courts? National Judicial Education Program, Legal Momentum in Association with the National Association of Women Judges. 2013. www.njep.org


2:6.2 **General History**

The general history should include the following information:

- Past relevant medical/surgical/psychiatric/family history.
- Medications.
- Allergies.
- Social history: alcohol intake/cigarettes/illicit drug use.
- Home circumstances, with a view to discharge planning.\(^1,2,3,5,6,7\)

**Gynaecological/Obstetric history including:**

- Menstrual cycle.
- Date of last menstrual period.
- Tampon/sanitary pad use.
- Obstetric history.
- The patient is asked if they had sexual intercourse within the last 7 days.
  
  If yes:
  - Type and frequency of sexual experience.
  - Use of a condom.
- Contraceptive use.
- Possibility of current pregnancy.\(^1,2,3,4,7\)

2:6.3 **Forensic History**

The forensic history provides a brief account of the incident (See overleaf). The patient must be informed that they may stop the questioning for a time if they wish and then continue, if and when ready. The patient is given the time throughout to find the words to articulate details of the event (See SATU National Patient Documentation: Specific Information Relating to the Incident; p. 7).\(^2\)
Forensic History Taking should Include:

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

Also noted is the following:

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

Any bleeding:

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

After the incident, document whether the patient has:

- Eaten/brushed teeth/washed out mouth (If the oral cavity was involved).
- Bathed/showered.
- Changed clothes, including panties/underpants.
- Opened their bowel (If anal involvement).
- Passed urine, if yes, how many times since the incident and the time they last urinated.
2:6.4 Prior to Commencing a Forensic Clinical Examination

Prior to Commencing a Forensic Clinical Examination

Record:
- Date and time (24 hour clock) of the examination.
- Date and time (24 hour clock) of incident.
- Time interval from incident until examination.
- Location of the examination.
- Name of the Support SATU person.
- Name of any other person present (e.g. interpreter).
- Garda Name, Garda Station and Garda Registration Number.

The Sexual Offences Examination Kit

Check and record:
- The expiry date on the outside of the Sexual Offences Examination Kit.
- The Sexual Offences Examination Kit is opened in the presence of the Garda (Storage of evidence: See 2:21, p. 100).

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

2:6.5 Collection of Clothing

The patient should be asked to remove their clothing, including underwear (if relevant). A disposable gown is provided. If appropriate the patient may be asked to undress standing on a clean paper sheet, which will collect any debris that might be used as evidence. The clothing may need to be retained for forensic evidence\(^1,2,3,4,5,6\) (See 1:7, p. 28).
2:6.6 General Physical Examination

General Physical Examination:

- Appropriate measures are taken to prevent contamination of evidence (See 5:5 p. 138).
- A thorough physical examination is performed.
- It is best to begin the examination with a non-threatening approach, such as examining the head and neck first.
- A head-to-toe survey is carried out.
- The forensic samples may be collected as the examination progresses (Table 2: p 63). Where body fluids may have been deposited, or if there are marks or injuries on the skin, that the patient attributes to direct contact with the attacker, use the double swab technique (See below).

Double Swab Technique

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

Assessment of Non-Genital Physical Trauma

- Non-genital trauma may include: mouth trauma, lacerations, bruises, abrasions, evidence of bite marks, kicks, hand tie marks, tape marks etc. or marks from attempted strangulation (See 2:12, p. 79).

Documentation

- The Forensic Clinical Examiner should document all findings in detail as the physical examination proceeds.
- Documentation of general appearance, presentation and behaviour may also be appropriate, bearing in mind that individuals respond to stressful circumstances in different ways (See 3:2; p. 115).
- Relevant negative findings should also be documented.
- Body maps are helpful and are included in the National Patient Documentation Template and should be used to document injuries.
References

1 American College of Obstetricians and Gynaecologists. Committee Opinion. April 2014; No. 592.


5 Faculty of Forensic and Legal Medicine (FFLM). Recommendations for the collection of forensic specimens from complainants and suspects. July 2014 (Next review date January 2015) www.fflm.ac.uk


Collection of Forensic Samples

2:6.7 Collection of Forensic Samples

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

If there is an allegation of oral sex

The patient should not be given a drink until oral swabs have been taken either via an Early Evidence Kit (See 1:5, p. 25) or during the Forensic Clinical Examination (See Table 2 p. 63).

If toxicology is required

- Blood samples for toxicology should be taken as soon as possible (See Table 2, p. 66; 2:13, p. 85; 5:8, p. 142).

- If the patient needs to urinate, collect a urine sample in case it is required for toxicology (See Table 2, p. 66; 2:13, p. 85; 5:8, p. 142).

- Packaging of the toxicology specimens (See 2:13, p. 85).
<table>
<thead>
<tr>
<th>Unused swab</th>
<th>Control sample</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Submit one <strong>unopened</strong> swab (for every kit used).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>External lip swabs</th>
<th>Detection of body fluids on lips and skin around mouth e.g. semen; blood stain which may not be from the victim.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• If stain is moist, recover on a dry swab.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• If stain is dry, dampen swab with sterile water and rub lips and skin around the mouth.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Repeat with second swab.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Return swabs immediately to the tubes.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mouth swabs</th>
<th>Detection of semen if oral penetration within 1 day.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Take 2 sequential samples by rubbing swab around inside of mouth, under tongue and gum margins or over dentures and dental fixtures.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Return swabs immediately to the tubes.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skin swabs</th>
<th>Detection of body fluids on skin e.g. semen; saliva on kissed, licked, bitten area; blood stain which may not be from the victim.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• If stain is moist, recover on a dry swab.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• If stain is dry, dampen swab with sterile water.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Repeat with second swab.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Return swabs immediately to the tubes.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Head hair</th>
<th>Rationale for Collecting</th>
<th>Method of Collecting</th>
<th>Method of Packaging</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Detection of semen.</td>
<td>A. Cut or swab relevant area if applicable.</td>
<td>A. Place hair in plastic bag/ return swabs immediately to the tubes.</td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>Detection of fibres, foreign particles, foreign hairs.</td>
<td>B. Draw comb with cotton wool through all the hair.</td>
<td>B. Place in plastic bag.</td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td>Control sample for microscopic hair comparison.</td>
<td>C. Cut a representative sample of 10-20 hairs.</td>
<td>C. Place the hair in plastic bag.</td>
<td></td>
</tr>
</tbody>
</table>
**Panties/underpants and sanitary protection**

Detection of semen on sanitary protection and panties/underpants worn after incident.

**Panties/underpants and sanitary pads**

- Take panties/underpants worn at time of examination.
- Panties/underpants in paper bag. If wet, put paper bag into a plastic bag.
- Leave pad attached to panties if present.
- Pack in the tamper evident bag with the kit.

**Tampons**

- Take tampon if worn.
- Tampon in plastic bag.

**Vulval swabs**

Detection of body fluids if vaginal intercourse within 7 days or if anal intercourse within 3 days, or ejaculation onto perineum.

**First sample** (Moisten swabs with sterile water if required)

- Rub 2 sequential swabs over whole of vulval area.
- Return swabs immediately to their tubes.

**When using a speculum or proctoscope, take the sample beyond the instrument and avoid contact with its sides to prevent contamination.**

**Vaginal swabs – Low**

Detection of body fluids if vaginal intercourse within 7 days or if anal intercourse within 3 days.

**Second sample** (Moisten swabs with sterile water if necessary)

- Take 2 sequential swabs approx 1 cm above hymen, using a speculum.
- Return swabs immediately to their tubes.

**Vaginal swabs – High**

Detection of body fluids if vaginal intercourse within 7 days or if anal intercourse within 3 days.

**Third sample**

- Take 2 sequential swabs from the posterior fornix via the speculum.
- Return swabs immediately to their tubes.

**Endocervical swabs**

Take only if vaginal intercourse more than 48 hours previously.

**Final sample**

- Take 2 swabs via the speculum.
- Return swabs immediately to their tubes.

**Mons pubis area swabs**

Take only if pubic hair is absent. The detection of body fluids e.g. semen, saliva, blood that may not be from the victim.

- If stain is moist, recover on a dry swab.
- If stain is dry, dampen swab with sterile water.
- Repeat with second swab.
- Return swabs immediately to their tubes.
### PUBIC HAIR

**Take only if hair is present**

<table>
<thead>
<tr>
<th>Rationale for Collecting</th>
<th>Method of Collecting</th>
<th>Method of Packaging</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong> Detection of semen.</td>
<td><strong>A.</strong> Cut or swab relevant area if applicable.</td>
<td><strong>A.</strong> Place hair in plastic bag/return swabs immediately to the tubes.</td>
</tr>
<tr>
<td><strong>B.</strong> Identification of foreign hairs.</td>
<td><strong>B.</strong> Comb pubic hair.</td>
<td><strong>B.</strong> Place in plastic bag.</td>
</tr>
<tr>
<td><strong>C.</strong> Control sample for microscopic hair comparison.</td>
<td><strong>C.</strong> Cut a representative sample of about 10 hairs.</td>
<td><strong>C.</strong> Place the hair in plastic bag.</td>
</tr>
</tbody>
</table>

### Penile swabs

Detection of body fluids if intercourse within 7 days.

- Use swabs moistened with sterile water.
  - **A.** 2 sequential swabs from shaft & external foreskin.
  - **B.** 2 sequential swabs from coronal sulcus.
  - **C.** 2 sequential swabs from glans.
  - **D.** 2 sequential swabs from base of penis including pubic hair and scrotal sac.
- Return swabs immediately to their tubes.

### Perineum swabs

Detection of body fluids if vaginal or anal intercourse within 7 days.

- Take 2 sequential swabs from the perineum area using swabs moistened with sterile water.
- Return swabs immediately to their tubes.

### Perianal swabs

Detection of body fluids if vaginal or anal intercourse within 3 days.

- Take 2 sequential swabs from the perianal area using swabs moistened with sterile water.
- Return swabs immediately to their tube.

### Rectal swabs

Detection of body fluids if anal intercourse within 3 days.

- Pass a proctoscope 2-3 cm into the anal canal. (Use lubricant if necessary).
- Take 2 swabs from the lower rectum.
- Return swabs immediately to their tubes.
### Fingernails including false fingernails

Recovery of trace evidence (e.g. body fluid, possible fibres) or connection with fingernail broken at scene (if the circumstances suggest this as a possibility).

- **Preferably cut nails.**
- Place in evidence bag.
- If the nails are too short or cutting is unacceptable, moisten a swab with sterile water and thoroughly swab the area underneath each fingernail of one hand.
- Use a second swab for the fingernails of other hand.
- Return swabs immediately to their tubes.

### Blood EDTA

For DNA analysis

- Approximately 1 x 5ml of blood *(no more than ¾ full).*
  - Take 3ml of blood.
  - Place blood sample into sealed plastic containers provided.

### Buccal/FTA (FTA – Flinders Technical Associates)

DNA reference sample

- As per FTA instructions.
- Place in the evidence bag.

### Toxicology Samples

#### Blood

Detection of alcohol and drugs of abuse. Only taken if within **48 hours of incident.**

- Approximately 2 x 5ml of blood (no more than ¾ full).
- Place blood samples into sealed plastic containers provided and then into tamper evident bag.
- **REFRIGERATE OR FREEZE.**

#### Urine

Detection of alcohol and drugs of abuse. Only taken if within **120 hours of incident.**

- Ask subject to urinate into the wider foil capped container and decant into the 2 smaller glass tubes containing tablet *(no more than ¾ full).*
- **Do not discard tablet** (preservative for sample).
- Place urine samples into sealed plastic containers provided and then into tamper evident bag.
- **REFRIGERATE OR FREEZE.**

Testing cut hair for drugs of abuse is done 1 month after the incident (See 5:8 p. 142).
Table 3: Female External Genitalia

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

(See Table 4)

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

Hymen: Anatomical variations

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

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

2:7.2 The Vagina: Definition and Descriptive Terms
(See Table 5)

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

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

Descriptive terms for the vagina
- Anterior/Posterior.
- Left/Right.
- Lower third/Middle third/Upper third.

The Fornix: Spaces in which the upper vagina is divided; the spaces are formed by the protrusion of the cervix into the vagina. The spaces are referred to as:
- Anterior/posterior.
- Right/left.
2:7.3 Anal Canal: Definition and Descriptive Terms
(See Table 6)

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

- **Definition of the anal canal:** The terminal part of the large intestine extending from the rectum to the anal orifice.\(^5\)

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

### 2:8 Male External Genitalia

Table 7: Male External Genitalia (See Figure 2, p. 71)

<table>
<thead>
<tr>
<th><strong>Penis</strong></th>
<th>Male organ of reproduction and urination,(^6) composed of erectile tissue, through which the urethra passes. It has a shaft and glans (head); the glans may be covered by the foreskin.(^7,8)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shaft of the penis</strong></td>
<td>The shaft of the penis is the area from the body of the male to the glans penis and is composed of three cylindrical masses of erectile tissue.(^8) The dorsal surface of the penis is located anteriorly on the non-erect penis, and its ventral surface is in contact with the scrotum.(^9)</td>
</tr>
<tr>
<td><strong>Glans of the penis</strong></td>
<td>The cone shaped head of the penis,(^6) distal to the coronal sulcus.</td>
</tr>
<tr>
<td><strong>Foreskin</strong></td>
<td>The movable hood of skin covering the glans of the penis.(^6)</td>
</tr>
<tr>
<td><strong>Frenulum</strong></td>
<td>The thin fold of tissue that attaches the foreskin to the ventral surface of the glans penis.(^9) It attaches immediately behind the external urethral meatus.(^10)</td>
</tr>
<tr>
<td><strong>Corona</strong></td>
<td>The widest portion around the glans,(^10) the ridge that delineates the glans from the shaft of the penis.(^8)</td>
</tr>
<tr>
<td><strong>Coronal sulcus</strong></td>
<td>The groove at the base of the glans.(^9)</td>
</tr>
<tr>
<td><strong>Urethral meatus</strong></td>
<td>Situated at the end of the penis the external opening of the urethra which serves as the duct for both urine and ejaculate flow.</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Scrotum</strong></td>
<td>The scrotum is a pouch of deeply pigmented skin, fibrous and connective tissue and smooth muscle. It is divided into two compartments each containing one testis, one epididymis and the testicular end of a spermatic cord.</td>
</tr>
<tr>
<td><strong>Median Raphe</strong></td>
<td>A ridge or furrow that marks the line of union of the two halves.</td>
</tr>
<tr>
<td><strong>Perineum (Male)</strong></td>
<td>The area between the base of the scrotum and the anus.</td>
</tr>
<tr>
<td><strong>Anus</strong></td>
<td>See 2.7.3, p. 70</td>
</tr>
</tbody>
</table>

Figure 2: **Male Patients: Genital Landmarks**
Prevalence

In 2013, 677 patients attended the 6 Irish SATUs for care, 29 (4.3%) were male. Under-reporting is a feature of all sexual assaults, but it is an even greater entity in male victims. Cultural factors and social norms regarding masculinity and male sexuality may influence existing myths about male rape. The subject of male sexual assault therefore may remain "invisible and marginalised."
Service Provision

The vast majority of research on rape pertains to female victims.\(^1,2,4\) Feelings of shame and fear continue to discourage men from reporting and seeking services.\(^3\) Male victims fear they will be blamed\(^6\) and that relevant authorities will not believe them.\(^3\) In response, the services should promote a person/patient centred approach to service delivery, acknowledging and addressing the person’s fears,\(^5\) in a sensitive, non-judgmental and caring environment.

2:9.1 Obtaining a History from a Male Patient

The patient may have additional difficulties giving a history, due to some of the following:

- Societal norms, beliefs and myths about male sexual assault\(^1,2,3,7\)
- Fear that their sexual orientation may be questioned.\(^1\)
- Lack of understanding of the normal physiological response of the male body to high levels of physiological arousal associated with fear and anxiety and anal stimulation e.g. some men may experience an erection and/or ejaculation during the sexual assault.\(^1\)

2:9.2 Examination of the Male Patient

The Sexual Offences Examination Kit is used in both male and female patients.\(^8\) The history taking and examination of the male patient takes the same format as that for a female patient (See 2:5; p. 44, 2:6, p 56). The relevant forensic swabs and samples are taken (See 2:6.7, p.62 and Table 2; p. 63).

Genital examination and forensic swab collection is performed, if indicated:

- The external genitalia, perineum and peri-anal area are carefully inspected (See Figure 2, p. 71 and 2:8, Male External Genitalia, p. 70).
- It is important to note if the foreskin is present or if circumcision has been performed.
- The foreskin, if present, should be gently retracted where possible to view the urethral meatus and frenulum, for any signs of abnormality or any injury.
- Any retained foreign materials or secretions under the foreskin are collected.\(^9\)

History of Penetration of the anus

- Penetration of the anus may be by an object, digit or penis.\(^10\) (See 2:7.3; p. 70, Anal Canal: Definition and Descriptive Terms).
- Inspection of the anus for lacerations, bleeding or abrasions should be performed.
If there is reason to suspect that a foreign object has been inserted in the anal canal, then a digital rectal examination is performed prior to a proctoscopy or anoscopy.\footnote{11} Proctoscopy is usually only performed when anal assault is alleged or in cases of anal bleeding or severe anal pain post-assault. Swabs should be taken from the ano-rectal area (See Table 2: p. 65).

Ano-Genital Injury

If an ano-genital injury is present it should be clearly documented using standard accepted descriptive terminology for classifying wounds (See 2:12, p. 79). Further details on Ano-Genital injury see 2:11, p. 76.

References

2:10 Ano-Genital and Pelvic Examination

When relevant, following the general physical examination, patients should be offered a comprehensive assessment of the ano-genital area; during which injuries, scars and medical conditions are noted. This part of the examination may be particularly difficult for the patient because it may remind them of the assault.¹ Prior to commencing, inform the patient of any expected discomfort that they can stop the examination at any time.² Swabs are taken as suggested in the Sexual Offences Examination Kit (See Table 2: p. 63) for forensic evaluation from the external genitalia. A gentle stretch at the posterior fourchette may help reveal abrasions that are otherwise difficult to see.²

Vaginal Examination

The speculum examination should be performed after the complete examination of the external genitalia. A transparent plastic speculum, should if possible, be used for the vaginal examination to inspect the vaginal walls and cervix.¹ Assessment is made for vaginal and/or cervical bleeding, lacerations and/or foreign bodies. Any foreign body e.g. a tampon or hair should be removed and retained for forensic analysis.³ Swabs are taken as suggested in the Sexual Offences Examination Kit for forensic evaluation (See Table 2: p. 63).

Anal Examination

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

Proctoscopy is usually only performed when anal assault is alleged or in cases of anal bleeding or severe anal pain post-assault. The recommended swabs should be taken from the ano-rectal area (See Table 2: p. 63).

Pelvic Examination

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

References

2:11 Ano-genital Injuries

Ano-genital injury may be identified after either consensual or non-consensual sexual intercourse.\(^1,2,3,4\)

Based upon the available scientific evidence, in most clinical cases, it will not be possible to definitively determine whether individual ano-genital injuries were caused by non-consensual or consensual sexual acts. It is certainly accepted that there is conflicting evidence in relation to ano-genital injury after non-consensual compared with consensual intercourse. It is also accepted that ano-genital injury is not an inevitable consequence of sexual assault. The balance of evidence, however, appears to suggest that ano-genital injury (if present) is more likely to be identified following non-consensual (rather than consensual) intercourse.\(^2,3,4\)

Nevertheless, the majority of patients who undergo a sexual assault forensic examination will not have an ano-genital injury.\(^5,6\) Therefore it is very important to note that the absence of an identified injury does not disprove sexual assault.\(^7,8,9,10\) Since ano-genital injury is not an inevitable consequence of sexual assault, the absence of ano-genital injury does not imply consent by the victim, or mean that penetration did not occur.\(^11\) When ano-genital injury does occur, often the injuries are generally minor\(^10,12\) although less frequently, the injury may be so extensive as to require hospital admission for surgical repair.

Existing research has demonstrated a very wide range of injury prevalence data following rape and sexual assault.\(^13\) This is primarily due to the heterogeneity in research methodologies between studies.\(^13\) Variation in results depend on the aim of the study, age groups, race and population being studied, the duration between incident and examination, the clinical environment in which the examinations were performed, the grade of the examining physician and the assessment technique (e.g. colposcopy compared with direct visualisation) used by the examiner.\(^13\)

If injury does occur, it is most commonly seen at the posterior fourchette, fossa navicularis, the labia minora, the hymen and the perianal region\(^14,15\) (See Figure 1, p. 68). Abrasions, bruises and lacerations are the most common forms of injury. Using direct visualisation, the Forensic Clinical Examiner should record the presence or absence of any injury. If an ano-genital injury is present it should be clearly documented using standard accepted descriptive terminology for classifying wounds (Section 2:12, p. 79).
KEY POINTS: Ano-genital Injury

- Ano-genital injury is not an inevitable consequence of sexual assault.\(^5, \, 6, \, 10\)
- Absence of ano-genital injury does not imply consent by the victim, or mean that penetration did not occur.\(^11\)

On the basis of the available literature:
- It is not possible to determine from the genital and anal injuries whether the sexual acts were consensual or non-consensual.
- The balance of research evidence appears to suggest that ano-genital injury (if present) is more likely to be identified following non-consensual (rather than consensual) intercourse.

2:11.1 Role of Colposcopy in Sexual Assault Forensic Examination

The potential advantages of colposcopic examination include provision of a light source, magnification and the ability to obtain photo documentation.\(^10\)

It is known that colposcopy increases the rate of detection of injury after both consensual and non-consensual intercourse, particularly if it is carried out within 48 hours of intercourse.\(^4\) However, as discussed above, there continues to be discussion on the evidential significance of ano-genital findings at sexual assault forensic examination, and the increased identification of genital injury when colposcopy is used, which does not precisely define the aetiology of that injury.\(^12, \, 2, \, 3\)

Colposcopy is not currently in routine use for examination of adult women* in Irish SATUs. Other factors that need to be considered if routine use of colposcopy is to be explored, include acquisition and storage of equipment and images, maintenance and de-contamination of equipment, training of relevant personnel and data protection of acquired images.\(^16, \, 17\)

*See operational definition: Adult Forensic Clinical Examination: Glossary of Terms, p. 202

References


AEQUITAS A Prosecutor’s Reference: Medical Evidence ant the role of sexual assault nurse examiners in cases involving adult victims. Washington: AEQUITAS The Prosecutors’ Resource on Violence Against Women, 2010; p. 4. [www.AEQUITAS.RESOURCE.ORG](http://www.aequitasresource.org/)


Faculty of Forensic & Legal Medicine (FFLM) Guidance for best practice for the management of intimate images that may become evidence in court Royal College of Paediatrics and Child Health Association of Chief Police Officers: FFLM, June 2010 [www.fflm.ac.uk](http://www.fflm.ac.uk)

Faculty of Forensic and Legal Medicine (FFLM) Guidelines on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse FFLM, October 2012. [www.fflm.ac.uk](http://www.fflm.ac.uk)
2:12 Classification and Documentation of Wounds and Injuries

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

<table>
<thead>
<tr>
<th>Table 8: Standard Descriptive Terms for Classifying Wounds\textsuperscript{1,2} (adapted)</th>
</tr>
</thead>
</table>
| **Abrasion** | Defined as: *superficial injuries to the skin caused by the application of blunt force.* 
Produced by a combination of contact pressure and movement applied simultaneously to the skin. 
Different types of abrasions subdivided as: 
  - Scratches. 
  - Imprint e.g. pattern of the weapon leaving imprint abrasion on the skin. 
  - Friction e.g. grazes from contact with carpet or concrete. |
| **Bruise** | Defined as: *an area of haemorrhage beneath the skin* 
Bruising follows blunt trauma; the discolouration is caused by blood leaking from ruptured vessels. The site of the bruise is not necessarily the site of the trauma and may not necessarily reflect the shape of the weapon/s. Some bruises may bear features that may well assist in their interpretation. 
  - Bite marks: Oval or circular bruises with a pale central area (p. 81). 
  - Fingertip bruises: Caused by the forceful application of fingertips. Usually appear as 1 – 2 cm round shaped clusters of three to four bruises. There may also be a linear or curved abrasion from contact with fingernails. 
  - Patterned (imprint) bruises: Occurs when a bruise takes on the specific characteristics of the weapon used (e.g. the sole of a shoe). Clothing imprints may also occur. 
  - Petechial bruises: Pinpoint areas of haemorrhage and are caused by the rupture of very small blood vessels. Usually seen on the face, scalp or eyes after neck compression. 
  - Trainline bruises: These are parallel linear bruises with a pale central area produced by forceful contact with a linear object (e.g. stick or a baton) (See also 2:12.1 Bruising p.82). |
| **Laceration** | Defined as: *ragged or irregular tears or splits in the skin, subcutaneous tissues or organs resulting from blunt trauma. (e.g. trauma by impact)* 
Characteristics of a lacerated wound: 
  - Ragged, irregular or bruised margins, which may be inverted. 
  - Intact nerves, tendons and bands of tissue within the wound. 
  - The presence of foreign material or hair in the wound. 
The shape of the laceration may reflect the shape of the causative implement. |
**Incised wounds**

**Defined as:** *injuries produced by sharp edged objects whose length is greater than their depth.*

May be produced by a knife, razorblade, scalpel, sword or glass fragment.

Characteristics of an incised wound:
- Borders: sharply defined edges.
- Surrounds: minimal damage.
- Blood loss: variable, often profuse.
- Contents: rarely contaminated.

**Stab wounds**

**Defined as:** *incised wounds whose depth is greater than their length on the skin surface.*

Important points to note:
- The degree of penetration and depth of resulting stab wounds are affected by a number of factors, including:
  - the amount of force delivered;
  - the robustness of protective clothing;
  - the sharpness of the tip of the blade;
  - tissue resistance and any movement of the victim.

**Scab**

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

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

### Table 9: Documenting and Describing Features of Physical Injuries and Wounds

<table>
<thead>
<tr>
<th>Site</th>
<th>Record the anatomical position of the wound (reference to the nearest bony point can be helpful).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size</td>
<td>The dimensions of the wound(s) should be measured.</td>
</tr>
<tr>
<td>Shape</td>
<td>Describe the shape of the wound(s) (e.g. linear, curved, irregular).</td>
</tr>
<tr>
<td>Surrounds</td>
<td>Note the condition of the surrounding or the nearby tissues (e.g. bruised, swollen).</td>
</tr>
<tr>
<td>Colour</td>
<td>Observation of colour is relevant when describing wounds e.g. bruises (See Section 2:12.1 Bruising p. 82).</td>
</tr>
<tr>
<td>Course</td>
<td>Comment on the apparent direction of the force applied (e.g. in abrasions – horizontally; vertically; obliquely).</td>
</tr>
<tr>
<td>Contents</td>
<td>Note the presence of any foreign material in the wound (e.g. dirt, glass).</td>
</tr>
</tbody>
</table>
Injuries Caused by Teeth: Bite Marks

- Swab the affected area\textsuperscript{1,2,3} where saliva may be deposited using the double swab technique.\textsuperscript{2} (p. 61).
- Measure and record a full description and record also on body maps.
- Liaise with Garda Photographer.\textsuperscript{2,3} (p. 86).
- An odontologist’s opinion may be considered if appropriate.

Management

A wide range of pathogens may infect bites; the risk of infection increases with puncture wounds, hand injuries, full thickness wounds and those involving bones, tendons and ligaments.\textsuperscript{2} Therefore referral to the relevant emergency services may be required. Wound irrigation is recommended and antibiotics may need to be considered. Tetanus (See 2:16.1 p. 88) and Hepatitis B immunisation status of the patient should be established.\textsuperscript{2} (See section 4.2.2 p. 125)

\begin{itemize}
  \item Pyrek KM. Forensic Nursing. New York: Taylor Francis Group; 2006 p. 145 -156
  \item Faculty of Forensic and Legal Medicine (FFLM) & The British Association for Forensic Odontology. Management of Injuries Caused by Teeth. 2011. www.fflm.ac.uk
\end{itemize}
2:12.1 Bruising

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

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

When assessing a bruise the forensic examiner should document the individual characteristics of each bruise. This may include: its size, shape, location, colour(s), distinction of margins, and whether it is indurated or tender.\(^13\) If the patient is able to provide a history in relation to the bruise, then the explanation should be noted verbatim.\(^14\) On occasion, bruising may have a ‘patterned imprint,’ which may be representative of characteristics of the weapon or object used e.g. handprint, or a loop or belt print.\(^12,13\) It is also the case that there may be multiple bruises, that when examined as a whole, may demonstrate a ‘pattern of injury,’ (e.g. a history of being forcibly grasped may be consistent with a finding of finger-tip bruising, which is evident as a group of ovoid bruises, caused by the fingers, with a single ‘thumb’ mark).\(^13,15\) In all cases, it is important to consider bruising in the context of the history provided and, in particular, whether the bruising is consistent with the history.

Points worth noting:

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


7. CORE INFO: *Cardiff Child Protection Systematic Reviews*. [www.core-info.cardiff.ac.uk/reviews/bruising/ageing/](http://www.core-info.cardiff.ac.uk/reviews/bruising/ageing/)


2:12.2 Female Genital Mutilation (FGM)

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

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

### Table 10: WHO Classification of FGM 2008\(^{4}\)

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

For further sub-divisions of typology: [www.who.int/reproductivehealth.topics.fgmoverview/en/](http://www.who.int/reproductivehealth.topics.fgmoverview/en/)

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

**References**


On Completion of the Forensic Evidence Collection:

The Sexual Offences Examination Kit and Form

- Gloves are worn until the tamper evident bag is sealed.
- Check each sample is correctly labelled.
  - Patient’s name.
  - Patient’s Date of Birth (DOB).
  - Date sample was taken.
  - Sample description e.g. endocervical.
- Each sample is signed by the Forensic Clinical Examiner.
- Each sample is also signed by the Garda. (Storage of Evidence: See 2:31, p. 105).
- All specimens are packed in the tamper evident bag provided in the kit (except toxicology specimens).
- The Garda seals, dates and signs the tamper evident bag in the presence of the Forensic Clinical Examiner (Storage of Evidence: See 2:31, p. 105).
- All relevant information should be completed on the form by the Forensic Clinical Examiner and the form is signed and dated.
- The form is attached to the outside in a sealed bag, with the patient’s name, DOB and the date of examination on the outside.

Samples for Toxicology (See 5.8 p. 142)

- Samples are labelled as above and the time the specimen was taken is recorded on all toxicology samples.
- Keep the toxicology specimens separated from the Sexual Offences Examination Kit i.e. they are not packaged together.
- The Garda seals, completes and signs the tamper evident toxicology bag (Storage of Evidence: See 2:31, p. 105).
- Both tamper evident bags and the form for the Sexual Offences Examination Kit are submitted via the Gardai to Forensic Science Ireland (Storage of Evidence: See 2:31, p. 105).
Photographic Evidence

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

Consent to Photographic Evidence

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

Who Takes the Photographs?

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

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

The Future

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

Take photographs if:
- They would be relevant to convey the extent and impact of any injuries.

Taken following:
- Consultation with patient and Gardaí.
- The patient’s consent.

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

Record in the Patient Documentation:
- If a Garda Photographer is requested to attend SATU.
- Garda Photographer details if they attend SATU.

2:15 Care of the Patient

- Offer the patient a shower and a change of clothing after the examination.
- Emergency contraception (See 2:17, p. 89).
- Wound management and Tetanus Immunisation (See 2:16.1, p. 88).
- STI screening and treatment at Forensic Clinical Examination (See 4:2, p. 124).
- STI infection prophylaxis for bacterial infection (See 4:2.1, p. 125).
- Assessment for HIV PEP (See 4:3, p. 128).

Referral, follow-up care and discharge planning

- Referral, follow-up care and discharge planning (See 2:18.1 – 2:18.3 p. 92-94).
- STI follow-up (See 4:4, p. 130).
- Information regarding counselling re: Rape Crisis Centre (See section: 3.5, p. 120).
2:16 Wound Management

If the wound is considered minor it should be treated according to best practice for wound care.\(^1\),\(^2\) For more significant wounds, appropriate referral to the relevant ED\(^3\) should be made after taking forensic samples.

2.16.1 Tetanus Immunisation

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

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

**NB.** Occasionally, apparently trivial injuries can result in tetanus.\(^4\)

Check the patient’s tetanus immunisation status; if appropriate follow the Immunisation Guidelines for Ireland.\(^4\)

**NB.** Staff giving any immunisations (Tetanus or Hepatitis B) should ensure that they have training in Basic Life Support and anaphylaxis and that retraining is provided in accordance with best practice i.e. every 2 years.\(^5\)

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**Staff should be familiar with the following documents**\(^5\) adapted

A. Immunisation Guidelines for Ireland, 2013.  


C. Immunisation training slides for Health Professionals, National Immunisation Office, 2011.  

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

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**References**


2:17 Emergency Contraception (EC)

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

The most suitable method of EC will depend on the patient characteristics, the time that has elapsed since the assault and the timing of any unprotected consented intercourse.\(^4\) EC is offered as soon as possible after exposure, to maximise effectiveness.\(^1,5\) In general EC is effective and well-tolerated, although woman should be advised that no contraceptive method is 100% reliable.\(^1,4\) It is most effective if given within 72 hours (3 days) although it can be given up to 120 hours (5 days).\(^1\)

### 2.17.1 Emergency Contraceptive Pill (ECP): Levonorgestrel

There is some evidence to suggest that the ECP Levonorgestrel (LNG) is of value up to 5 days (120 hours) after unprotected intercourse,\(^1,6,7,8\) but it is not licensed for use after 72 hours. Local medication protocols for the supply and administration of the ECP LNG should be followed and patients should be provided with the appropriate information. A single dose of one LNG 1.5 mg. tablet is given orally.

### 2.17.2 ECP: Ulipristal Acetate - After 72 hours within 120 hours (5 days)

Ulipristal acetate (UPA) is licensed for use in Ireland as emergency contraception for use within 120hrs (5 days) of unprotected sexual intercourse or contraceptive failure.\(^9,10,11\) UPA should be considered for female patients who present to the SATU after 72 hours but within 120hrs (5 days). Local medication protocols for the supply and administration of UPA should be followed and patients should be provided with the appropriate information. A single dose of UPA 30mg tablet is given orally.\(^9\)

**Key Performance Indicator**

\(^1\) **KPI:** % of female patients who present within 72 hours and appropriately receive emergency (EC) contraception.
2.17.3 Insertion of Copper Intrauterine Device

Insertion of a copper containing intrauterine contraceptive (Cu-IUD) device is a highly effective method of preventing pregnancy,\(^\text{12, 13, 14, 15}\) and could be considered for women presenting after 72 hours but within 5 days (120 hours) of unprotected intercourse or expected date of ovulation. Each SATU should develop local pathways to facilitate patient access to Cu-IUD (Table: 11).

<table>
<thead>
<tr>
<th>Table 11: Time Frames for Emergency Contraception</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>METHOD</strong></td>
</tr>
<tr>
<td>Single dose of Levonorgestrel 1.5 mg. (one tablet) orally.</td>
</tr>
<tr>
<td>Ulipristal acetate 30mg (one tablet) orally</td>
</tr>
<tr>
<td>A copper containing intra-uterine device</td>
</tr>
</tbody>
</table>

2.17.4 Relevant Drug Interactions\(^\text{12}\)

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

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

Although it can take several days for liver enzyme-inducing drugs to take effect\(^\text{16}\) and there have been no interaction studies looking at the impact of dual administration of LNG and PEPSE, the Faculty of Sexual & Reproductive Healthcare (FSRH) Clinical Effectiveness Unit (CEU), recommends 3 mg LNG (two tablets) if a Cu-IUD is not available or not acceptable.\(^\text{17}\)

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

Women should be advised not to use UPA if they are currently taking drugs that increase gastric pH (e.g. antacids, histamine H2 antagonists and proton pump inhibitors).
2.17.5 Updated Information on Body Weight and Efficacy of ECP

Following meta-analysis concerns were raised that obese women (BMI >30 kg/m²) using LNG were at greater risk of pregnancy compared with those using LNG with a normal or low body mass index (BMI). This prompted changes in labelling of LNG containing emergency contraceptive products stating that in clinical trials, contraceptive efficacy was reduced in women weighing more than 75kg and LNG was not effective in women who weighed more than 80kg.

However, the European Medicines Agency (EMA) recently undertook a review of emergency contraception and have concluded that LNG and UPA are suitable emergency contraceptives for all women, irrespective of body weight.

References


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

2:18.1 Referrals

SATUs need to have a system in place whereby patients have access to a broad range of services/expertise which is immediately available, if the need arises e.g. Emergency Departments, gynaecology and mental health services1 (See Box: 11). Some of these needs are identified at the time of the Forensic Clinical Examination, whereas others may become apparent during the follow-up examinations. The examiner will use professional judgement and in consultation with the patient and/or parent/guardian, make the decision regarding appropriate referrals for support and care. This may include wound care, vaccinations (Tetanus, Hepatitis B vaccine) (See
Prevention and/or treatment of short and long term health problems. Referral is discussed with the patient and clearly documented in the SATU chart.

Box 11: Possible Follow-up Referrals

- Services / expertise from other services e.g. Emergency Department, Gynaecology, Mental Health Services.
- Follow up appointment or referral for STI screening (See 4:2, p. 124).
- Psychological support services (See 3:4, p. 119).
- For a patient under the age of 18 years, Children First 2 referral procedures must be followed.
- Social worker referral of vulnerable persons if appropriate (See 2:18.2).
- GP and/or other Primary Health Care Professionals (See 6:2, p. 153).

2:18:2 Social Services Referral

A Social Services referral is made for any person who may benefit from Social Services support and intervention. Each SATU should have local referral arrangements in place in conjunction with the local Child and Family Agency. The key aim of the Child and Family Agency (Tusla) and Children First Guidance is to promote the safety and wellbeing of children. For a person under the age of 18 years who attends SATU, Children First referral procedures must be followed. (KPI) All health care providers are obliged to follow Children First guidance and any person who makes a report in good faith, in the child’s best interests, is protected under common law by the defense of qualified privilege. The “Withholding of Information” Act 2012 ensures that all information regarding the safety and welfare of children and vulnerable persons is disclosed to An Garda Síochána, and it is an offence not to disclose this information.

If the child is in imminent risk of harm, emergency or Out-of-hours Social Services should be contacted. This may be facilitated via local arrangements between the SATU and local emergency Social Work services and/or An Garda Síochána.

A referral form is completed and sent to the patient’s local Duty Social Work department. Referrals should also be sent for children who may be

Key Performance Indicator

1 KPI: % of patients less than 18 years of age who had a referral made to the HSE Children and Family Services, at the first SATU visit.

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

If concerns exist regarding domestic violence/interpersonal violence it is vital that as well as being provided with a place of safety if required, the patient should also be given information of their local support services. A full list of national and local services available in Ireland can be accessed from the Cosc website www.cosc.ie. In the situation where children may be at risk Children First Guidance 2 must be adhered to. It is also recommended that the contact telephone number of the Garda Station proximate to the SATU, as well as the telephone number of the patient’s local Garda Station be made available. A full list of Garda Stations is available at www.garda.ie

Where there are concerns of elder abuse the HSE Elder Abuse guidelines are consulted and followed. If the alleged perpetrator of the abuse is a member of the Health Services Executive staff, the document “Trust in Care” gives policy guidance for the procedures to be followed.

2:18.3 Follow-up care

Appropriate follow-up care is arranged depending on individual patient needs and local services. For Sexually Transmitted Infection follow-up see 4:4 p.130. (KPIs)

2:19 Discharge

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

(See Box 12 for discharge information which is given to the patient.)

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

Key Performance Indicator

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

2. **KPI:** % of patient SATU documentation completed, with regard to the patient being asked (at the first SATU visit) if their home was safe.
2:19.1 Patient Feedback Mechanism

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

Box 12: Discharge information given to the patient:

1. Patient Information Leaflet\textsuperscript{10} which should include:
   - Date of attendance
   - Tests/procedures performed
   - Medications given
   - Follow-up appointment date and time, and what will take place at that appointment
   - Contact details for SATU, Gardaí and RCC as relevant
2. Instruction on the care of any injuries.
3. Medication instructions, if applicable.
4. Referral letter, if applicable.
5. Information re: Social Work referral as per Children First Guidance\textsuperscript{2}
6. If the patient consents a letter is provided for the G.P.
7. Letter for work, college, school, if required.
8. Phone number and printed information leaflet from the RCC.
9. Relevant information leaflets specific to the individual patient’s needs, e.g:
   - Domestic Violence\textsuperscript{6, 7, 8}
   - Interpersonal Violence.
   - Drug and Alcohol programmes\textsuperscript{11}
   - Personal Safety Awareness programmes\textsuperscript{12}

References

2:20 Legal Report Writing

The Forensic Clinical Examination report should be dictated/typed as soon as possible after the Forensic Clinical Examination. A legal report template, covering all the salient points may be useful (See Appendix 3: SATU Legal Report Template; p. 175).

2:20.1 Responding to an Additional or Alternative Opinion

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

- Will be furnished with a copy of the additional or alternative opinion.
- May be asked for their opinion on the additional or alternative opinion.
- The original Forensic Clinical Examiner's further opinion may then become particularly important; sometimes explaining or indeed changing the opinion they gave in their original report.
• The Forensic Clinical Examiner responds with their comment on the findings and the academic content in the additional or alternative report, focusing always on the relevance to the particular case.

• No new or undisclosed material should be brought by the Forensic Clinical Examiner into court. Any such material e.g. literature etc. that is used in response to the additional or alternative opinion should be disclosed in advance (See 7:4, p. 160).
### Option 3: Collection and Storage of Forensic Evidence Without Immediate Reporting to An Garda Síochána

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

2:21 Introduction to Option 3

This care pathway (Option 3) allows for the collection and preservation of evidentially valuable forensic samples, in circumstances where the person has yet to decide to report to An Garda Síochána. Women and men over 18 years of age can now choose to attend a SATU, where they will receive the full package of care, including examination and collection of forensic samples (See 2:6, p. 56). These samples will then be stored in an appropriate facility within the SATU for up to one year with all checks in place to ensure continuity of evidence. Over that time, the person can come to an informed decision, regarding whether or not they wish to report the incident to An Garda Síochána. As the evidence will be in secure storage, this can subsequently be released to An Garda Síochána to facilitate detection of the reported crime.

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

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

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

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

Should a prosecution proceed following the Option 3 pathway, the reason for any delay in reporting the incident to An Garda Síochána will need to be explained by the complainant.
If the incident happened in another jurisdiction Option 3 is still available, but the evidential value of the samples will be subject to the national law of that jurisdiction, as such there may be unforeseen restrictions on their probative value.

It is hoped that the provision of Option 3 will increase the rates of reporting of sexual crime; as people who are uncertain about their reporting intentions will not make a rapid decision not to report the incident, which they may subsequently regret. In the United States Military Model, in 2007, 14% of victims who had initially chosen to restrict their reports later reported to allow a criminal investigation to ensue. Whilst there is no ‘statute of limitation’ in respect of serious offences and delayed reporting should therefore not be considered an impediment to prosecution per se or indeed to affect the credibility of a complainant, there are legal consequences to delayed reporting which are discussed more fully at See 7:6, p. 162.

References


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

Not reporting to An Garda Síochána* at the initial SATU visit but having:

- A Forensic Clinical Examination without Garda involvement.
- Storage of the Sexual Offences Examination Kit/Toxicology Kit for the defined duration of 1 year (unless a further year is requested in writing by the patient, samples are destroyed).
- Contemporaneous medico-legal report to be written and filed confidentially in the SATU (i.e. not issued to An Garda Síochána at this juncture).

- The person has a choice at a later date to make a formal report to An Garda Síochána:
  - The Sexual Offences Examination Kit/Toxicology Kit and the medico-legal report will then be released to An Garda Síochána (ensuring the continuity of evidence).

*Subject to statutory reporting requirements e.g. Children First Guidance¹ or Withholding Information Act.²


2:22 Aim/Objectives/Scope/Service Provision

2:22.1 Aim

The aim of this section of the document is to define best practice for SATUs who offer patients: Option 3: Forensic Clinical Examination with collection and storage of evidence without the immediate involvement of An Garda Síochána.
2:22.2 Objectives

To define:

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

2:22.3 Scope

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

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

2.23 Who Can Avail of Option 3?

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

2.24 Who Cannot Avail of Option 3?

- Persons less than 18 years of age.\(^1,2\)
- A person lacking the capacity to consent (See 2:5.2, p. 46).
- If the incident happened more than 7 days ago (See 5:6, p. 139).

2.25 Option 3: SATU Process

**NB.** The person may firstly contact another agency e.g. Rape Crisis Centre, An Garda Síochána or Healthcare Personnel and subsequently be referred on to a SATU.
2:25.1 SATU Process: Setting up an Appointment

- Give the person information regarding their options.
- Schedule an appropriate appointment.
- Link with appropriate supports.

2:26 When the Person Presents to the SATU

- The person is introduced to the SATU Team and is offered the services of the Psychological Support worker.
- The Sexual Offences Examination Kit is opened:
  - By the Forensic Clinical Examiner in the presence of the Support Nurse/Midwife.
  - Identifying details of the Kit and personnel are documented in the SATU chart.
- Consent:
  - Consent is obtained and **PART A** of the relevant consent form (SATU National Patient Documentation, p. 24) is completed.

2:27 Forensic Clinical Examination and Care

The history, examination and associated care follow the National Guidelines format (See 2:6, p. 56 onwards) and the SATU National Patient Documentation is used.

2:28 What can be stored?

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

2:29 What cannot be stored?

- Clothes other than underwear (See Box 13).
Box 13: Patient may decide to store relevant items of their clothing

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

2:30 DNA Database

The Criminal Justice (Forensic Evidence and DNA Database System) Act, was passed on the 22nd June 2014. Following establishment of procedures, advice will be given regarding the collection of appropriate samples in this context.

2:31 Packaging the Sexual Offences Examination and Toxicology Kits

Pack the tamper evident bags with the specimens signed by the Forensic Clinical Examiner.

Sexual Offences Examination Kit

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

Toxicology Kit

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

2:32 Legal Report

- The Forensic Clinical Examination legal report\(^1\) should be prepared as soon as possible after the Forensic Clinical Examination.
- If a formal report of the incident is made to An Garda Síochána, an addendum is made to the legal report\(^2\) prior to its release, outlining that the forensic samples had been stored and details of their release to An Garda Síochána.

---

\(^1\) Appendix 3: SATU Legal report template: Sample. (p.175)
\(^2\) Appendix 4: Addendum to legal report: Sample. (p.187)
2:33 Storage Facilities and Storage of Forensic Evidence

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

2:34 Pre-Discharge care is provided as per Section 2

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

References

2:35 Person Subsequently Reports the Incident to An Garda Síochána

(See also Flowchart: Figure 3: p. 110).

2:35.1 Mechanism of Formally Reporting to An Garda Síochána

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

2:35.2 An Garda Síochána: Process

- The complainant is treated as a first time reporter. The Garda follows the procedures as outlined (See 1:2, p. 21) with the following exceptions:
  - The Forensic Clinical Examination has already been conducted.
  - The investigating Garda must make arrangements for transporting the forensic evidence from the relevant SATU to the Forensic Science Ireland.
- The complainant is requested to sign the appropriate consent form for the release of stored forensic evidence and a legal report from the SATU to An Garda Síochána.
- The investigating Garda informs the relevant SATU as soon as possible that a formal report has been made.
- The investigating Garda will ensure that an appointment is made with the SATU, to collect the stored forensic evidence and, when available, the legal report from the Forensic Clinical Examiner.
- The Garda responsible for collecting the forensic evidence brings the completed consent form to the SATU, authorising the release of the stored forensic evidence and issue of a legal report.
- The Garda and SATU staff confirm the integrity of the tamper evident bags, prior to signing the stored evidence record. Any irregularity is documented by the Garda.

---

1 Appendix 10: Consent authorising release of stored forensic evidence and a legal report to An Garda Síochána: Sample. (p. 194).
• The Garda completes the SATU Stored Evidence Record form for continuity of evidence and two photocopies are made
  o The original copy is retained by the SATU.
  o The two photocopies are taken by the attending Garda:
    • One photocopy is retained by the Gardaí (‘true copy’) as a possible future exhibit with regard to continuity of evidence.
    • Second photocopy will be taken by the Gardaí with the forensic evidence to the Forensic Science Ireland.

• The investigating Garda should check with the complainant whether s/he had decided to self-store relevant items of clothing and, where appropriate, arrange for the delivery of such clothing to the Forensic Science Ireland.

• The Garda transports the Sexual Offences Examination Kit and the Toxicology Kit in a cool box and a copy of the completed SATU Stored Evidence Record form to the Forensic Science Laboratory.

**SATU**

**2:35.3 SATU releasing stored evidence to An Garda Síochána: Process**

• Any communication from An Garda Síochána that the person has made a formal complaint is clearly recorded in the patient’s SATU documentation.

• The completed consent form\(^i\) is brought by the Gardaí to SATU, authorising the release of the stored forensic evidence and a legal report to An Garda Síochána.
  o A copy of the consent form is kept by SATU: to be filed in the patient’s SATU documentation.

• The patient’s SATU documentation is located and the consent form is checked against the:
  o Patient’s name, date of birth, date of examination.

• The patient’s SATU documentation is then used to locate the correct stored tamper evident bag/s, cross-checking the following:
  o Patient’s name, date of birth, SATU reference number, date of examination and the tamper evident bag numbers.

• The integrity of the tamper evident bag/s is confirmed in the presence of the Garda.

\(^{\text{i}}\) Appendix 7: Stored Evidence Record form for Continuity of Evidence (p. 191).

\(^{\text{ii}}\) Appendix 10: Consent authorising release of stored forensic evidence and a legal report to An Garda Síochána: Sample. (p. 194).
• **Section B of the Stored Evidence Record** is completed in the SATU by a Forensic Clinical Examiner or Registered Nurse/Midwife and the Garda receiving the forensic evidence (same incorporated into the SATU National Patient Documentation, p. 25). Two photocopies are made:

  o The original Stored Evidence Record form is filed in the patient’s documentation.

    This original record must be retained by the SATU, in the event that it is required by the court.

  o The two photocopies are given to the Garda,

    • One photocopy is retained by the Gardaí (‘true copy’) as a possible future exhibit with regard to continuity of evidence.

    • Second photocopy will be taken by the Gardaí with the forensic evidence to Forensic Science Ireland.

• The Forensic Clinical Examiner who carried out the forensic examination is notified to complete the legal report addendum, prior to the release of the legal report to the Gardaí.

• The SATU database is updated at the appropriate section to reflect the fact that the case has converted from Option 3: Forensic Clinical Examination with storage of the forensic evidence, to the person making a formal report to An Garda Síochána.

**Forensic Science Ireland**

2:35.4 **Forensic Science Ireland: Process**

**Processing Forensic Evidence Previously Stored in a SATU**

- The Garda delivers the forensic evidence and a photocopy of the Stored Evidence Record form to Forensic Science Ireland.

- A record is made in Forensic Science Ireland that the evidence had been stored for a given period in a SATU.

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1 Appendix 7: Stored Evidence Record form for Continuity of Evidence (p. 191).

2 Appendix 4: Addendum to legal report: Sample. (p. 187)
Recent Rape/Sexual Assault: National Guidelines on Referral and Forensic Clinical Examination in Ireland. 3rd edition; 2014.

Figure 3: Flowchart - Formally Reporting the Incident to An Garda Síochána when the Forensic Evidence has been Stored in a SATU.

- RCC/Other
  - RCC facilitates person contacting An Garda Síochána.
  - Record made.

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

- SATU
  - SATU Staff facilitates patient contacting An Garda Síochána.
  - Record made in patient’s documentation.

Contact made with the Garda Station local to the incident.
Details of all Garda Stations/Divisions at www.garda.ie
Request made to speak to a Garda Sergeant, where possible.
Garda Sergeant is informed of the nature of the complaint and of the previous SATU visit and that evidence is being stored in the SATU.

**An Garda Síochána**

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

¹ Appendix 10: Consent authorising release of stored evidence and a legal report to An Garda Síochána (p. 194).
² Appendix 7: Stored Evidence Record form for Continuity of Evidence (p. 191).

**SATU releasing stored evidence to An Garda Síochána¹**

- SATU receives the completed consent form from the Gardai,² authorising the release of the stored forensic evidence and a legal report to them. Copy of same kept by SATU, filed in patient’s documentation.
- The SATU staff and Garda confirm the integrity of the tamper evident bags, prior to completing and signing Section B of the SATU stored evidence record³ (Incorporated in SATU National Patient Documentation, p. 25).
- The original completed stored evidence record must be retained for potential court purposes by SATU.
- The medico-legal report addendum is completed prior to release of the legal report to the Garda.⁴

¹ Appendix 11: Checklist re: releasing stored evidence and legal report (p. 195).
² Appendix 10: Consent authorising release of stored evidence and a legal report to An Garda Síochána (p. 194).
³ Appendix 7: Stored Evidence Record form for Continuity of Evidence (p. 191).
⁴ Appendix 4: Addendum to the legal report (p. 187).

**Forensic Science Ireland**

- Garda delivers the forensic evidence and the copy of the stored evidence record⁴ to Forensic Science Ireland
- Forensic Science Ireland makes a record that this evidence had been stored for a given period in a SATU

¹ Appendix 7: Stored Evidence Record form for Continuity of Evidence (page 191).
2:36. Destruction and Disposal of Forensic Evidence

2:36.1 Reasons the forensic samples would be destroyed and disposed of:

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

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

2:36.2 Principles to be followed:

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

2:36.3 Destruction and Disposal of the Sexual Offences Examination and Toxicology Kits

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

1 Appendix 12: Checklist for destruction/disposal of forensic samples. Sample (p. 196).
2 Appendix 7: Stored Evidence Record form for Continuity of Evidence (p. 191).
• The forms accompanying the Kits are destroyed appropriately.

• The sealed clinical waste container is delivered by both the person disposing of the Kits and the witness, to the designated collection point as per local and national policy.¹

• The destruction and disposal tag number, the date and the signature of both the person destroying the Kits and the witness are entered in the patient’s SATU documentation.

• Local protocol is followed when recording the date and tag number for future audit purposes.

• The completed checklist is filed appropriately in the patient’s SATU documentation.

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SECTION 3: PSYCHOLOGICAL SUPPORT

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3:2 Possible Victim/Survivor Reactions. 115

3:3 The Place of Psychological Support within a Multi-Agency SATU Service. 116

3.3.1 Structures to Support a Multi-Agency SATU Service. 117

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3.5 When a Victim/Survivor Leaves the SATU. 120
PSYCHOLOGICAL SUPPORT

Active SATU
Multi-Agency Steering Group with RCC member

Current RCC Liaison Person to the SATU

Contact & Referral Protocols between RCCs and SATUs

Information Leaflets for Victims

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

Chooses to Attend a SATU

At SATU
Psychological Support Worker provides:
- Crisis Intervention
- Advocacy
- Psychological Support
- Information for Family/Friends

Leaving SATU
Psychological Support Worker ensures:
- Information
- Links to appropriate services
- Any advocacy/counselling appointments if scheduled
3.1 Psychological Trauma and Sexual Violence

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

3.2 Possible Victim/Survivor Reactions

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

References


Psychological Support Response

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

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

Subject to statutory reporting requirements e.g. Children First Guidance¹ or Withholding Information Act.²

References


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

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

The focus of Rape Crisis Psychological Support Workers is on immediate crisis intervention and advocacy, as well as providing a tangible and personal connection to longer-term sources of advocacy, support and counselling. When Psychological Support Workers support victims/survivors, Forensic Clinical Examiners can more easily maintain an objective stance. The provision of psychological support from rape crisis personnel is vital in terms of victim/survivors ability to access needed services, and if they choose to report the crime, their willingness to continue with a prosecution.\(^1\)

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

### 3.3.1 Structures to Support a Multi-Agency SATU Service

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

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

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

- The liaison person is responsible for regular and on-going communication between the RCC and the SATU. It is helpful if the nominated liaison person is one who is generally available during day-time hours, as this will facilitate contact. This ongoing communication is useful so that the RCC and other SATU personnel are aware of current available services and can sort out any potential difficulties.

- The liaison person is ideally the same person as the RCC representative on the multi-agency steering group.

- It is the responsibility of the RCC liaison person to inform other SATU personnel of any service delivery changes or developments. The nominated liaison person, as well as all other SATU personnel, needs to be aware of the availability of any other community services that are potentially useful for victims/survivors, such as refugee information services and women’s support services and refuges.

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

- This protocol needs to encompass contacting the Psychological Support Worker when the SATU is aware that a victim/survivor is on the way, or if the SATU has not had any advance notice, when a victim/survivor arrives in the SATU. This enables the victim/survivor to make a real choice about whether they want to speak with a Psychological Support Worker. Best practice is that a Psychological Support Worker from the RCC is immediately available to speak with victims/survivors if they choose. (KPI)\(^1\)

4. **A protocol to ensure that the RCC has a mechanism to quickly contact the SATU if a victim/survivor contacts the RCC and then chooses to attend the SATU**

- This protocol needs to be designed to expedite the victim/survivor’s access to the SATU.

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

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

- Leaflets need to be written in simple language.

- Leaflets should be available in as many languages as possible.

---

**Key Performance Indicator**

\(^1\) **KPI:** % of patients who had the opportunity to speak with a Psychological Support Worker at the first SATU visit.
3.4 Psychological Support Worker Role

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

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

The Psychological Support Worker is also available to provide support and information to anyone else who comes to the Unit with the victim/survivor. Many victims/survivors may prefer to use rape crisis personnel for useful support, even when family or friends are present. Some victims/survivors may not be sure what their family or friends will think or how they will react. Other victims/survivors are sure that their family or friends will react badly. If the Psychological Support Worker arrives at the SATU and, at that point, the victim/survivor chooses not to speak with the Psychological Support Worker that choice will be respected. For the specific services provided by Psychological Support Workers (See Box 14).
Box 14: Specific Services provided by Psychological Support Workers include:7

- Supporting victims/survivors through each component of the SATU service that they choose. This includes deciding whether to have a Forensic Clinical Examination or a Health Check, going through an Examination or Health Check and speaking with An Garda Síochána.

- Serving as an information resource for victims/survivors.

- Providing victims/survivors with crisis intervention and support to help cope with the trauma of the assault and begin the healing process.

- Actively listening to victims/survivors to assist in sorting through and identifying their feelings.

- Letting victims/survivors know their reactions to the assault are normal and dispelling misconceptions regarding sexual assault.

- Advocating for victims/survivors’ self-articulated needs to be identified and their choices to be respected, as well as advocating for appropriate and coordinated response by all involved professionals.

- Assisting victims/survivors in planning for their safety and well-being.

- Aiding victims/survivors in identifying individuals who could support them as they heal.

- Linking victims/survivors with relevant services.

- Responding in a culturally and linguistically sensitive and appropriate manner to victims/survivors from different backgrounds and circumstances and advocating for the elimination of barriers to communication.

3.5 When a Victim/Survivor Leaves the SATU

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

- Referrals to or contact information for relevant support agencies.
  This information needs to be specifically tailored to the victim/survivor – e.g. gender, age, sexual orientation, ethnicity, ability/disability, geographical location, etc.

- Information about any appointments that the victim/survivor has with a local RCC or any other local support agency.

- Information about sexual violence and potential after-effects. This can be in the form of a leaflet.
If a victim/survivor has chosen to speak with a Psychological Support Worker, the Psychological Support Worker is responsible for ensuring that all of this is provided to the victim/survivor. (KPI) If the victim/survivor has chosen not to speak with a Psychological Support Worker, other SATU personnel are responsible for making sure that all of this is provided.

References


Key Performance Indicator

KPI: % of victims/survivors attending a SATU for the first time who were given the appropriate contact information by the RCC Psychological Support Worker.
Recent Rape/Sexual Assault: National Guidelines on Referral and Forensic Clinical Examination in Ireland. 3rd edition; 2014.
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4:1 Epidemiology and Demography

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

It is difficult to determine the incidence of STIs following sexual assault, as infection may pre-date the sexual assault. Prior history of sexual activity is an important factor in determining risk of STI. In the general Irish population the most frequently identified STIs are chlamydia, genital warts and herpes. Others include gonorrhoea, trichomoniasis, syphilis, Hepatitis B, Hepatitis C and Human Immunodeficiency Virus (HIV). Chlamydial and gonococcal infections in women are of particular concern because of the possibility of ascending infection and potential tubal infertility.

Of 149 STI screens performed at the SATU Rotunda Hospital in 2008 (the last year in which routine prophylaxis was not offered) 27 (18%) were positive, with *Chlamydia trachomatis* being the organism identified in 10 of the 27 (37%) positive results. However in the same year, 49% of patients who were seen at the Rotunda SATU following an alleged assault defaulted on the follow up STI screening appointment.

STIs are identifiable at varying periods of time post-exposure depending on the incubation period of the infection and it is widely accepted that the optimum time for screening is two or more weeks post potential exposure. It is important to acknowledge that the identification of an STI in the immediate period after sexual assault is seldom useful in court, as it can be used by the defence to denigrate the patient's character. In view of this, and also considering the low patient return rates for screening, the service is aiming to offer appropriate STI prophylaxis for all women and men presenting after alleged sexual assault. Appropriate follow-up screens and defined protocols for management of any STIs identified are also integral to the provision of a comprehensive sexual assault service.

4:2 Screening and Treatment at Forensic Clinical Examination

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

**Key Performance Indicators**

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

2. **KPI:** % of patients who attended a scheduled first STI review appointment following first SATU attendance.
Recent Rape/Sexual Assault: National Guidelines on Referral and Forensic Clinical Examination in Ireland. 3rd edition; 2014.

Recommended treatment depends on factors specific to the assault and assailant as well as local disease prevalence but prophylaxis for \textit{C. trachomatis} should be considered. A Hepatitis B immunisation schedule can also be commenced and need for HIV post-exposure prophylaxis (PEP) should also be evaluated.\textsuperscript{8,9}

**KEY POINTS:** Recommended treatment depends on:

- The assault
- The assailant
- Local disease prevalence

Prophylaxis should be considered for:

- \textit{Chlamydia trachomatis} (See 4:2.1)
- \textit{Neisseria gonorrhoeae} (See 4.2.1)
- Hepatitis B (See 4:2.2)
- HIV (See 4:2.3)

**4:2.1 Antibiotic Prophylaxis for Bacterial STIs**

The efficacy of antibiotics in preventing bacterial STIs following sexual assault has not been proven. Antibiotic choices should be based on local disease prevalence, but prophylaxis against \textit{C. trachomatis} and \textit{N. gonorrhoeae} should be considered. At present most Irish SATUs are only offering routine prophylactic treatment for \textit{C. trachomatis} (KPI)\textsuperscript{i} as prevalence of \textit{N. gonorrhoeae} is low\textsuperscript{3}.

Sensitivities of these organisms to antibiotics, particularly \textit{N. gonorrhoeae}, may change and recommendations must reflect the likely sensitivities in the population. At present, appropriate prophylaxis against \textit{C. trachomatis} is Azithromycin 1g PO stat and for \textit{N. gonorrhoeae} is Ceftriaxone 500mg IM stat\textsuperscript{10}.

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

British and US guidelines\textsuperscript{4,8} recommend that all patients be offered vaccination against Hepatitis B following sexual assault. (KPI)\textsuperscript{i} There is evidence that where there is a risk of Hepatitis B acquisition, administration of Hepatitis B vaccine may prevent Hepatitis B infection\textsuperscript{11}. This is a course of 3 vaccines over 6 months, and is administered in the SATU when the patient initially presents, and then 1 month and 6 months following the incident.

Key Performance Indicators

\textsuperscript{i} KPI: % of patients offered prophylactic treatment against Chlamydia Trachomatis, at the first SATU visit.

\textsuperscript{ii} KPI: % of patients aged 14 years and over, who were appropriately given prophylactic Hepatitis B vaccination, at the first SATU visit.
When the perceived risk of Hepatitis B is high (for example where the alleged assailant is known to be Hepatitis B positive) Hepatitis B immunoglobulin should be considered within 48 hours and no later than 7 days. In most SATUs this will mean referral to the Emergency Department. In patients who have previously been vaccinated, or in whom natural immunity is likely, urgent Anti-Hepatitis B full markers (specimen sent to the National Virus Reference Laboratory at UCD or your local lab) can be checked to assess the need for vaccination. Administration of Hepatitis B vaccine to a patient who is already immune is not harmful.

Adequate Hepatitis B immunity following completion of the vaccine course should be confirmed by checking titres of antibody to Hepatitis B surface antigen (anti- HBsAg) 8 weeks after the final vaccine dose (See table 12).

### Table 12: Actions Required Following Post-HB Vaccination Testing (Except for Patients with Renal Failure)²

<table>
<thead>
<tr>
<th>Anti-HBsAg level (Hepatitis B antibodies)</th>
<th>Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 or &lt;10 mIU/ml Non-responder</td>
<td>Non responder.</td>
</tr>
<tr>
<td></td>
<td>It is advisable to test for anti-HB core antigen. If this is negative, repeat full course of Hepatitis B vaccine using a different brand of vaccine. Double dosing vaccine may also be considered. Recheck anti-HBsAg at 8 weeks post completion. If anti-HBsAg remains &lt;10mIU/ml, person is susceptible to HBV.</td>
</tr>
<tr>
<td>10-99 mIU/ml Low response</td>
<td>If low level anti-HBsAg confirmed by 2 different assays, administer one booster dose of vaccine. There is no need to retest for anti-HBsAg.</td>
</tr>
<tr>
<td>100 mIU/ml or greater Good response</td>
<td>No need for further vaccination or anti-HBsAg levels.</td>
</tr>
</tbody>
</table>
HIV PEP

Although pathogenesis studies indicate that there may be a window of opportunity to abort HIV infection by inhibiting viral replication following an exposure, PEP against HIV following sexual exposure is controversial. While animal studies showed benefit if medication was administered within 72 hours and continued for 28 days\(^1\), prospective studies in humans are difficult due to ethical problems of withholding potentially efficacious treatment. Retrospective studies in the context of occupational exposure show health care workers who received PEP with zidovudine after needlestick injury were 81\% less likely to become seropositive for HIV\(^1\), although there are instances where PEP has failed to protect\(^1\). With regard to sexual exposure, prospective observational studies suggest benefit\(^1\).

The British Association for Sexual Health and HIV (BASHH) guideline for PEP following Sexual Exposure (PEPSE)\(^1\) and Health Service Executive and Health Protection Surveillance Centre Guidelines for the Emergency Management of Injuries\(^9\) should be consulted. The decision to proceed with HIV PEP must be made on a case-by-case basis, depending on factors specific to the nature of the assault and the assailant (Table 13). The risks and benefits must be discussed with the patient in the knowledge that the drugs can be difficult to tolerate (headache, nausea, diarrhoea) and their effectiveness remains unproven. Each unit should have close links with Infectious Disease specialists for additional advice and follow-up.
### 4.3 High Risk Indicators

**Table 13: The Decision to Proceed with HIV PEP: Consider the Type of Sexual Assault (Exposure Type) and the Assailant (The Source)**

<table>
<thead>
<tr>
<th>Exposure Type</th>
<th>Source known HIV positive</th>
<th>HIV Status of assailant unknown but from high prevalence group/area*</th>
<th>HIV Status of assailant unknown but from low prevalence group/area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receptive anal sex</td>
<td>Recommend</td>
<td>Recommend</td>
<td>Not Recommended</td>
</tr>
<tr>
<td>Insertive anal sex</td>
<td>Recommend</td>
<td>Consider</td>
<td>Not Recommended</td>
</tr>
<tr>
<td>Receptive vaginal sex</td>
<td>Recommend</td>
<td>Consider</td>
<td>Not Recommended</td>
</tr>
<tr>
<td>Insertive vaginal sex</td>
<td>Recommend</td>
<td>Consider</td>
<td>Not Recommended</td>
</tr>
<tr>
<td>Fellatio with ejaculation</td>
<td>Consider</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
</tr>
<tr>
<td>Fellatio without ejaculation</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
</tr>
<tr>
<td>Splash of semen into eye</td>
<td>Consider</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
</tr>
<tr>
<td>Cunnilingus</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
</tr>
<tr>
<td>Digital/Object penetration</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
</tr>
<tr>
<td>Unsure if assault occurred</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
<td>Not Recommended</td>
</tr>
</tbody>
</table>

*High prevalence group/area = Intravenous drug users (IVDU)/Men that have sex with men (MSM)/Commercial sex worker (CSW)/Endemic country

**CONSIDER**

- Breaches in the mucosal barrier such as: genital injury, first intercourse, mouth/genital disease, menstruation/other bleeding
- ‘Stranger’ or ‘recent acquaintance’
- Multiple assailants
- Known presence, signs or symptoms of STI in source or the victim
- Multiple risk factors or cumulative risk
A starter pack for HIV PEP should be kept in all units and staff should be familiar with its prescription, possible drug interactions and local follow-up arrangements. It is important to note that when deemed appropriate, HIV PEP should be administered as soon as possible after the assault up to 72 hours. Individual units should develop a referral pathway with local Infectious Disease or Genitourinary Medicine services to ensure availability within 5 days.

The decision to administer HIV PEP is made locally with discussion with the Department of Infectious Diseases if needed. EMI guidelines recommend that patients are given of Truvada® (Tenofovir, Emtricitabine) and Isentress® (Raltegravir, an integrase inhibitor) as PEPSE for HIV. Truvada® is taken once daily and Isentress® is taken twice a day. Most SATUs have 5 day starter packs and an appointment is given to attend the local Infectious Diseases Genitourinary Medicine services for follow-up, within those five days of commencing treatment to discuss completion of a 28 day treatment course.

**NB. CONFIDENTIALITY**

Samples and information relating to sexually transmitted infections may be dealt with by health care professionals and personnel outside of the forensic arena. It is important that any person who comes in contact with information regarding an attendance at a SATU is aware of the confidentiality of that information and if there is a need to respond in terms of treatment and follow-up, that this will be through the SATU examining Forensic Clinical Examiner. If, for any reason, this is not possible, contact with the patient will be in a sensitive and appropriate manner.
### Table 14: Appropriate STI Screening Tests

<table>
<thead>
<tr>
<th>Infection</th>
<th>Test</th>
<th>Site</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gonorrhoea</strong></td>
<td>Screening with Nucleic Acid Amplification Tests (NAAT)</td>
<td>Swabs from sites of penetration or attempted penetration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Vagina</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Rectum</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Pharynx</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- First void (bladder not emptied for 1 or more hours) urine (FVU) from males</td>
</tr>
<tr>
<td></td>
<td>Culture and Sensitivity if NAAT positive prior to treatment</td>
<td>Use charcoal swab from site of contact or plate directly on NYC agar and place in CO₂ rich environment</td>
</tr>
<tr>
<td><strong>Chlamydia</strong></td>
<td>Screening with Nucleic Acid Amplification Tests (NAAT)</td>
<td>Swabs from sites of penetration or attempted penetration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Vagina</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Rectum</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Pharynx</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- FVU from males</td>
</tr>
<tr>
<td></td>
<td>Culture and Sensitivity</td>
<td>Rarely required</td>
</tr>
<tr>
<td><strong>Trichomoniasis vaginalis</strong></td>
<td>Charcoal swab</td>
<td>Vagina</td>
</tr>
<tr>
<td></td>
<td>Wet prep if available</td>
<td></td>
</tr>
<tr>
<td><strong>Syphilis (Treponema pallidum)</strong></td>
<td>Serology</td>
<td>Venous blood</td>
</tr>
<tr>
<td><strong>Hepatitis B</strong></td>
<td>Serology</td>
<td>Venous blood</td>
</tr>
<tr>
<td><strong>Hepatitis C</strong></td>
<td>Serology</td>
<td>Venous blood</td>
</tr>
<tr>
<td><strong>HIV</strong></td>
<td>Serology</td>
<td>Venous blood</td>
</tr>
</tbody>
</table>

**NB.**
- Each SATU should liaise with their laboratory to discuss the best means of collecting and processing specimens according to local facilities.
- Window period for syphilis and Hepatitis C remains 90 days, although new combined antigen/antibody tests have shortened window period for HIV to 4 weeks after the exposure.
- Repeat screening for HIV, Hepatitis B and C and syphilis 3 months after the incident (to reflect the window period for seroconversion).
- Each SATU will have local arrangements and protocols for follow-up of patients including STI treatment, test of cure where appropriate, contact tracing, vaccination and infectious disease notification.
Table 15: Recommended Timeline for Routine STI Prophylaxis and Follow-Up

<table>
<thead>
<tr>
<th>Time</th>
<th>Treatment/Test</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1g Azithromycin po</td>
<td>Prophylaxis/treatment of <em>C. trachomatis</em></td>
</tr>
<tr>
<td></td>
<td>1st Hepatitis B Vaccine</td>
<td>Immunisation against Hepatitis B</td>
</tr>
<tr>
<td>1 month</td>
<td>Combined gonorrhoea/chlamydia NAAT from appropriate site(s)</td>
<td>Screening for <em>C. trachomatis</em> and <em>N. gonorrhoeae</em> Test of cure if prophylactic Azithromycin was given at Time 0*</td>
</tr>
<tr>
<td></td>
<td>Serology</td>
<td>HIV/Hepatitis B &amp; C/Syphilis</td>
</tr>
<tr>
<td></td>
<td>2nd Hepatitis B Vaccine</td>
<td>Immunisation against Hepatitis B</td>
</tr>
<tr>
<td>If positive results treat ASAP</td>
<td>Culture and sensitivity for gonorrhoea + Ceftriaxone 500 mg IM.</td>
<td>If screening NAAT is positive for gonorrhoea, recall patient for culture and treatment. Check Test of Cure (NAAT) two weeks later.</td>
</tr>
<tr>
<td></td>
<td>Azithromycin 1g po</td>
<td>If screening NAAT is positive for chlamydia</td>
</tr>
<tr>
<td>3 months</td>
<td>Serology</td>
<td>HIV/Hepatitis B &amp; C/Syphilis</td>
</tr>
<tr>
<td>6 months</td>
<td>3rd Hepatitis B Vaccine</td>
<td>Immunisation against Hepatitis B</td>
</tr>
<tr>
<td>8 months**</td>
<td>Serology</td>
<td>Anti-HBsAg to ensure hepatitis B immunity (See table 12)</td>
</tr>
</tbody>
</table>

NB:
* Using NAAT testing the time to clearance of *C. trachomatis* following 1g Azithromycin is up to 17 days.\(^8\)
** Can be checked by GP/local services.

References

3 Sexually Transmitted Infections in Ireland 2011. [www.hspc.ie](http://www.hspc.ie)
Centres for Disease Control and Prevention (CDC) Sexually Transmitted Diseases Treatment Guidelines. CDC, 2006; 55:80-83.


Health Service Executive (HSE) and Health Protection Surveillance Centre (HPSC) Guidelines for the Emergency Management of Injuries (including needlestick and sharps injuries, sexual exposure and human bites) where there is a risk of transmission of bloodborne viruses and other infectious diseases. *emi toolkit*. Report on the Scientific Advisory Committee of the HPSC. Revised June 2014. www.emitoolkit.ie


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5.1 History and Role of Forensic Science Ireland

Mission Statement

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

History

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

Forensic Science Ireland is divided into 9 functional teams. One of these teams is the Sexual Assault Team, which consists of a Scientific Team Manager, Scientists and Analysts. The workload of Forensic Science Ireland has steadily increased throughout the years as An Garda Síochána and the courts realised the value of forensic scientific evidence. In 2014 there are 90 staff members, including administrative staff.

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

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

DNA Service

The initiation of a DNA service in 1994 was a quantum leap in Forensic Science Ireland’s ability to compare biological samples. DNA profiling is the technique used to identify areas of high variability in the DNA of individuals. DNA (Deoxyribonucleic Acid) is present in all body tissues, except for red blood cells. But those most commonly encountered in criminal cases for forensic analysis are stains, or deposits such as blood, semen, vaginal fluid, saliva and vomit. Also cellular material (epithelial cells) can be profiled where there has been skin to skin contact (e.g. gripping the arm). The DNA from crime stains is compared with the control DNA from suspects and complainants. This control DNA is extracted from either blood samples, or from buccal (mouth) swabs. Cases of alleged rape/sexual assault are usually dealt with by the Sexual Assault Team.
5:2 Key Objectives of Forensic Science Ireland

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

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

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

(See 2:6.7: Table 2, p. 63 Re: Taking Forensic Samples)

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

Sexual Offences Examination Kit

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

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

Supply of Sexual Offences Examination Kits

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

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

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

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

5:4 Risk of Contamination

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

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

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

DNA Reference Elimination Swabs from Healthcare Personnel

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

The ‘Elimination sample’ packs can be collected from any SATU. Each pack contain one FTA (Flinders Technical Associates) swab and card and a consent form. The consent form should be completed which requests details of your occupation etc. and describes the purpose of the elimination swabs. These can be stored at room temperature and subsequently posted to the Biology/DNA Section, Forensic Science Ireland.

Environmental Monitoring of SATUs

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

These swabs are submitted to Forensic Science Ireland.

5:5 Prevention of Contamination

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

- The examination couch should be cleaned with bleach or a recommended cleaning agent before and after examinations (See Box 14).
- Fresh paper roll should be used under complainants.
- Chairs on which the complainant may have sat before or after the Forensic Clinical Examination should also be cleaned with bleach or a recommended cleaning agent.
- The practitioner should wear disposable apron and gloves.
- Gloves must be worn when handling specimens and clothing.
- Ensure that the gloves reach the cuffs and that the wrists are not exposed.
- If coats have shrunk or the wristbands have become loose, the coats should be replaced.
- A chronological log or record should be kept of cases examined on each examination couch.
Box 14: Recommended Cleaning Agents

- Vircon
- Actichlor
- Klor Kleen
- Or any 10% bleach based product.

NB. The above cleaning agents were tested for efficacy at the Lab in 2014.

Masks should be worn at all times during the medical examination

- All swabs should be placed into their vials immediately after taking the sample.

KEY POINTS: Prevention of Contamination

- Clean with bleach or the recommended cleaning agent (See Box 14)
  - Examination couch, trolley and any other equipment (eg colposcope).
  - Chairs on which complainant sat before or after exam.
- Fresh paper roll for the couch after each case.
- A log or record should be kept of cases examined on each examination couch.

When handling specimens and clothing:

- Use disposable gloves and aprons.
- Ideally gloves should reach the cuffs – wrists should not be exposed.

5:6 Analysing Samples for Semen

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

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

When the suspect denies that intercourse took place, or when the complainant has had a previous sexual partner, DNA profiling will be carried out on seminal staining on the swabs or on the clothes. In cases of “stranger rape”, where the victim does not know the assailant, DNA profiling will always be carried out on any seminal staining recovered and this profile is kept on file for future reference (See Figure 4).
5:7 Time Frames For Detecting Semen

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

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

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

<table>
<thead>
<tr>
<th>Site</th>
<th>Time Limits for Examination for Semen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal</td>
<td>7 days</td>
</tr>
<tr>
<td>Rectum</td>
<td>3 days</td>
</tr>
<tr>
<td>Mouth</td>
<td>1 day</td>
</tr>
<tr>
<td>Skin</td>
<td>Semen can persist until washing</td>
</tr>
<tr>
<td>Dead bodies</td>
<td>Semen can persist for a much longer period of time</td>
</tr>
<tr>
<td>Dried seminal staining on clothing</td>
<td>Semen persists until clothes are washed</td>
</tr>
</tbody>
</table>

Washing, douching, bathing, toileting or menstruation may accelerate the loss of semen

### Other Samples

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

The clothes of the complainant will be tested for seminal staining or saliva depending on the circumstances of the case. The clothing will also be checked for damage (See 5:11, p. 146) and blood staining. In some cases, the Forensic Scientist will look for hairs (See 5:10, p. 144) and fibres (see section on fibres), which may have transferred between the two parties. If necessary, samples of urine and blood will be sent for toxicology (See 5:8, p. 142). Depending on the circumstances of the case, items from the scene may also be analysed for the presence of blood, semen and fibres.

### Role of the Forensic Clinical Examiner as an Investigator.

While the samples to be taken are listed and instructions on how they are to be taken are set out clearly in the Sexual Offences Examination Kit, it cannot cover every eventuality. The Laboratory views the Forensic Clinical Examiner as having an investigative role in the procedure of evidence collection, just as the Gardaí do in collecting evidence at the scene of a crime. It is important that they have as complete an account from the complainant as possible, in order to guide them in the direction of potential forensic evidence. Any opportunity that the alleged assailant had to deposit DNA on the victim, or vice versa, should be considered and areas of contact should be swabbed (See 2:6.7: p. 62). Stains, which are at odds with the account of what happened, should also be swabbed for further examination in Forensic Science Ireland.
Samples for Toxicology

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

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

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

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

Urine samples can be collected by non-medical staff and should be collected, as soon as possible, after the incident is reported (See 1:6, p. 27 and 5:9 p. 143). The most important factor in cases of suspected drug facilitated sexual assault is speed of response. The sooner the samples are collected, the more likely that a useful forensic toxicological examination can be carried out. If there is any doubt as to whether or not a particular sample should be taken, it should be collected and submitted to the laboratory for evaluation, to establish what analysis is appropriate.

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

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

Hair samples may also be considered (See 5.10, p. 144: trace evidence).

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

<table>
<thead>
<tr>
<th>Substance</th>
<th>Blood</th>
<th>Urine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>24 hours</td>
<td>N/A</td>
</tr>
<tr>
<td>Drugs of Abuse</td>
<td>48 hours</td>
<td>120 hours</td>
</tr>
</tbody>
</table>

**Sending Samples for Toxicology Screening**

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

**Detection of Ingested Drugs from Hair**

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

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

**5:9 Early Evidence Kits**

In 2004 Forensic Science Ireland introduced an Early Evidence Kit. Sometimes, it may not be possible for the victim of an alleged rape/sexual assault to see a Forensic Clinical Examiner immediately after reporting the crime. Some complainants have to travel long distances in order to be examined at the nearest SATU, or a Forensic Clinical Examiner may not be immediately available. With every hour that passes physical evidence may be lost or deteriorate. Because of this, an Early Evidence Kit is available to be used by An Garda Síochána in cases of rape/ sexual assault. For details
5:10 Trace Evidence

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

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

Transfer of Fabric Traces on Contact

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

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

Example

It is suspected that John Smith attacked Mary Jones. The finding of 20 fibres matching her jumper and 15 fibres matching her trousers on John Smith’s clothes may support the allegation of contact. If, in addition, fibres matching John Smith’s jacket were found on Mary Jones clothing, this may also support the suggestion that they were in contact. Given these findings an evaluation could be made regarding the strength of evidence given. This is so, notwithstanding the fact that all the garments are mass produced.

Difficult Fabrics

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

relating to the use of the Early Evidence Kit see under An Garda Síochána guidelines (See 1:5, p. 25).
**Hair**

Hair is continuously shed from the body throughout life. The main types of hair encountered in Forensic Clinical Examinations are head and pubic hair. Samples submitted to the laboratory on which hair may be found include: balaclavas, clothing and bedclothes. Control samples of hair from the complainant and from the suspect are desirable for visual comparison (See Table 2, p. 63). Microscopic comparison of hairs alone is considered to be weak evidence. DNA profiling would be carried out on selected hair roots.

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

**Contamination of Trace Evidence**

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

Contamination is probably the greatest problem that exists in the area of trace evidence (See tables 17 & 18). The possibility of accidental contamination exists from the first moment of contact between the Gardai and the scene, suspect or complainant.

<table>
<thead>
<tr>
<th>Table 17: Contamination of Evidence.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contamination can be due to:</td>
</tr>
<tr>
<td>Primary transfer of evidence from direct contact between items.</td>
</tr>
<tr>
<td>Secondary transfer of evidence caused, for example, by the same person handling items from different aspects of a case, or by packing items from different persons or scenes in the same room.</td>
</tr>
</tbody>
</table>
Table 18: Precautions to Avoid Contamination of Evidence

Taking clothing etc. as soon as possible at source (e.g. at the home of the complainant) avoids the issues of contamination.

- The same car should not be used to convey the suspect and complainant, for example, the complainant to the SATU and the suspect to the Garda station.

- If the suspect denies contact with the complainant or vice versa, any Garda who has had contact with the suspect should not have contact with the complainant.

- Within the Garda Station the suspect and the complainant should not be interviewed in the same room, or sit on the same seat.

- Clothing and other samples from the complainant and suspect should be taken, packed and sealed by different Gardai in different rooms. The bags should be sealed using sellotape or staples.

- Sealed bags should be labelled immediately to eliminate any need for reopening.

- The history of the handling and packing must be available to the Forensic Scientist.

- If the same Forensic Clinical Examiner takes samples from the complainant and the suspect, this should be done at separate locations and the examiner should ideally wear different disposable scene of crime suits and gloves for each.

References


5:11 Damage to Clothing

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

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

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

- **Damage Due to Normal Wear and Tear.** This is to be distinguished from other forms of damage, which may be related to a crime. It may include unravelling of hems and seams, snags (especially in nylon stockings/tights), pilling and the thinning of fabric prior to hole formation).

- **Rip.** A severance caused by breaking or unravelling of the sewing thread usually at a seam.

- **Tear.** A severance caused by the pulling apart of a material, leaving ragged or irregular edges.

- **Cut.** A severance with neat edges caused by a sharp edged instrument. Types of cuts include stab cuts, slash cuts and scissor cuts.

- **Puncture.** Penetration through material by an implement producing an irregular hole.

- **Abrasive damage.** Caused by the material rubbing against another surface.  

**References**


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

See 2:35.4, p. 109
SECTION 6: GENERAL PRACTITIONERS (GPs)

6:1 Care Of A Patient Who Discloses Rape/Sexual Assault. 150

6:2 Follow-up Care Of a Patient Who Has Attended a SATU. 153
6:1 Care of a Patient Who Discloses Rape/Sexual Assault

This section will provide concise guidance for General Practitioners (GPs) when an adult patient makes a disclosure of recent sexual violence. The complete Recent Rape and Sexual Assault Guidelines are available at www.hse.ie/satu

First steps:

1. The medical stability of the patient always takes priority over the collection of evidence. It is important to evaluate the general condition of the patient and consider if emergency medical treatment is needed. If so, immediate care at an Emergency Department may be appropriate. It is also appropriate to contact a SATU in such cases, provided the patient gives their informed consent, as it may be possible for a Forensic Clinical Examiner to carry out a Forensic Clinical Examination at the Emergency Department (Contact details for SATUs p. 16).

2. It is important to establish the time frame from the incident. Forensic evidence, including both physical injuries and “trace” (DNA/Semen/ etc.) evidence, decays rapidly with time. Thus, if the patient is agreeable, Forensic Clinical Examination at a SATU should take place as soon as possible. Generally forensic samples are not taken if more than seven days have elapsed since the incident; however, it remains very important for a patient to be examined in a timely manner as there may still be evidence of physical injury (See p.14: SATU Response and Options Available).

If the patient is willing to attend the SATU for a Forensic Clinical Examination, the patient should be advised with regard to the preservation of forensic evidence (See p. 17,18: Preservation of Forensic Evidence).

If the patient does not want to report the incident to An Garda Síochána, it is usually possible for the patient to attend a SATU without Garda involvement. The GP can contact their local SATU to arrange an appointment, which will normally include STI follow-up if indicated. Where a patient is undecided as to whether or not to report the incident to An Garda Síochána, it may be possible for forensic evidence to be obtained and stored for use in later criminal investigations (See p. 14 for all SATU Response Options).

Patient Declines SATU Attendance

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

- Carefully document the history of sexual violence that has been disclosed. Where possible, use the patient’s own words in quotation marks. This may form the basis of a medico-legal report at a later date.
• If the patient is not well known to you, take a complete medical history.

• Consider the need for a chaperone prior to performing an examination.

• Perform a head-to-toe survey, looking for evidence of injury and a systems examination. Carefully record the findings of the examination, with particular regard to documentation of physical injury (See 2:12, p. 79). Ideally, a genital examination is performed so that genital injury can be identified and, if necessary, treated. However, if the patient is unwilling to allow genital examination and if the risk of significant life-threatening genital injury is low, then it is reasonable not to examine the genital area. It is important that the patient knows that potential evidence (i.e. evidence of genital injury) will not then be available for use in any future Garda investigation. Identify and treat any acute medical needs or injuries.

• Assess the need for appropriate Emergency Contraception. This is most commonly provided in the form of a single oral dose of Levonorgestrel 1500mcg or Ulipristal Acetate 30mg. Intra-uterine contraceptive devices are occasionally used (See 2:17, p. 89).

• Consider the need for antibiotic prophylaxis against Chlamydia. If not contra-indicated, a single oral dose of 1G of Azithromycin can be prescribed (See 4:2.1, p. 125).

• Consider the need for HIV/Hepatitis Post-Exposure Prophylaxis following Sexual Exposure (PEPSE). This decision is largely based upon the known or suspected risk of the alleged perpetrator being HIV or Hepatitis B positive and the type of sexual exposure that may have occurred (See 4:2.3, p. 127: HIV PEPSE decision-making flow chart). Try to establish if the alleged perpetrator is known to be HIV or Hepatitis B positive or if (s)he is from a high risk group (e.g. intravenous drug abusers; men who have sex with men; from a high prevalence country). If uncertain, consider seeking an urgent opinion from a Consultant in Infectious Disease.

• Assess and manage the risk of self-harm. If high risk, consider the need for urgent psychiatric review.

• Ensure adequate psychological support is in place. The National Rape Crisis Centre (RCC) 24 hour helpline number is 1800 778888. Provide the patient with the contact details of the local or a preferred RCC. (RCCs details available at www.rapecrisishelp.ie or www.drcc.ie). Consider the need to offer a GP follow-up consultation for psychological support.

• Arrange follow-up Sexually Transmitted Infection (STI) screening in accordance with the patient’s preference to attend a GP, Genito-Urinary Medicine clinic or other setting (See 4:4, p. 130).

• If the patient is under 18 years of age, then Children’s First reporting procedures apply. Complete and send the appropriate Social Services referral form.

• In all cases of sexual violence, particularly those that involve domestic violence, it is important to consider the patients safety in the home environment. Consideration must also be afforded to the safety of any
children in the household. A Social Services referral should be made if appropriate.

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

**KEY POINTS: Care of a Patient who Discloses Rape/Sexual Assault**

**Medical stability of the patient always takes priority over collection of evidence**
- If indicated ED referral – SATU Staff can carry out forensic medical examination in ED

**If patient is stable**
- Discuss the option of SATU referral with the patient (Contact details p. 16).

**If not involving SATU:**
- Examine patient, document findings and treat accordingly (See 2:6, p. 56).

**Consider and assess re:**
- Emergency contraception (See 2:17, p. 89).
- Chlamydia prophylaxis (See 4:2.1, p. 125).
- Hepatitis B vaccine (See 4:2.2, p. 125).
- HIV PEPSE (See 4:2.3, p. 127).
- STI follow up (See 4:4, p. 130).
- Risk of self harm, if risk high consider urgent Psychiatric review if appropriate
- Ensure adequate psychological support is in place. The National RCC 24 hour helpline number is 1800 778888. Provide contact details of the local or a preferred RCC. (RCCs details available at www.rapecrisishelp.ie or www.drcc.ie).
- If under 18 years: Children First reporting procedures apply*
- Safety in the home environment, (e.g. domestic violence) for patient and consider children*
- Support of family, friends
- If appropriate social work referral and/or wider Primary Care Team referral.

*Subject to statutory reporting requirements: Children First Guidance. Withholding Information Act.
6:2 Follow-up Care Of a Patient Who Has Attended a SATU.

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

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

- **Emergency Contraception (EC):** In many cases the patient will have been provided with emergency contraception at the SATU. Follow-up pregnancy testing may be considered. In the event that EC was not used, then the GP should consider if it is indicated (See 2:17 p. 89).

- **Sexually Transmitted Infection (STI) screening:** Some patients will choose not to return to SATU for follow-up STI screening. The GP can provide or arrange STI screening, a 1 month interval between the alleged incident and STI screening is appropriate (See 4:4, p. 130).

- **Hepatitis B vaccination:** Patients who have not previously been vaccinated against Hepatitis B are frequently offered the first dose of the vaccine schedule at SATU. It may be necessary for the GP to provide subsequent doses to complete the schedule (See 4:2.2, p. 125).

- **Assess and manage the risk of self-harm.** If high risk, consider the need for urgent psychiatric review.

- **Ensure adequate psychological support is in place.** Check if the patient met with RCC personnel in SATU and that they were given the RCC details. If not provide the patient with the contact details of the local or a preferred RCC. (RCCs details available at www.rapecrisishelp.ie or www.drcc.ie). Consider the need to offer a GP follow-up consultation for psychological support.

- **If the patient is under 18 years of age, then Children’s First reporting procedures apply.**

- **In all cases of sexual violence, particularly those that involve domestic violence, it is important to consider the patients safety in the home environment.** Consideration must also be afforded to the safety of any children in the household.

Finally, it may be helpful for GPs to know that most SATUs have a doctor or nurse on-call at all times. GPs may contact the on-call clinician for advice if they so wish.
KEY POINTS: Follow-up Care of a Patient Who Has Attended a SATU

Core issues that usually need to be addressed:

- EC: Question if given: Follow-up pregnancy testing considered.
- STI screening: after a period of 2 weeks from the alleged incident (See 4:4, p. 130).
- Hepatitis B vaccination: First dose of schedule may have commenced at SATU. GP may complete the schedule (See 4:2.2, p. 125).1
- Risk of self-harm: if risk high, refer for urgent psychiatric review if appropriate.
- Check if the patient met with or was given the RCC details. If not, contact details available for RCC at www.rapecrisishelp.ie or www.drcc.ie. Consider the need to offer a GP follow-up consultation for psychological support.
- If under 18 years Children’s First reporting procedures apply.*
- Safety in the home environment, (e.g. domestic violence) for patient and children.2,3
- Support of family, friends.
- Social Services referral and/or wider Primary Care Team referral, if appropriate.

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

References


SECTION 7: LEGAL

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Legal Section

This section is intended to provide an overview of the legal process as it relates to sexual offences. It does not provide legal advice, but rather tries to answer the questions commonly asked about the law/legal process in the aftermath of a sexual assault.

7: Introduction

Depending on the circumstances, there are a wide range of sexual acts that have the potential to be sexual offences. In the broadest of terms, this may be because the injured party did not consent to the sexual act, or, because they could not consent to it, because they lacked capacity, by virtue of age or disability.

7:1 The Role of Consent in Sexual Offences

Therefore the absence or presence of consent, for those who have attained the relevant age, is often the key legal issue for consideration. The Court of Criminal Appeal has stated that:

"Consent means voluntary agreement or acquiescence .......by a person of the age of consent with the requisite mental capacity. Knowledge or understanding of facts material to the act being consented to is necessary for the consent to be voluntary or constitute acquiescence."

When Must Absence of Consent Be Proven?

Where consent is in issue, the prosecution bears the burden of proof (beyond reasonable doubt) that the complainant did not consent.

Examples include:

- rape,
- sexual assault,

References

1. If you need legal advice, you should talk to a solicitor.
4. S. 2 of the Criminal Law (Rape) (Amendment) Act 1990 as amended re-named the offence of ‘indecent assault’ as ‘sexual assault’; the consent requirement in those offences appears to arise from the ‘assault’ element; see, for example, Lord Lane L.J. in Faulkner v Talbot [1981] 3 All ER 468, 471: “An assault is any intentional touching of another person without the consent of that person and without lawful excuse.”
When Is Consent Not In Issue?

Children aged 16 years or younger cannot consent in law to a ‘sexual act’ which is defined as:-

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

Children aged 14 years or younger cannot consent in law to any of the above mentioned acts, and, in addition, cannot consent to acts amounting to **sexual assault** or **indecent assault**.

There is an absolute **prohibition** of sexual intercourse or buggery with ‘mentally impaired’ persons and of acts of gross indecency between males and ‘mentally impaired’ males.

References

1. Concerning defilement of children under 15 and 17 years of age - Ss. 2 and 3 of the Criminal Law (Sexual Offences) Act 2006 respectively provide that it is not a defence to proceedings for an offence under those sections for the accused to prove that the child consented (the Act came into effect on 2 June 2006).

2. Defined by s. 1 (2) of the Criminal Law (Rape) Act 1981 by reference to s. 63 of the Offences Against the Person Act 1861.

3. Defined by s. 3 of the Criminal Law (Rape) (Amendment) Act 1990.

4. Defined by s. 4 (1) of the Criminal Law (Rape) (Amendment) Act 1990.

5. S. 14 of the Criminal Law Amendment Act 1935 provides that “[i]t shall not be a defence to a charge of indecent assault upon a person under the age of fifteen years to prove that such person consented to the act alleged to constitute such indecent assault.”

6. See s. 5 of the Criminal Law (Sexual Offences) Act 1993 - concerning the protection of mentally impaired persons - where ‘mentally impaired’ is defined as “… suffering from a disorder of the mind, whether through mental handicap or mental illness, which is of such a nature or degree as to render a person incapable of living an independent life or of guarding against serious exploitation.”

**N.B** This provision is under review and will in all likelihood be repealed and replaced in the near future.
7:2 Reporting Sexual Offences

It is widely acknowledged that the decision to report a sexual offence is often difficult for a victim. However, in terms of ensuring the best possible investigative/prosecutorial outcomes, early reporting is important.

7:2.1 Delayed Reporting

Whilst there is no ‘statute of limitation’ in respect of serious offences, delayed reporting and the consequential loss of forensic evidence may be a significant impediment to the potential investigation/prosecution of sexual offences, particularly so where sexual contact with the injured party is denied by the suspect(s). Forensic evidence of sexual contact can have particular significance when the conduct is of a nature that the complainant lacks the capacity in law to consent.

Furthermore, delay can be seen, in certain circumstances, to affect the credibility of a complainant. However, developments in the criminal justice system reflect a growing awareness of the sensitivities involved in reporting such personal crimes, [including]: “A greater awareness of the reasons why a complainant may not have made a complaint of a sexual offence at the first reasonable opportunity”1 (See 3:2, p. 115).

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

References


7:3 The Legal Process

An Garda Síochána conducts investigations, forwarding the investigation file to the Director of Public Prosecutions (DPP) for a decision on prosecution.

An Garda Síochána’s investigative role and the DPP’s prosecution role are independent of each other.

A large number of offences can be prosecuted by An Garda Síochána without reference to the Office of the DPP, however, they cannot charge a sexual offence without the consent of the DPP.

7:3.1 The Decision to Prosecute

The decision to prosecute sexual offences is made exclusively by the Office of the DPP.

Prosecution decision-making is a two stage process:
1. Is there a *prima facie case*? – This requires “admissible, substantial and reliable evidence that a criminal offence known to the law has been committed by an identified suspect. The evidence must be such that a jury, properly instructed on the relevant law, could conclude beyond a reasonable doubt that the accused was guilty of the offence charged.”¹

2. If there is a *prima facie case*, does the public interest require a prosecution? - “Once the prosecutor is satisfied that there is sufficient evidence to justify the institution or continuance of a prosecution, the next consideration is whether, in the light of the provable facts and the whole of the surrounding circumstances, the public interest requires a prosecution to be pursued”.²

A more comprehensive description of the decision to prosecute is contained within the DPP publication “Guidelines for Prosecutors’ available at: www.dppireland.ie

References

1 Paragraph 4.10, *Guidelines for Prosecutors*.
2 Paragraph 4.18, *Guidelines for Prosecutors*.

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**An Garda Síochána & DPP Roles are INDEPENDENT of Each Other**

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<thead>
<tr>
<th>An Garda Síochána</th>
<th>DPP</th>
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<tr>
<td><strong>An Garda Síochána:</strong></td>
<td><strong>DPP:</strong></td>
</tr>
<tr>
<td>• Investigates, prepares file</td>
<td>• Receives file from An Garda Síochána</td>
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<tr>
<td>• Forwards file to DPP for decision to prosecute</td>
<td>• Exclusively makes the decision to prosecute in sexual offences</td>
</tr>
<tr>
<td>• Cannot charge a sexual offence without consent of DPP</td>
<td><strong>Decision-making is a two-stage process</strong></td>
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<tr>
<td></td>
<td>1. Is there a <em>prima facie case</em>?</td>
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<td>Admissible, substantial and reliable evidence that a crime has been committed by a known suspect.</td>
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<td>2. If yes - there is a <em>prima facie case</em>; does the public interest require a prosecution?</td>
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Figure 5: The independent roles of An Garda Síochána and the DPP in sexual offences.
7:4 **Disclosure**

In the event of a prosecution, the prosecution must disclose to the defence all relevant material in their possession, or procurement which could be of assistance to the defence in establishing a defence, by damaging the prosecution case, or in providing a lead on evidence that goes to either of these two things.¹

It is important therefore that an injured party understands that the usual doctor/patient privilege, giving rise to an expectation of confidentiality, does not apply in circumstances where they have made a formal report of a sexual assault. All material generated on foot of a SATU examination, including notes/documents² generated as a result of the provision of SATU care and Forensic Clinical Examination, are likely to be considered ‘relevant’ and therefore disclosable to an accused, but not the complainant, in any criminal proceedings.

Ordinarily, the SATU legal report is served within the Book of Evidence. All other material, notes, charts, etc. are served on the accused as part of general disclosure. Copies of any original notes, charts, diagrams etc. are only disclosed to the Defence with strict conditions.

**References**

1 With the exception of a number of limited exceptions e.g. material protected by a recognised ‘privilege’.

2 ‘records’ & ‘notes’ includes, inter alia, medical notes, counseling notes, psychiatric reports, nursing notes/reports and social worker notes/reports, the witness/party to whom the material relates must consent to such disclosure.

7:5 **Which Court?**

Once the decision to prosecute has been made, and a suspect(s) charged, which court will hear the case is determined by the nature of the offence charged.

Every rape offence (including the offence of rape under s.4¹) or aggravated sexual assault² must be tried before the Central Criminal Court.

The District Court can try a sexual assault case provided it is fit to be tried summarily, and the judge, the DPP and the accused all consent to the matter being dealt with in the District Court.

All other sexual offences are dealt with in the Circuit Court.

For further information on the structure of the courts see [www.courts.ie](http://www.courts.ie).
In Open Court?

Sexual offences are heard ‘otherwise than in public’. This means the judge will generally exclude from court all people who do not need to be there, importantly. Both the injured party and the accused are allowed to have a family member/friend present. In addition, a support person from the RCC may accompany the injured party, or Victim Support at Court service (V-SAC www.vsac.ie) is available. Bona fides members of the press will be allowed in court, and will be allowed to report on proceedings, they will however be subject to restrictions on reporting the identity of the injured party/accused, as outlined in the following section.

7:5.1 Anonymity

Following the decision to charge a sexual offence, no information likely to lead to the identification of the victim may be published without the express permission of the judge (such permission is very rare).

7:5.2 Is the Injured Party Entitled to Legal Representation?

Legal advice is available through the Legal Aid Advice and Assistance provisions – s.26(3)(A) of the Civil Legal Aid Act 1995, which provides that legal advice will be made available (no means test or payment of contribution required) to complainants in prosecutions for certain sexual offences who wish to seek such advice.

Rights to separate legal representation arise within very narrowly defined and restricted circumstances. Where an accused standing trial in respect of a sexual offence wishes to ask a question or introduce evidence relating to the complainant’s sexual experience, they need the leave of the judge to do so. ss. 34 & 35 of the Sex Offenders Act 2001 provides that the defence must give notice of their intention to make an application to introduce such evidence; and further provides that the complainant is entitled to separate legal representation for the purpose of the defence application, which is made in the absence of the jury. Further information is available from the Legal Aid Board, specifically leaflet 14.

7:5.3 Making a Victim Impact Statement

Victim Impact Statements were first introduced in Ireland in 1993. They afford a victim of violent or sexual crime a right to participate in the sentencing process by the provision of Victim Impact Statements. s. 5 of the Criminal Justice Act 1993, was recently repealed and replaced, on the 1st September 2010, by the Criminal Procedure Act 2010. The category of person now allowed to make such a statement is extended to the family of the deceased; a parent, guardian or other person acting in loco parentis where the victim is a child and is unable to give evidence; and a “family or guardian of a victim who has a mental disorder”. The Victim Impact Statement is only given following a guilty conviction. The Act requires a sentencing court to take into account the impact of a violent or sexual crime upon the victim, to that end the court may order the production of a Victim Impact Statement for that purpose. The same provision provides
the complainant with a statutory right, upon application, to address the sentencing court as to the impact of the crime.

References

1 Criminal Law (Rape) (Amendment) Act 1990, s.4, see:

2 Criminal Law (Rape) (Amendment) Act 1990, s.3, see:

3 s.3 of the Criminal Law (Rape) Act 1990

4 http://www.legalaidboard.ie/lab/publishing.nsf/content/information_leaflets

7:6 Legal Considerations Re: Option 3 Collection and Storage of Forensic Evidence Without Immediate Reporting to An Garda Síochána

I. The primary purpose of Option 3: Collection and Storage of Forensic Evidence Without Immediate Reporting to An Garda Síochána (See 2:21, p. 100), is the removal of barriers to reporting/prosecuting by preserving potentially evidentially valuable forensic samples in circumstances where the complainant has yet to decide to report.

II. Underreporting and delayed reporting are particular features of offences of a sexual nature. An Irish study conducted in 2009, found a significant minority of complainant’s delayed reporting: 18% of complainants waited a month or more before reporting, the longest delay in the sample was 18 months. The most common reason given for delayed reporting related to the psychological trauma of rape. ‘Many were in shock or felt numb following the assault. Others tried to cope with what had happened privately before deciding to go to the Gardai.’

III. Delayed reporting and the consequential loss of forensic evidence may be a significant impediment to potential prosecution, particularly where sexual contact with the complainant is denied or the complainant lacked the capacity in law to consent.

IV. There is no ‘statute of limitation’ in respect of serious offences. Delayed reporting is not an impediment to prosecution per se (One of the most significant cases on this point was the Supreme Court’s decision in H v. Director of Public Prosecutions, [2007] IEHC 325. The Court considered a number of cases over the last decade where there have been accusations of child sexual abuse and a significant delay between the alleged abuse and the complaint. The Court was of the opinion that a key issue in each case is the constitutional right to a fair trial. In reality the core inquiry is not so much the reason for a delay in making a complaint by a complainant but rather whether the accused will receive a fair trial or whether there is a real or serious risk
of an unfair trial. The fact that a person who was the victim of a serious crime had delayed in bringing the commission of that crime to the notice of the State authorities is not of itself a ground upon which the State should refuse to bring a prosecution or the courts to entertain one. However, delay can be seen in particular circumstances to affect the credibility of a complainant, but that should not in general be a ground for preventing a trial proceeding. The prosecuting authorities should decide whether there is evidence of sufficient weight to warrant a charge being preferred and it is also their duty to consider whether a fair trial can be afforded to an accused person.

V. Whilst developments in the criminal justice system reflect a growing awareness of the general issues surrounding delayed reporting, it is important to note that if someone makes a delayed report to An Garda Síochána s/he will almost certainly be asked to explain the particular reason(s) for the delayed report in their case.

References


7:7 Legal Resources/Further Reading:


Irish Statute Book link: http://www.irishstatutebook.ie
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Sexual Violence Prevalence Information & Barriers to Disclosure

The prevalence of sexual violence is difficult to measure. It depends on what is defined as sexual violence, who is being asked about their sexual violence experiences, how they are being asked and whether they trust the questioner enough to answer. While overall the majority of victims are female and the majority of perpetrators are male, different groups of people are differently vulnerable to sexual violence.

Prevalence rates vary by gender, gender identity, age, sexual orientation, relationship of the perpetrator to the victim, ethnicity or race, and disability. Rates also vary depending on where in the world someone lives, whether people are fleeing their country of origin due to persecution, whether they are trafficked, whether they are in prostitution, whether they define themselves as sex workers, whether they are homeless or whether they are confined in an institution.

Specific Irish research does not exist for many groups and most Irish specific prevalence information is unfortunately more than a decade old, therefore other sources of information are also included to give a potential indication of different vulnerabilities. Obviously an individual person may well fit into more than one category. The links below are to the specific documents. The organisational websites cited provide further information.

In addition to rates for women and for men, this appendix includes what is known about prevalence for many groups of people who have differing levels of vulnerability to sexual violence (in alphabetical order).

Part of the reason that prevalence information is not readily available is that there are many barriers to disclosing the violence to formal sources and supports. Overall, victims may (1) feel the violence was their fault, (2) be ashamed, (3) not want others to know, (4) be afraid that they will not be believed for a variety of reasons, (5) be concerned because they were drinking at the time, (6) have a fear of secondary victimisation, (7) have a lack of faith in the official systems, and/or (8) not identify the behaviour as sexual violence. These barriers are drawn from a number of different pieces of research including: McGee et al., The SAVI Report, Liffey Press 2002 and Hanly et al., Rape & Justice in Ireland, Liffey Press 2009. Some of the barriers, as they specifically apply to individual groups, are included within each category below.
WOMEN

Prevalence

Violence against Women European Survey

EU Agency on Fundamental Rights


5% of Irish women experienced sexual violence by a non-partner since the age of 15. 6% of Irish women experienced sexual violence by an intimate partner since the age of 15.

Barriers

Reporting, Prosecution and Pre-Trial Processes

Australian Law Reform Commission


All of the above-named barriers apply. Specifically women may not have felt the ‘incident’ was serious enough. In addition, if the perpetrator is a partner, she may be afraid of the perpetrator and be economically dependent on him/her.

MEN

Prevalence

National Intimate Partner and Sexual Violence Survey 2010

US National Centers for Disease Control, National Center for Injury Prevention & Control, Division of Violence Prevention


1 in 71 men experienced rape in their lifetime and 1 in 5 men experienced other forms of sexual violence in their lifetime.

Barriers

Various survivor organisations including:

http://www.malesurvivor.org/myths.html

Survivors may fear being perceived as gay as a result of the assault, or fear the assault means they are gay. ‘Allowing’ oneself to be assaulted does not fit with many men’s perceptions of masculinity. Survivors may also be concerned that experiencing physical arousal means they wanted the assault.
DISABILITY & MENTAL ILLNESS

Prevalence

Violence Against Adults and Children with Disabilities

World Health Organisation (WHO)

http://www.who.int/disabilities/violence/en/

Adults with disabilities are at an increased risk of all forms of violence, including sexual violence. Risk overall is 1.5 times higher than for adults without a disability. For adults with a mental illness, the risk is 4 times greater.

Barriers

Sexual Violence Against People with Disabilities

Rape Crisis Network Ireland


There is a lack of information and education for people with disabilities around sexuality and sexual violence. Communications issues may also exist. People with mental health challenges may be concerned they will not be believed. People with severe disabilities may need someone’s assistance to report a crime and therefore have to convince two sets of people.

HOMELESSNESS

Prevalence

Housing & Sexual Violence Online Collection

National Sexual Violence Resource Center (USA) - NSVRC

http://www.nsvrc.org/publications/housing-and-sexual-violence-online-collection

Homelessness a risk factor in terms of experiencing sexual violence and a consequence of having experienced sexual violence. A higher percentage of homeless persons than the population as a whole have experienced sexual violence prior to becoming homeless and a higher percentage experience sexual violence while homeless.

Barriers

PCAR Journal Article – Sexual Violence and Homelessness

Pennsylvania Coalition Against Rape


There is a double stigma attached to sexual violence and homelessness. Fear of punishment is another issue. Homeless people may also have a problematic relationship with police.
MINORITY RACE & ETHNICITY

Prevalence

Translating Pain Into Action: A Study of Gender-Based Violence and Minority Ethnic Women in Ireland

Women’s Health Council Ireland (now subsumed into the Department of Health)


Traveller women and certain categories of non-indigenous minority ethnic women in Ireland do face an increased risk of gender-based violence.

Barriers

The SAVI Report

Royal College of Surgeons in Ireland & Dublin Rape Crisis Centre

http://epubs.rcsi.ie/psycholrep/10/

Language difficulties may be present. People may have awkward and difficult relationships with police services. For some, disclosing would bring shame on the entire family. Marriage and family are held in high regard in the Travelling Community. If a girl is sexually abused and she discloses it would be detrimental to her future marriage prospects. These are also views held by some other minority ethnic groups.

OLDER AGE

Prevalence


National Sexual Violence Resource Center (USA) - NSVRC


Sexual violence remains the least reported of all form of violence and abuse against elderly people.

Barriers

Various programmes including:

Halton Region, Canada, Public Health

http://www.halton.ca/living_in_halton/public_health/health_wellness/sexual_health/sexual_violence/barriers_that_survivors_face/

There is more likely to be discomfort talking about sexual matters. Survivors may have kept sexual violence a secret for a long time. Older people are more likely to have had a negative experience talking about sexual violence in the past. There can be a fear that disclosure will lead to loss of independence.
**PRISON**

There are significant differences in prison regimes around the world. Most of the research done on the prevalence rates of sexual violence within prisons is U.S.A. based.

**Prevalence**

*Report on Sexual Victimization in Prisons and Jails: Review Panel on Prison Rape April 2012, US Department of Justice*

4.4% of prison inmates and 3.1% of jail inmates experienced sexual victimisation within a period of twelve months or since admission, if the admission took place within the past twelve months.


**Barriers**

*The SAVI Report*  
*Royal College of Surgeons in Ireland*  
http://epubs.rcsi.ie/psycholrep/10/

Prisoners do not confide easily in ‘officialdom’. Sex offenders are so reviled that no one wants to be associated with the crime, even as a victim. For male prisoners, if there is no evidence of physical force, there may well be a belief by prisoners and staff that “he must have agreed to it”. Disclosure would threaten the ‘macho’ image which may be necessary for survival.

**PROSTITUTION**

**Prevalence**

*Solutions and Strategies: drug problems and street sex markets*  
*Drug Strategy Directorate UK*  

More than half of women in prostitution have been raped and or seriously assaulted and at least 75% have been physically assaulted at the hands of the pimps and punters.

**Barriers**

*The SAVI Report*  
*Royal College of Surgeons in Ireland*  
http://epubs.rcsi.ie/psycholrep/10/

Survivors may not identify the ‘incident’ as sexual violence and have a fear of belittling and negative responses if engaging at all with health and legal personnel.
SEXUAL ORIENTATION

Prevalence

National Intimate Partner and Sexual Violence Survey 2010

US Centers for Disease Control, National Center for Injury Prevention & Control, Division of Violence Prevention


Rates of sexual violence experienced from an intimate partner by gay men and lesbian women were roughly similar to those rates experienced by heterosexual women. Rates for bisexual women and men were considerably higher. Sexual violence rates for violence perpetrated by a non-partner were higher for lesbian women and gay men and considerably higher for bisexual women and men.

Barriers

Various programmes including:

Halton Region, Canada, Public Health

http://www.halton.ca/living_in_halton/public_health/health_wellness/sexual_health/sexual_violence/barriers_that_survivors_face/

Survivors are likely to have perceptions that homophobia, biphobia or heteronormativity may be experienced from services. There is a fear of being pathologised and a fear that the survivor’s sexual orientation or their partner’s sexual orientation will be made public.

TEENAGERS

Prevalence

National Intimate Partner and Sexual Violence Survey 2010

US National Centers for Disease Control, National Center for Injury Prevention & Control, Division of Violence Prevention


42% of females who have been raped reported experiencing their first completed rape before the age of 18 (30% between 11-17 years old and 12% at or before age 10). More than one-quarter of male victims of completed rape (28%) were first raped when they were 10 years old or younger.

Barriers

Young People, Alcohol and Sex: What’s Consent Got To Do With It?

Rape Crisis Network Ireland


Consent is a grey area in practice for this group. Alcohol consumption is understood to be a facilitator of the majority of “sexual hook ups”. Sexual violence other than vaginal rape of a female by a male was difficult to name.
**TRANSGENDER/GENDER IDENTITY**

**Prevalence**

*Culturally Competent Service Provision to Lesbian, Gay, Bisexual and Transgender Survivors of Sexual Violence*

VAWnet.org  Gentlewarrier & Fountain

[http://new.vawnet.org/Assoc_Files_VAWnet/AR_LGBTSexualViolence.pdf](http://new.vawnet.org/Assoc_Files_VAWnet/AR_LGBTSexualViolence.pdf)

The most common finding across surveys and needs assessments is that about 50% of transgendered people report unwanted sexual activity at some point in their lives.

**Barriers**

*Trans Mental Health and Emotional Wellbeing Study 2012*

Scottish Transgender Alliance, TransBareAll, Trans Resource and Empowerment Centre, Traverse Research and Sheffield Hallam University


Many transgendered people have transphobic experiences as part of daily life. Many have had previous bad experiences with official personnel, including health and legal personnel. There is a fear of being pathologised.

**TRAFFICKING**

**Prevalence**

*Trafficking in Human Beings*

Eurostat


Ireland is both a transit and a destination country for trafficking. The majority (62%) of identified and presumed victims of trafficking across Europe between 2008 and 2010 were trafficked for the purpose of sexual exploitation.

**Barriers**

Please refer to the barriers faced by members of minority racial and ethnic backgrounds. In addition there is a lack of access to police, health services, psychological support as evidenced by the requirement for websites such as [http://www.blueblindfold.gov.ie](http://www.blueblindfold.gov.ie) to support and to recognise the signs and assist someone who is not in a position to assist themselves.
## Appendix 2:

### Record of Request for SATU Services

<table>
<thead>
<tr>
<th>SATU and Hospital/Healthcare Logo/s identifiers should be added</th>
</tr>
</thead>
</table>

### A. REQUEST DETAILS

<table>
<thead>
<tr>
<th>Date request received:</th>
<th>Time request received (24 hour clock):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Garda or Contact Person:</th>
<th>If Garda, enter Station:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Contact's Mobile No:</th>
<th>Contact's Landline No:</th>
</tr>
</thead>
</table>

#### Request for Services by:

<table>
<thead>
<tr>
<th>Nature of SATU Services request:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Advice</td>
</tr>
<tr>
<td>☐ Forensic Clinical Examination</td>
</tr>
<tr>
<td>☐ Health Check</td>
</tr>
<tr>
<td>☐ Other: Comment:</td>
</tr>
</tbody>
</table>

#### B. DETAILS OF PERSON INVOLVED IN THE INCIDENT AND INCIDENT TIMES

<table>
<thead>
<tr>
<th>Person is medically stable: Yes ☐ No ☐ If NO Advise: EmergencyDept/GP</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Age:</th>
<th>Gender: ☐ Female ☐ Male</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Person’s first language:</th>
<th>Garda or other Interpreter reqd. Yes ☐ No ☐ (If an interpreter is needed see National Guidelines, 2014; p. 49)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Incident date:</th>
<th>Incident time: (24 hr clock):</th>
<th>Time interval from incident:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Travel time to SATU approx:</th>
<th>Early Evidence Kit used? Yes ☐ No ☐</th>
</tr>
</thead>
</table>

#### Able to give CONSENT? Yes ☐ No ☐ Comments: |

#### If NO:

| ☐ Parent/guardian required |
| ☐ Temporary loss of capacity (e.g. alcohol) |
| ☐ Permanent loss of capacity |
| ☐ Vulnerable adult |
| ☐ Other: |

### C. FORENSIC CLINICAL EXAMINATION OR HEALTH CHECK BOOKED FOR:

<table>
<thead>
<tr>
<th>Date:</th>
<th>Time: (24 hr clock):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>SATU Team contacted:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forensic Clinical Examiner ☐</td>
</tr>
<tr>
<td>Support Nurse ☐</td>
</tr>
<tr>
<td>RCC Psychological Support ☐</td>
</tr>
</tbody>
</table>

If there is a delay of more than 3 hours please complete section D overleaf.

### Signed:

<table>
<thead>
<tr>
<th>Role:</th>
</tr>
</thead>
</table>

### Printed Name:
<table>
<thead>
<tr>
<th>Reason for delay of more than 3 hours</th>
<th>Length of delay in hours:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ No Forensic Clinical Examiner available</td>
<td>hours</td>
</tr>
<tr>
<td>☐ No Assistant Nurse/Midwife available</td>
<td></td>
</tr>
<tr>
<td>☐ No female Garda available</td>
<td></td>
</tr>
<tr>
<td>☐ No RCC Psychological Support available</td>
<td></td>
</tr>
<tr>
<td>☐ No Interpreter available</td>
<td></td>
</tr>
<tr>
<td>☐ Distance</td>
<td></td>
</tr>
<tr>
<td>☐ Other (please state):</td>
<td></td>
</tr>
<tr>
<td>☐ Patient request</td>
<td></td>
</tr>
<tr>
<td>☐ No Sexual Offences Exam Kit</td>
<td></td>
</tr>
<tr>
<td>☐ SATU Unavailable for use</td>
<td></td>
</tr>
<tr>
<td>☐ Obtaining consent</td>
<td></td>
</tr>
<tr>
<td>☐ Medical reason</td>
<td></td>
</tr>
<tr>
<td>☐ Not indicated within 3 hours (e.g. non-urgent health check)</td>
<td></td>
</tr>
</tbody>
</table>

Signed: 
Printed Name: 
Role:
Appendix 3:

SATU Legal Report Template

**NB.** The SATU legal report template included in the following pages gives a suggested layout, with some guidance for the author of the legal report. The SATU legal report template should be viewed as a dynamic tool. As such, the SATU legal report template can have relevant sections added, removed, or adjusted by the author.

---

**CONFIDENTIAL**

**FORENSIC CLINICAL EXAMINATION REPORT**

Sexual Assault Treatment Unit, Address

SATU Tel. Number:

Report by:  
Date of examination:  
Requesting Garda:  
Registration No:  
Garda Station Address:
## Contents Page

<table>
<thead>
<tr>
<th>Paragraph Number</th>
<th>Paragraph Contents</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Introduction</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>The Report Author’s Details</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Patient Details</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Consent to Forensic Clinical Examination</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Forensic Clinical Examination Details</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Relevant Health History</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Patient’s Brief Account of the Incident</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>General Examination: Head-to-Toe</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Genital Examination</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Anal Examination</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Forensic Swabs/Specimens</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Clothing</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Photographs</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Continuity of Evidence</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Pre-discharge</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Summary of Forensic Clinical Examination</td>
<td></td>
</tr>
<tr>
<td>Appendix 1</td>
<td>Glossary of Terms</td>
<td></td>
</tr>
</tbody>
</table>

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

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

2. The Report Author

<table>
<thead>
<tr>
<th>Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td></td>
</tr>
<tr>
<td>Professional P.I.N.</td>
<td></td>
</tr>
<tr>
<td>Work Address:</td>
<td></td>
</tr>
<tr>
<td>Work Telephone Number:</td>
<td></td>
</tr>
</tbody>
</table>

**Professional Qualifications:**

**Relevant Experience**

---

**Position of employment at time of writing this report**

At the time of writing this report I am a **enter role**, at **enter SATU name, Hospital Name, Address**.

I was on duty on **xx/xx/xxxx** as the Sexual Assault Forensic Examiner, for the SATU, when I carried out the Forensic Clinical Examination outlined in this report.
### 3. Patient Details

<table>
<thead>
<tr>
<th>Name:</th>
<th>SATU Chart Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>Date of Birth:</th>
<th>Age at time of Examination:</th>
<th>Gender:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 4. Consent to Forensic Clinical Examination

Following full explanation of the Forensic Clinical Examination procedures to the patient, I obtained signed consent, prior to commencing the Forensic Clinical Examination. *If there are any special considerations regarding consent then they should be outlined. If an interpreter was used then their details should be entered.*

### 5. Forensic Clinical Examination Details

- **Date of examination:** xx/xx/xxxx  
  **Time examination commenced:** 00.00 hours  
- **Location:** The Forensic Clinical Examination was carried out in [enter location]  
  *NB. If the location was other than a SATU then the reason should be recorded.*

**Sexual Offences Examination Kit**

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

- Garda: [complete]  
- Registration No: [complete]  
- Garda Station: [complete]  

The Sexual Offences Examination Kit expiry date was: [enter number]  
The opened Sexual Offences Examination Kit bag number was: [enter number]  
*NB. If An Garda Síochána was not present and evidence was stored see 2:31, p. 105.*

**Also present during the Forensic Clinical Examination**

*Note any other person present during the Forensic Clinical Examination and their role e.g.*

- SATU Team Support Person: xxxxxx

### 6. Relevant Previous Health History

**Sexual Intercourse Within the Previous 7 Days Record:**

- Date/s and time/s.
- Type/s of sexual intercourse.
- Condom/s used.
7. Patient's Brief Account of the Incident

<table>
<thead>
<tr>
<th>Date of the incident: xx/xx/xxxx</th>
<th>Time of the incident: 00.00 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time interval from the incident till the examination: enter time interval</td>
<td></td>
</tr>
</tbody>
</table>

I took the following brief account of the incident, to guide the care given, the Forensic Clinical Examination and forensic evidence collection. Where the patient’s own words are used they appear in inverted commas.¹

*It is important that the clinician does not stray into the role of an investigator. Keep the details recorded to those which seem relevant to the clinician’s role.*²

The full history of the incident and recording of the statement is the remit of *An Garda Síochána*, not the Forensic Clinical Examiner.

The purpose of the brief account taken by the Forensic Clinical Examiner is to guide and facilitate:

- Care
- The Forensic Clinical Examination and forensic evidence collection
- Safe discharge planning and follow-up care.²

Key practice points re: taking and recording the brief account of the incident:

- The account must accurately and precisely reflect what the patient says.
- To ensure accuracy, the recorded account may be read back to the patient.¹

Actions Since the Incident

*If relevant record whether since the incident, the patient has:*

- Eaten/brushed teeth/washed mouth (if allegation of oral assault)
- Bathed or showered
- Changed clothes, including panties/underpants
- Passed a bowel motion (if allegation of anal assault)
- Passed urine: If yes: how often and time last urinated.⁴
### General Examination: Head-to-toe

**Height:** enter height  **Weight:** enter weight  **Body Mass Index (BMI) xx kg/m²**

*Put in other observations as appropriate:

<table>
<thead>
<tr>
<th>Findings</th>
<th>Wounds:</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1. Head</td>
<td>• Use standard descriptive terms for classification and documentation of wounds (See 2:12, p. 79 and Table 9, p. 80)</td>
</tr>
<tr>
<td>8.2. Face</td>
<td>• Anatomical position</td>
</tr>
<tr>
<td>8.3. Neck</td>
<td>• Distance from a fixed point.</td>
</tr>
<tr>
<td>8.4. Shoulders</td>
<td>• Shape</td>
</tr>
<tr>
<td>8.5. Back</td>
<td>• Size in measurement of all dimensions where possible</td>
</tr>
<tr>
<td>8.6. Buttocks</td>
<td>• If appropriate borders or edges</td>
</tr>
<tr>
<td>8.7. Right arm hand and fingers*</td>
<td>• Colour</td>
</tr>
<tr>
<td>8.8. Left arm hand and fingers</td>
<td>• Contents: e.g. any foreign body</td>
</tr>
<tr>
<td>8.9. Chest and breasts</td>
<td>• If apparent: course or direction</td>
</tr>
<tr>
<td>8.10. Abdomen</td>
<td>• Physical deformities</td>
</tr>
<tr>
<td>8.11. Right leg: upper, lower and foot</td>
<td>• Previous scar/s pre-dating the incident</td>
</tr>
<tr>
<td>8.12. Left leg, upper, lower and foot</td>
<td>• Physical deformities</td>
</tr>
</tbody>
</table>

#### General Examination

*All sections should be completed, if relevant. Completion acts as confirmation that you have examined each area, unless details of the case indicate otherwise. Important negative findings show the clinician as being objective in reporting all findings.²*

*Example of recording a finding

**Bruise:** Right upper arm, posterior (back) aspect, 4 cm proximal (above) the tip of the olecranon process (tip of the elbow joint), there was an oval shaped purple bruise, 4 cm width x 2 cm length.² The bruise had clearly defined margins and was tender and indurated (hard) on palpation (See 2:12.1, p. 82).

The general examination may also include general appearance / presentation / behaviour. Factual behavioural observations are recorded e.g. crying / sobbing / shaking.

**NB.** Subjective assessments should not be used

*E.g. distressed / very distressed / upset / very upset / upset a little / calm etc.*
## 9. General Examination: Female

### Patient's Position for Genital Examination

*Example:* With the use of additional lighting, I examined the patient's genital area, using the modified lithotomy position (i.e. the patient lying on their back, knees bent, with the heels together and legs apart).

I noted and recorded the following:

<table>
<thead>
<tr>
<th>9.1</th>
<th>Inner Thighs</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.2</td>
<td>Mons Pubis area</td>
</tr>
<tr>
<td>9.3</td>
<td>Labia majora</td>
</tr>
<tr>
<td>9.4</td>
<td>Labia minora</td>
</tr>
<tr>
<td>9.5</td>
<td>Vestibule</td>
</tr>
<tr>
<td>9.6</td>
<td>Clitoral hood/glans</td>
</tr>
<tr>
<td>9.7</td>
<td>Urethral orifice</td>
</tr>
<tr>
<td>9.8</td>
<td>Fossa navicularis</td>
</tr>
<tr>
<td>9.9</td>
<td>Posterior fourchette</td>
</tr>
<tr>
<td>9.10</td>
<td>Hymen</td>
</tr>
<tr>
<td>9.11</td>
<td>Perineum</td>
</tr>
<tr>
<td>9.12</td>
<td>Pubic Hair</td>
</tr>
</tbody>
</table>

### Internal Examination

The vagina and cervix were examined using a *small* plastic speculum (an instrument designed for internal vaginal examination), which was lubricated using *enter name of lubricant if used*.

| 9.13 | Interior vaginal wall |
| 9.14 | Cervix |

**Genital injuries:** (See 2:11, p. 76)

Record use of:

- Speculum; proctoscope; Foley Catheter
- Lubricant *type if used*
### 9. General Examination: Male

**Patient’s Position for Genital Examination**

*Example: With the use of additional lighting, I examined the patient’s genital area while he was lying in the supine position (i.e. the patient lying on their back, with their arms by their sides).*

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.1</td>
<td>Inner thighs</td>
</tr>
<tr>
<td>9.2</td>
<td>Mons Pubis area</td>
</tr>
<tr>
<td>9.3</td>
<td>Foreskin</td>
</tr>
<tr>
<td>9.4</td>
<td>Frenulum</td>
</tr>
<tr>
<td>9.5</td>
<td>Glans</td>
</tr>
<tr>
<td>9.6</td>
<td>Coronal sulcus</td>
</tr>
<tr>
<td>9.7</td>
<td>Penile shaft</td>
</tr>
<tr>
<td>9.8</td>
<td>Scrotum</td>
</tr>
<tr>
<td>9.9</td>
<td>Testes</td>
</tr>
<tr>
<td>9.10</td>
<td>Perineum</td>
</tr>
<tr>
<td>9.11</td>
<td>Pubic Hair</td>
</tr>
</tbody>
</table>

### 10. Anal Examination

**Patient’s Position for Anal Examination.**

*Example: The patient was lying in the left lateral position (lying on their left side), with both knees bent up to their chest.*

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.1</td>
<td>Natal fold</td>
</tr>
<tr>
<td>10.2</td>
<td>Perianal/anal region</td>
</tr>
</tbody>
</table>

The rectum was internally examined using a small proctoscope (plastic instrument designed for internal rectal examination) lubricated with enter name of lubricant if used.

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.3</td>
<td>Internal rectal findings</td>
</tr>
</tbody>
</table>
11. Forensic Swabs/Specimens

I took the following swabs/specimens:

- The swabs/specimens taken and how many taken

Toxicology:

- Toxicology specimens taken

*NB. If the Forensic Clinical Examination was done without the presence of An Garda Síochána and the evidence stored in the SATU see 2:35.3, p. 108 and Appendix 4, p. 187.*

---

12. Clothing

*If clothing was taken and given to the Garda state:*

- Was this clothing worn at the time of the incident
- Item
- Colour
- Wet, dirty, blood stained etc.

*NB: If wet/heavy blood stained state how packaged (See 1:7, p. 28)*

---

13. Photographs

- Photograph taken:
  - If photographs were taken in the SATU: State the name and details of the Garda Photographer or person who took the photographs
  - For continuity of evidence state: the Garda photographer maintained possession of the camera containing the photographic evidence
14. Continuity of Evidence

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

**Toxicology Specimens**
The toxicology specimens I packed in the Toxicology tamper evident bag no: *enter number*

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

15. Pre-discharge

The following medication/s were given: *entry*
The appropriate support contact information and follow up information were given.

*Any other relevant information can be entered here*
16. Summary of Forensic Clinical Examination

Enter a summary of your findings, which should include any wound/s or injuries found. The inclusion of a copy of any relevant line drawing body map/s is helpful.

One of the following range of phrases could be chosen as appropriate for interpretation of the findings in the Forensic Clinical Examination report:

- Precludes
- Does not preclude
- Consistent with
- Suggests
- Strongly suggests

Example
To conclude xxxx is an xx year old fe/male who presented to the xxxx SATU on xx/xx/xxxx.

The patient gave a brief account of the incident as having been xxxxx on xx/xx/xx (See section 7).

Findings on Examination

Bruise: Right upper arm, posterior (back) aspect, 4 cm proximal (above) the tip of the olecranon process (tip of the elbow joint), there was an oval shaped purple bruise, 4cm width x 2cm length. The bruise had clearly defined margins and was tender and indurated (hard) on palpation (See 2:12.1, p. 82). This injury was consistent with the history given of .................

Genital Examination – No Injury/Injury (See 2:11, p. 76)
If no genital injury is found on examination then it is helpful to include the following caveat:

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

or

On genital examination there was no sign of recent genital injury. No genital injury, does not rule out the possibility of unconsented sexual intercourse.

Injuries which are Recorded but Not Commented On
If a wound or injury is documented, but not commented on, state why it is not commented on e.g.
The wound on ............. is not commented on, as it pre-dates this incident.

Date examination finished: xx/xx/xxxx  Time examination finished: 00.00 hours
I hereby declare that this report is true to the best of my knowledge and belief and that I make it knowing that if it is tendered in evidence I will be liable to prosecution if I state anything in it that I know to be false or do not believe to be true.

A copy of my contemporaneous notes which were used to generate this report is available (from xxx) on request.

Forensic Medical Examiners include:
I hereby certify the foregoing pursuant to Section 25 of the Non-Fatal Offences against the Person Act 1997.

Signed: _________________________ Date this report was signed _______________
Forensic Clinical Examiner

Printed Name: _________________________ Date report was typed _______________
Forensic Clinical Examiner

References


2 White, C. Sexual Assault: A Forensic Clinician’s Practice Guide. St. Mary’s Centre Manchester. 2010, Ch. 5, p.22. www.stmarycentre.org


4 Forensic Science Laboratory. Sexual Offences Examination Kit Form. 2014. Forensic Science Laboratory, Republic of Ireland.

Appendix 4:

Addendum to Legal Report – When Evidence has been Stored

<table>
<thead>
<tr>
<th>NB. When using the SATU legal report template (p. 175) follow instructions 1 - 5 below</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. REMOVE THE CLOTHING SECTION FROM THE REPORT</td>
</tr>
<tr>
<td>2. CONTINUITY OF EVIDENCE SECTION: COMPLETE THIS SECTION</td>
</tr>
</tbody>
</table>

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

**Toxicology Specimens**  
The blood and urine specimens I packed in the Toxicology tamper evident bag no: **enter bag number**

<table>
<thead>
<tr>
<th>3. ADD THE FOLLOWING TO THE CONTINUITY OF EVIDENCE SECTION</th>
</tr>
</thead>
</table>

**Sealing and Storing of Forensic Evidence Kits (If both kits taken otherwise amend)**  
I sealed and signed both the Sexual Offences Examination Kit and the Toxicology Kit tamper evident bags, containing the forensic specimens. I placed the above tamper evident bag/s containing the kit/s in the locked freezer in the password controlled secure storage area on **xx/xx/xxxx** at **00.00** hours.

This was witnessed by **enter the name of the witness**  
Grade **enter their grade**

<table>
<thead>
<tr>
<th>4. COMPLETE THE SUMMARY SECTION, SIGN, PRINT NAME AND DATE</th>
</tr>
</thead>
</table>

**Release of the Forensic Samples to An Garda Síochána (If both kits taken otherwise amend)**  
On receipt of written instruction from the patient, the above Sexual Offences Examination Kit and the Toxicology Kit tamper evident bags were removed from the locked freezer on **xx/xx/xxxx** at **00.00** hours; by **enter the name of person who signed as removing the kit/s from freezer and grade** and released to Garda **enter Garda name who signed as witnessing removal of the kit/s from freezer**  
Reg. No **enter Garda Reg. Number** attached to **enter** Garda Station.

Sign & Grade **Sign & Grade**  
Printed Name **print name**  
Date **xx/xx/xxxx**
Appendix 5:

Information Regarding Freezers

Objectives

- Reliable freezing for preservation of biological forensic evidence.
- Safe forensic evidence storage, to ensure compliance with continuity of evidence requirements.

Purchasing the Freezer

The freezer:

- Is purchased following consultation with the Hospital Clinical Engineering Dept.
- Must have a locking mechanism and a digital temperature display unit.
- Should have an audio/visual alarm system which can be programmed to alert via text the key holder’s mobile phone should a power failure occur.
- Be of sufficient size to accommodate the projected number of tamper evident bags containing the Sexual Offences Examination Kits and the tamper evident bags containing the Toxicology Kits.

Location of the Freezer

- The freezer must be held in a password or swipe card protected secure area.
- The area where the freezer is located should have a generator back up electricity supply.

Operating, Calibrating, Maintenance, Service and/or Repair of the Freezer

- The manufacturer’s instructions are adhered to.
- Freezer temperature adjustment is according to the manufacturer’s instructions.
- Calibration of the freezer temperature is carried out by the Hospital Clinical Engineering Department.
- Calibration should be done:
  - On all new freezers
  - Annually on all freezers
  - Following any maintenance, service and/or repair.
• Service maintenance is according to the manufacturer’s instructions.
• A record is kept of the service maintenance, repairs and/or calibrations performed.²

Monitoring of Freezers

• The required temperature for storage of forensic evidence is between minus 10º to minus 30º centigrade.¹
• The freezer temperature should be monitored at least weekly.¹,³
• Any adjustment to the freezer temperature should be noted in the comments section of the temperature record sheet.
• Freezer temperature records should be monitored over time for any significant drift or trend in the temperature.¹,² If observed this should be reported to the Hospital Clinical Engineering Department.
• Completed temperature record sheets and service maintenance records are archived.³

Local Policy Development

A local policy should be developed incorporating key stakeholders covering:

• Monitoring and recording of the freezer temperature at least weekly.
• If the freezer provides an electronic printout of the freezer temperature, this printout should be retained.
• Annual service maintenance and calibration check of the freezer.
• Recording of all maintenance, repairs and calibration of the freezer.
• Procedure in place in the event of a freezer breakdown:
  o During weekdays
  o Out of hours.
• Storage of freezer record archives.
• The policy should clearly indicate roles and responsibility.

References

1 Forensic Science Ireland: Calibration of Temperature Monitored Equipment. FSLBTS007
2 Appendix 9: Form for Recording Freezer Maintenance/Service/Repair/Calibration p. 193
3 Forensic Science Ireland: Temperature Monitoring DNA. FSLBTS071
**Appendix 6:**

**List of Key Personnel with Access to the Password Protected Area**

<table>
<thead>
<tr>
<th>Name</th>
<th>Grade/Role</th>
<th>Date access commenced</th>
<th>Date access finished</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
Appendix 7: 

Stored Evidence Record for Continuity of Evidence: 
Incorporated into the SATU National Patient Documentation, p. 25

<table>
<thead>
<tr>
<th>NB. STORED EVIDENCE RECORD - FOR CONTINUITY OF EVIDENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SECTION A. COMPLETED BY THE FORENSIC CLINICAL EXAMINER</td>
</tr>
<tr>
<td>Patient's Name</td>
</tr>
<tr>
<td>Date of Examination</td>
</tr>
<tr>
<td>Sexual Offences</td>
</tr>
<tr>
<td>Examination Kit Tamper</td>
</tr>
<tr>
<td>Evident Bag No</td>
</tr>
<tr>
<td>Toxicology Kit Tamper</td>
</tr>
<tr>
<td>Evident Bag No (If no toxicology write N/A)</td>
</tr>
</tbody>
</table>

COMPLETED BY FORENSIC CLINICAL EXAMINER

<table>
<thead>
<tr>
<th>Date Kit/s put in Freezer</th>
<th>Time Kit/s put in Freezer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of Forensic Clinical Examiner who placed the kit/s in the freezer</td>
<td>Printed Name of Forensic Clinical Examiner who placed the kit/s in the freezer</td>
</tr>
<tr>
<td>Witness Signature</td>
<td>Printed Name of Witness</td>
</tr>
<tr>
<td>(i.e. either Forensic Clinical Examiner, or Reg. Nurse/Midwife)</td>
<td>(i.e. either Forensic Clinical Examiner, or Reg. Nurse/Midwife)</td>
</tr>
</tbody>
</table>

SECTION B. COMPLETE: WHEN REMOVING KIT/S FROM FREEZER

<table>
<thead>
<tr>
<th>Date Kit/s Removed from Freezer</th>
<th>Time Kit/s Removed from Freezer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of person who removed Kit/s from Freezer (i.e. either Forensic Clinical Examiner, or Reg. Nurse/Midwife)</td>
<td>Printed Name of person who removed Kit/s from Freezer (i.e. either Forensic Clinical Examiner, or Reg. Nurse/Midwife)</td>
</tr>
<tr>
<td>Signature of Witness (NB. If Garda signs, also enters Reg. No and Garda Station. 2 photocopies of completed form handed to the Garda).</td>
<td>Printed Name of Witness:</td>
</tr>
</tbody>
</table>

Tick Reason for Removal of Kit/s from Freezer

- A = 1 year has elapsed since Forensic Clinical Examination and specimens were frozen, with no request for an extension.
- B = Extended time which had been requested has expired.
- C = Patient has signed a request to have the specimens destroyed and disposed of.
- D = Released to An Garda Síochána, the patient is making a formal complaint.

Garda signs as witness to removal of evidence from the freezer for continuity of evidence.

- Two photocopies of this completed form are handed to the Garda with the forensic evidence;
- One copy is retained by the Gardai (true copy) as exhibit for court; the second copy is taken with the evidence to the Forensic Science Lab.
**Appendix 8:**

**Freezer Temperature Monitoring Record: Sample**

<table>
<thead>
<tr>
<th>Freezer Make</th>
<th>Model</th>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchased from</td>
<td>Date purchased</td>
<td>Clinical Eng. Dept No</td>
</tr>
<tr>
<td>Clinical Eng. Dept No</td>
<td>Emergency Call Out Number</td>
<td></td>
</tr>
</tbody>
</table>

*NB.* The freezer temperature should be between minus 10º to minus 30º centigrade.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Temp</th>
<th>Any Comments</th>
<th>Signed</th>
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</thead>
<tbody>
<tr>
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</table>
## Appendix 9:

### Freezer Maintenance/Service/Repair/Calibration Record: Sample

Hospital/Healthcare Logo/s should be added

SATU Freezer Maintenance/Repair/Calibration Record

**NB.** The freezer temperature should be between minus 10º to minus 30º centigrade.

<table>
<thead>
<tr>
<th>Freezer Make</th>
<th>Model</th>
<th>ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchased from</td>
<td>Date purchased</td>
<td>Emergency Call Out Number</td>
</tr>
<tr>
<td>Clinical Eng. Dept No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Reason: Maintenance/Service/Repair/Calibration</th>
<th>Comments</th>
<th>Signed</th>
</tr>
</thead>
<tbody>
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Appendix 10:

Consent authorising release of stored evidence and a legal report to An Garda Síochána

Consent for Release of Stored Forensic Evidence and a Legal Report from the Sexual Assault Treatment Unit to the Custody of An Garda Síochána

Name ___________________________ Date of Birth ___________________________

SATU ___________________________ Date of Examination _______________________

I give my consent for the release/handover from the above Sexual Assault Treatment Unit, to the custody of An Garda Síochána of the following:

- All forensic samples both intimate and non-intimate that were collected during the Forensic Clinical Examination
- A legal report of the Forensic Clinical Examination

I understand that the forensic samples will be sent to Forensic Science Ireland and that the findings of the laboratory tests and the legal report may also be released to the courts for use in evidence.

Signed by complainant ___________________________ Date _________________

Signed by Garda ___________________________ Date _________________
Appendix 11:

Checklist for releasing stored forensic evidence and legal report

NB: The unique SATU identifiers and Hospital/Healthcare Logo/s should be added. This checklist should be securely attached to the documentation in line with best practice.¹

Checklist when Releasing Stored Forensic Evidence and a Legal Report to An Garda Síochána

Name ______________________________ D.O.B. __________________

SATU Number________________________ Date of Examination______________

Person removing the stored forensic evidence and giving it to An Garda Síochána

1. Check the Garda has a completed consent form authorising the release of stored forensic evidence and a legal report to An Garda Síochána
2. Make a copy of the completed consent authorisation form for the patient’s SATU records
3. Locate the patient’s documentation by checking the patient’s name, date of birth and date of examination
4. Locate the correct stored tamper evident bag/s, cross-checking the patient’s name, date of birth, SATU reference number, date of examination and the tamper evident bags numbers
5. The integrity of the tamper evident bag/s are checked in the Garda presence
6. The Stored Evidence Record form is completed by the SATU Staff member and the Garda receiving the forensic evidence
7. Two photocopies of the stored evidence record are made: original is filed in the patient’s documentation; the two copies are given to the Garda
8. The Forensic Clinical Examiner who carried out the Forensic examination is notified to complete the legal report addendum, prior to the release of the legal report to the Gardaí
9. The database is updated at the appropriate section to reflect the case has converted from storage of evidence to making a formal report to An Garda Síochána.

## Appendix 12:

### Checklist for Destruction and Disposal of Forensic Samples

| Name __________________________________________ | D.O.B. ____________________________ |
| Date of Examination __________________________ | SATU Number __________________________ |
| Sexual Offences Examination Tamper Evident Bag No: __________________________ |
| Toxicology Kit Tamper Evident Bag No: __________________________ |

<table>
<thead>
<tr>
<th>Checklist</th>
<th>Tick</th>
</tr>
</thead>
<tbody>
<tr>
<td>The patient’s details were checked against the patient’s SATU Documentation.</td>
<td></td>
</tr>
<tr>
<td>The tamper evident bag/s were opened.</td>
<td></td>
</tr>
<tr>
<td>Both the samples and the empty tamper evident bags were placed in a rigid yellow container.</td>
<td></td>
</tr>
<tr>
<td>The forms accompanying the Kit/s were shredded.</td>
<td></td>
</tr>
<tr>
<td>The container was sealed and tagged and signed by the person destroying the Kit/s and the witness.</td>
<td></td>
</tr>
<tr>
<td>The tag number, the date and the signature of the person destroying the Kits and the witness was entered in the appropriate place on the patient’s SATU notes.</td>
<td></td>
</tr>
<tr>
<td>The sealed clinical waste container was delivered to the central waste collection.</td>
<td></td>
</tr>
<tr>
<td>The Porter is notified and a C1 (or appropriate form) is completed with the date and Tag number entered.</td>
<td></td>
</tr>
<tr>
<td>The individual patient’s stored evidence record was completed.</td>
<td></td>
</tr>
<tr>
<td>Signature of SATU Staff Member (i.e. either a Forensic Clinical Examiner or Registered Nurse/Midwife) destroying/disposing of Forensic Kit/s (Plus grade):</td>
<td>Date:</td>
</tr>
<tr>
<td>Witness signature (Plus grade):</td>
<td>Date:</td>
</tr>
</tbody>
</table>

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## Appendix 13:

### Key Performance Indicators (KPIs) and Monitoring and Evaluation in Irish SATUs

<table>
<thead>
<tr>
<th>SATU Key Performance Indicators (KPIs)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SERVICE ATTENDANCE ACTIVITY</strong></td>
</tr>
<tr>
<td>• % of patients who attended a SATU, who have reported/or are reporting the incident to An Garda Síochána, at the first SATU visit.</td>
</tr>
<tr>
<td>• % of patients who attended a SATU, who chose to have a Health Check, at the first SATU visit.</td>
</tr>
<tr>
<td>• % of patients attending a SATU, who had already attended a SATU for this incident and were referred, SATU to SATU, to facilitate follow up care.</td>
</tr>
<tr>
<td>• % of patients who attended a SATU, who chose to receive advice only, at the first SATU visit.</td>
</tr>
<tr>
<td><strong>NB.</strong> Return visits see: Follow-up care – Sexually Transmitted Infections (STIs).</td>
</tr>
<tr>
<td><strong>QUALITY OF RESPONSE</strong></td>
</tr>
<tr>
<td>• % of patients, seen by a Forensic Clinical Examiner, within 3 hours of a request to a SATU, for a Forensic Clinical Examination.</td>
</tr>
<tr>
<td>• % of patients, who had the opportunity to speak with a Psychological Support Worker, at the first SATU visit.</td>
</tr>
<tr>
<td><strong>QUALITY OF CARE</strong></td>
</tr>
<tr>
<td><strong>Prophylactic care</strong></td>
</tr>
<tr>
<td>• % of female patients, who presented within 120 hours and appropriately received emergency contraception (EC).</td>
</tr>
<tr>
<td>• % of patients aged 14 years and over, who were appropriately given prophylactic Hepatitis B vaccination, at the first SATU visit.</td>
</tr>
<tr>
<td>• % of patients offered prophylactic treatment, against Chlamydia Trachomatis, at the first SATU visit.</td>
</tr>
</tbody>
</table>
**Patient Safety**
- % of patient SATU documentation completed, with regard to safety of home environment, on discharge from the first SATU visit.
- % of patients less than 18 years of age, who had a referral made to the Child and Family Agency (Tusla), at the first SATU visit.
- % of victims/survivors attending a SATU for the first time, who were given the appropriate contact information, by the RCC Psychological Support Worker.

**Follow-up care – Sexually Transmitted Infections (STIs)**
- % of patients who attended the SATU who were given an STI review appointment.
- % of patients who attended a scheduled first STI review appointment, following the first SATU attendance.

**QUALITY OF FORENSIC SERVICE**
- % of cases who had a Forensic Clinical Examination and had a legal report prepared.
- % of legal reports were prepared within eight weeks of the Forensic Clinical Examination.

**QUALITY OF SERVICE**
- % of records of attendance of first SATU visit were entered on the database, within 10 working days post the patient’s first SATU attendance.
- % of Parliamentary Questions (PQs), answered within 15 working days.
SATU Monitoring and Evaluation

Possible areas for audit using a structure, process and outcome approach are tabulated below.¹

## Table 19: Structure, Process and Outcome Audit.

<table>
<thead>
<tr>
<th>STRUCTURE</th>
<th>PROCESS</th>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Resources:</strong></td>
<td><strong>Processes:</strong></td>
<td><strong>Key performance Indicators for each specialist area should be defined. Examples for use within the SATU include the following:</strong></td>
</tr>
<tr>
<td>Appropriate Staff education e.g.</td>
<td>Explicit evidence of communication lines e.g.</td>
<td>• Ensure quality and appropriateness of response from victim/survivor’s perspective:</td>
</tr>
<tr>
<td>• Education criteria to fulfil practitioner role</td>
<td>• Referral pathways to SATU</td>
<td>▶ Service received</td>
</tr>
<tr>
<td>• Specialised induction packages</td>
<td>• Distinct referral processes from SATU to other relevant disciplines.</td>
<td>▶ Staff response</td>
</tr>
<tr>
<td>• Continuing professional development.</td>
<td>• Defined links with relevant Hospital support services e.g. Laboratory, Information Technology (IT), Human Resources (HR), laundry, post etc.</td>
<td>▶ Suitability of environment</td>
</tr>
<tr>
<td><strong>Buildings Appropriate:</strong></td>
<td>• Inter-agency/disciplinary Liaison meetings (a minimum of 2 per year held) with agenda, action plan and minutes.</td>
<td></td>
</tr>
<tr>
<td>• Physical space and equipment for: SATU care, Forensic Clinical Examination and follow-up.</td>
<td>• Partnership approach to a coordinated inter-disciplinary response.</td>
<td></td>
</tr>
<tr>
<td>• Patient and security measures.</td>
<td>• Cross-sectoral cooperation in line with national strategies.</td>
<td></td>
</tr>
<tr>
<td>• Forensic quality check:</td>
<td>• Partnership approach approach to a coordinated inter-disciplinary response.</td>
<td></td>
</tr>
<tr>
<td>Environmental monitoring carried out twice yearly.</td>
<td>• Readily available and accessible service information e.g. clear appropriate patient information, specific training packages, use of websites, etc.</td>
<td></td>
</tr>
<tr>
<td><strong>Documentation Use:</strong></td>
<td>• Confidentiality</td>
<td>• Measure against the Key Performance Indicators (KPIs) in the following categories:</td>
</tr>
<tr>
<td>• Standardised best practice documentation, policies, protocols, guidelines etc.</td>
<td>• Explicit systems are in place to ensure patient confidentiality.</td>
<td>• Service attendance activity</td>
</tr>
<tr>
<td>• Standardised prospective data collection, data analysis and production of clinical reports.</td>
<td>• Service received</td>
<td>• Quality of response</td>
</tr>
<tr>
<td>• Ensure availability of Recent Rape/Sexual Assault National Guidelines, 2014.</td>
<td>• Staff response</td>
<td>• Quality of care</td>
</tr>
<tr>
<td><strong>Service:</strong></td>
<td>• Service Expansion</td>
<td>• Quality of forensic service</td>
</tr>
<tr>
<td>• Available 24 hours a day 365 days a year.</td>
<td>• Ensure knowledge of services is available to all sections of the population.</td>
<td>• Quality of service</td>
</tr>
<tr>
<td>• All SATU Response Options are available (See p. 14).</td>
<td>• Forensic Quality checks</td>
<td></td>
</tr>
<tr>
<td>• STI follow-up in the SATU</td>
<td>• Encourage provision of DNA reference elimination profiles by all Staff.</td>
<td></td>
</tr>
<tr>
<td><strong>Finance</strong></td>
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</tr>
<tr>
<td>• Ring fenced local and national budgets</td>
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<td></td>
</tr>
</tbody>
</table>

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

References:

Appendix 14:

Critical Readers List

Bonner, Ms. Niamh, CNS (SAFE), SATU Galway, Hazelwood House, Parkmore Rd., Galway.

Boyle, Ms. Sinead. CNS (SAFE), SATU, University Hospital Waterford, Dunmore Rd., Waterford.

Columb, Dr. Gouri. Forensic Medical Examiner, SATU, Rotunda Hospital, Parnell Sq. Dublin 1.

Counihan, Ms. Caroline, B.L. Legal Director, Rape Crisis Network Ireland (RCNI), The Halls, Quay St. Galway.

Clune Mulvaney, Ms. Catherine. Lecturer & Programme Director, RCSI Faculty of Nursing & Midwifery, Royal College of Surgeons in Ireland, 123 St. Stephen’s Green, Dublin 2, Ireland.

Cremin, Dr. Suzanne. Forensic Medical Examiner, Cork SATU, South Infirmary Victoria University Hospital, Old Blackrock Road, Cork.

Crilly, Ms. Mary. Director, Sexual Violence Centre Cork, 5 Camden Place, Cork.

Domestic Violence Sexual Assault Investigation Unit (DVSAIU) Staff, National Bureau of Criminal Investigation, Harcourt St, Dublin 2.


Hallahan, Ms. Catherine. CNS (SAFE). SATU, Rotunda Hospital, Parnell Sq. Dublin 1.

Hanrahan, Ms. Fiona. Assistant Director of Midwifery/Nursing, Rotunda Hospital, Dublin 1.

Kennedy, Dr. Kieran. General Practitioner, Lecturer in Clinical Practice (NUI Galway) and Forensic Medical Examiner (Child, Adolescent and Adult Sexual Assault), Sexual Assault Treatment Unit, Hazelwood House, Parkmore Road, Galway. Author of GP Section; critical reader of the entire document.

Kavanagh, Ms. Siobhan. CNS (SAFE), SATU, University Hospital Waterford, Dunmore Rd., Waterford.

Marshall, Ms. Deborah, CNS (SAFE), SATU, Midlands Regional Hospital, Mullingar, County Westmeath.

McGilloway, Ms. Connie, CNS (SAFE) Donegal SATU, Letterkenny General Hospital, High Road, Letterkenny, County Donegal.

ní Riain, Dr. Ailís, General Practitioner, Co. Wicklow.


O’Herlihy, Ms. Alva. Prosecution Solicitor, Office of the DPP, 90 North King Street, Smithfield, Dublin 7.

O’Neill, Ms. Mary. Project Manager Sexual Health, HSE and SATU, Midlands Regional Hospital, Mullingar, County Westmeath.

Rape Crisis Centres throughout the Republic of Ireland sent combined feedback.

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Operational Definitions and Glossary of Terms

**Abrasion:** Superficial injury to the skin caused by the application of blunt force. Produced by a combination of contact pressure and movement applied simultaneously to the skin (p. 79 for different types of abrasions).4,19

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

**Adult Forensic Clinical Examination:** In law a person is an adult when they reach the age of 18 years.6 For the purpose of carrying out an adult Forensic Clinical Examination, 14 years of age is taken as the age where physical maturity has been reached in the average young person.

**NB.** For a person under the age of 18 years, Children First guidelines reporting mechanisms should be followed.

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

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

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

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

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

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

**Bruise:** An area of haemorrhage beneath the skin4,19 (See 2:12 p. 79 and 2:12.1, p. 82).

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

**Cervix:** The neck of the uterus, penetrated by the cervical canal, it is about 2.5cms. in length, with a rounded surface that protrudes into the vagina; for descriptive purposes the rounded surface is divided in half at the cervical os, into the anterior and posterior cervix.
**Clinical Nurse/Midwife Specialist**: A nurse or midwife in clinical practice who has undertaken formal recognised post-registration education relevant to his/her area of specialist practice.2

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

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

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

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

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

**Dentate line**: See anorectal line.14

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

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

**Erythema**: Redness of the skin and/or mucous membranes caused by dilatation of the underlying capillaries.17

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

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

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

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

**Forensic Clinical Examiner**: In the context of these guidelines, the term Forensic Clinical Examiner is deemed to be an appropriately trained healthcare professional who undertakes the Forensic Clinical Examination and collects forensic evidence from the patient, following alleged rape or sexual assault. This healthcare professional may be a Medical Doctor, a Registered Nurse or a Registered Midwife.3
**Foreskin:** The movable hood of skin covering the glans of the penis. 21

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

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

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

**Glans of the penis:** The cone shaped head of the penis, 21 distal to the coronal sulcus.

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

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

**Hymen:** A membranous collar or semi collar inside the vaginal introitus 14 (See 2:7.1, Table 4: Anatomical variations and terms relating to the hymen, p. 68).

**Intimate Partner:** A husband/wife, boyfriend/girlfriend or lover. 4

**Introitus:** An opening or entrance into a canal or cavity as in the vaginal introitus. 14

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

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

**Laceration:** Ragged or irregular tears or splits in the skin, subcutaneous tissues or organs resulting from blunt trauma (e.g. trauma by impact) 4, 19 (See 2:12, p. 79).

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

**Mons Pubis:** Mound of fatty tissue lying over the pubic symphysis. 25

**SATU National Patient Documentation:** The standardised individual patient record (“chart”) which is used in Irish SATUs.

**Online Sexual Exploitation:** Online Sexual Exploitation is an act or acts committed, by use of the Internet, that are Sexual Assaults. Injured parties are deceived or coerced into producing indecent images of themselves or engaging in sexual chat or sexual activity over webcam and then in
some cases coerced into producing more material in an effort to prevent disclosure online to family and friends.

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

**Penis:** Male organ of reproduction and urination, composed of erectile tissue, through which the urethra passes. It has a shaft and glans (head); the glans may be covered by the foreskin.14, 18 (See 2:8, Table 7, p. 70)

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

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

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

**Rape:** Definitions for rape as legally defined in Irish law available at: [http://irishstatutebook.ie](http://irishstatutebook.ie).

**Recent Acquaintance:** Someone who the person knew for less than 24 hours 5

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

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

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

**Sexual Assault:** Definitions for sexual assault as legally defined in Irish law available at: [http://irishstatutebook.ie](http://irishstatutebook.ie).

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

**Sexual Violence:** A term covering a wide range of crimes, including rape, sexual assault, incest and buggery available at: [http://irishstatutebook.ie](http://irishstatutebook.ie).

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

**Speculum:** An instrument for exposing a cavity or channel in the body by enlarging the opening to allow viewing.
**Speculum Examination:** The viewing of a canal of the body, using a speculum. Specifically viewing the vagina and cervix with a vaginal speculum.

**Stranger:** Someone whom the person has never met.

**Swab:** A swab in the context of a Forensic Clinical Examination is a one ended ‘cotton bud.’ Each swab comes in its own individual cylindrical container.

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

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

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

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

**Trafficking:** (See Human Trafficking)

**Urethral Orifice:** Opening into the urethra.

**Vagina:** A fibromuscular sheath extending upwards and backwards from the vestibule. 16 (See 2:7.2, Table 5: Descriptive terms for the vagina, p. 69).

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

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

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

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

**Wounds:** See Table 8: Standard Descriptive Terms for Classifying Wounds, p. 79.
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>BASHH:</td>
<td>British Association for Sexual Health and HIV</td>
</tr>
<tr>
<td>BMI:</td>
<td>Body Mass Index</td>
</tr>
<tr>
<td>CHP:</td>
<td>Countries of High Prevalence</td>
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<tr>
<td>Cu-IUD:</td>
<td>Copper containing intrauterine contraceptive device</td>
</tr>
<tr>
<td>CN/MS (SAFE):</td>
<td>Clinical Nurse /Midwife Specialist (Sexual Assault Forensic Examination)</td>
</tr>
<tr>
<td>DNA:</td>
<td>Deoxyribonucleic acid</td>
</tr>
<tr>
<td>DOB:</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>DOHC:</td>
<td>Department of Health and Children</td>
</tr>
<tr>
<td>DOJ:</td>
<td>Department of Justice</td>
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<tr>
<td>DPP:</td>
<td>Director of Public Prosecutions</td>
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<tr>
<td>DVSAIU:</td>
<td>Domestic Violence Sexual Assault Investigation Unit</td>
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<tr>
<td>EC:</td>
<td>Emergency Contraception</td>
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<tr>
<td>ECP:</td>
<td>Emergency Contraceptive Pill</td>
</tr>
<tr>
<td>FFLM:</td>
<td>Faculty of Forensic and Legal Medicine</td>
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<tr>
<td>FGM:</td>
<td>Female Genital Mutilation</td>
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<tr>
<td>FVU:</td>
<td>First Void Urine</td>
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<tr>
<td>GP:</td>
<td>General Practitioner</td>
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<tr>
<td>hCG:</td>
<td>Human Chorionic Gonadotropin</td>
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<tr>
<td>HIV:</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HQ:</td>
<td>Head Quarters</td>
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<tr>
<td>HR:</td>
<td>Human Resources</td>
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<tr>
<td>HSE:</td>
<td>Health Service Executive.</td>
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<tr>
<td>ICGP:</td>
<td>Irish College of General Practitioners</td>
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<tr>
<td>IT:</td>
<td>Information Technology</td>
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<tr>
<td>IVDA:</td>
<td>Intravenous Drug Addict/s</td>
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<tr>
<td>KPI:</td>
<td>Key Performance Indicator</td>
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<tr>
<td>LMP:</td>
<td>Last Menstrual Period</td>
</tr>
<tr>
<td>LNG:</td>
<td>Levonorgestrel</td>
</tr>
<tr>
<td>MSM:</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>NAATs:</td>
<td>Nucleic Acid Amplification Tests</td>
</tr>
<tr>
<td>NCBI:</td>
<td>National Council for the Blind of Ireland</td>
</tr>
</tbody>
</table>
References for Operational Definitions and Glossary of Terms


5. Lovett, J. and Kelly, L. Different systems, similar outcomes? Tracking attrition in reported rape cases across Europe. London: Metropolitan University, Child & Woman Abuse Study Unit; 2009 www.cwasu.org


The Irish SATU Logo

‘The Irish SATU Logo was designed to convey the overall essence and values of Irish SATUs. The Logo uses the image of two hands forming a shelter around the SATU lettering with the colours reflecting the different agencies involved. The Logo echoes some of the values of the various organisations involved: caring, support, trustworthiness, impartiality, partnership and professionalism.’

Andrea Mears, Graphic Designer.