MILITARY SPECIFICATION

INVESTIGATION KIT, SEXUAL ASSAULT DETERMINATION (Prepackaged)

This limited coordination military specification has been prepared by the Defense Personnel Support Center based on currently available technical information. However, pending its promulgation as a coordinated military specification, it may be used in procurement.

1. SCOPE

This specification covers a prepackaged kit for the investigation of sexual assaults.

2. APPLICABLE DOCUMENTS

2.1 Issues of documents. The following documents of the issue in effect on date of invitation for bids or request for proposals, form a part of this specification to the extent specified herein:

SPECIFICATIONS

FEDERAL

PPP-B-566	-	Boxes, Folding, Paperboard.
PPP-B-636	-	Boxes, Shipping, Fiberboard.
PPP-B-676	-	Boxes, Setup.

Beneficial comments (recommendations, additions, deletions) and any pertinent data which may be of use in improving this document should be addressed to: Defense Personnel Support Center, Directorate of Medical Materiel, DPSC-RST, 2800 South 20th Street, Philadelphia, PA 19101, by using the self-addressed Standardization Document Improvement Proposal (DD Form 1426) appearing at the end of this document or by letter.

FSC 6640

AMSC N/A

STANDARDS

MILITARY

MIL-STD-105	-	Sampling Procedures and Tables for Inspection by Attributes.
MIL-STD-129	-	Marking for Shipment and Storage.
MIL-STD-147	-	Palletized Unit Loads.
MIL-STD-794	-	Parts and Equipment, Procedures for Packaging of.

3. REQUIREMENTS

3.1 Design and construction. Shall be a prepackaged kit in a crushproof papered box for investigation of sexual assaults. Shall contain instructions, report forms and specimen containers for the treatment and orderly medicolegal examinations of victims of sexual assault. Shall also be suitable for use to support medicolegal examinations of suspects. Shall be supplied with components conforming to 3.2 and printed service data conforming to 3.3.

3.2 Components. Shall be supplied with the following components:

1. 25 each. Addressograph labels (1-1/2 X 3 inch size) preprinted with the following legend:

   (1st line) NAME_____
   (2nd line) SAMPLE_____

2. 1 each. 4 X 4 foot size sheet paper (For patient to stand on while disrobing).

3. 2 each. 18 X 18 inch size sheet paper (For collection of head and pubic hair combings).

4. 3 each. 9 X 12 inch size kraft envelopes (For the paper sheets).

5. 9 each. 3 X 5-1/2 inch size coin envelopes (For collection of saliva sample and control, hair standards and combings w/comb, and miscellaneous scrapings).

6. 2 each. 4 inch size (minimum) pocket comb with same height fine teeth.

7. 1 each. Nail clipper with a file.

8. 4 each. 25 X 75mm size microscope slide with frosted end (For checking sperm motility).

9. 2 each. 2 - slotted prelabeled slide holder for 25 X 75mm slides, with labeling to include:

_____name, _____sample.

10. 2 each. Gauze, sterile, 2 X 2 inch size (individually packaged and selected from same lot number). For use in obtaining saliva samples.

11. 2 each. Wood applicator, cotton - tipped.

12. 2 each. Ziplock bag, 2 X 3 inch size, 4 mil thick.

13. 3 each. Ziplock bag, 3 X 5 inch size, 4 mil thick.

14. 1 each. 15 cm long one piece 3 ml plastic pipet with a molded bulb, for vaginal aspirate (Falcon/Becton - Dickinson Labware P/N 7524, or equal).

15. 6 each. Plastic tube with a red color screw cap closure and two cotton tipped swabs affixed to the inside of the cap (Falcon/Becton - Dickinson Labware P/N 2085, or equal).

16. 1 each. Notes to the Investigator service data (see 3.2.1).

17. 1 each. Note to the Physician service data (see 3.2.2).

18. 1 each. Evidence Check List service data (see 3.2.3).

19. 1 each. Evidence Handling Notes service data (see 3.2.4).

20. 1 each. Medical Examination Report (see 3.2.5).

3.3 Printed forms.

3.3.1 Notes to the Investigator. The service data shall conform to requirements contained in Appendix A.

3.3.2 Notes to the Physician. The service data shall conform to requirements contained in Appendix B.

3.3.3 Evidence Check List. The service data shall conform to requirements contained in Appendix C.

3.3.4 Evidence Handling Notes. The service data shall conform to requirements contained in Appendix D.

3.3.5 Medical Examination Report. The service data, including releases and history, shall conform to requirements contained in Appendix E.

3.3.6 Unit package. Each white gloss-papered box shall be marked in accordance with requirements contained in Appendix F.

3.4 Workmanship. The investigation kit shall be free from defects which detract from its appearance or impair its serviceability.

4. QUALITY ASSURANCE PROVISIONS

4.1 Responsibility for inspection. Unless otherwise specified in the contract, the contractor is responsible for the performance of all inspection requirements as specified herein. Except as otherwise specified in the contract, the contractor may use his own or any other facilities suitable for the performance of the inspection requirements specified herein, unless disapproved by the Government. The Government reserves the right to perform any of the inspections set forth in the specification where such inspections are deemed necessary to assure supplies and services conform to prescribed requirements.

4.1.1 Records. Records of examinations and tests performed by or for the contractor shall be maintained by the contractor and made available to the Government, upon the Government's request, at any time, or from time to time, during the performances of the contract and for a period of three years after delivery of the supplies to which such records relate.

4.1.2 Inspection. Inspection, as used in this specification, is defined as both examination (such as visual or auditory investigation without the use of special laboratory appliances or procedures) and testing (determination by technical means of physical and chemical properties) of the item.

4.1.3 Certificates of Quality. Certificates of quality, supplied by the manufacturer of the component or material, may be furnished in lieu of actual performance of such testing by the contractor, provided lot identity has been maintained and can be demonstrated to the Government. The certificate shall include the name of the contractor, the contract number, the name of the manufacturer or supplier, the National Stock Number, the item identification, the name of the component/material, the lot number, the lot size, the sample size, the data of testing, the test method, individual test results, and the specification requirements.

4.2 Sampling for Inspections.

4.2.1 For examination. Sampling for examination shall be conducted in accordance with MIL-STD-105 and Table I. The unit of product for sampling purposes shall be the kit.

TABLE I. FOR EXAMINATION.

	INSPECTION LEVEL	AQL (PERCENT DEFECTIVE)
For Visual Examination		
Major Defects	II	1.0
Minor Defects	II	2.5

4.3 Classification of Defects. Examination shall be conducted in accordance with the classification of defects shown in Table II. Examination shall not be restricted to the possible defects that are listed in the table.

TABLE II. CLASSIFICATION OF DEFECTS.

Categories	Defects
Major	
101	Kit not complete with all component parts.
102	Components not free of damage or deformation which renders them unsuitable for intended use.
103	Microscope slides not free of obstructions or clusters of scratches that impair optical clarity.
104	Slide holders not capable of holding the required microscope slides.

TABLE II. CLASSIFICATION OF DEFECTS CON'T.

105	Printed forms not completely legible, or not free of discontinuities.
106	Pages of Medical Examination Report not securely attached in packet form.
107	Pages of Medical Examination Report not readily detachable from packet.
Minor	
201	Identification marking not complete, permanent or legible.
202	Crushproof box not free of dents, damage of deformation which does not affect suitability of use of contents.

4.4 Inspection of packaging. The sampling and inspection of the packing and marking for shipment and storage shall be in accordance with the quality assurance provisions of the applicable container specification and the marking requirements of MIL-STD-129.

5. PACKAGING

5.1 Preservation. Preservation shall be level A or C, as specified (see 6.1).

5.1.1 Level A.

5.1.1.1 Unit package. All components as specified in 3.2 shall be neatly packaged in a crushproof white gloss-papered box conforming to PPP-B-566 or PPP-B-676. Closure shall be as specified in the applicable box specification.

5.1.1.2 Intermediate package. Six unit packages shall be packaged in a box conforming to PPP-B-566, PPP-B-636, class domestic, or PPP-B-676. Closure shall be as specified in the applicable box specification.

5.1.2 Level C.

5.1.2.1 Unit package. Preservation for the investigation kit shall conform to the requirements of MIL-STD-794 for level C.

5.1.2.2 Intermediate package. Six unit packages shall be packaged in accordance with the requirements of MIL-STD-794 for level C.

5.2 Packing. Packing shall be level A, B, or C, as specified (see 6.1).

5.2.1 Level A. Four intermediate packages (24 units) shall be packed in an exterior container designed for a type 2 load and conforming to PPP-B-636, class weather-resistant. Closure, strapping and waterproofing shall be as specified in the box specification.

5.2.2 Level B. Four intermediate packages (24 units) shall be packed in an exterior container designed for a type 2 load and conforming to PPP-B-636,class domestic. Closure shall be as specified in the box specification.

5.2.3 Level C. Four intermediate packages (24 units) shall be packed in accordance with the requirements of MIL-STD-794 for level C.

5.2.4 Packing variation permitted. If the required number of units to be shipped is less than the number of units specified to be overpacked in an exterior container, such units shall be packed in an exterior container of suitable size and design, acceptable to a common carrier, which will insure safe delivery to destination.

5.2.5 Unitized loads. Unitized loads, commensurate with the level of packing specified in the contract or order, shall be used whenever total quantities for shipment to one destination exceed 250 lbs (excluding the pallet) or 20 cubic feet. Loads shall be unitized as specified in MIL-STD-147, on Type IV or Type V 4-way entry pallets. Pallet shall have a length of 40 inches and a width of 48 inches. Pallet loads including the pallet shall not exceed 54 inches in height, 40 inches in length and 48 inches in width. Quantity for shipment to one destination of less than 250 lbs or 20 cubic feet need not be palletized.

5.2.5.1 Levels A and B. Investigation kits packed as specified in 5.2.1 and 5.2.2 shall be unitized on pallets as specified in 5.2.5.

5.2.5.2 Level C. Investigation kits packed as specified in 5.2.3 shall be unitized as specified in MIL-STD-794.

5.3 Marking.

5.3.1 Unit package. In addition to markings required in 3.3.6 each unit shall be marked with the following information:

National Stock Number (NSN)
Item Identification
Quantity and Unit of Issue
Contract or Purchase Order Number
Contractor's Name or Registered Trademark
The Initials "U.S."
Level of Protection and Date

5.3.2 Levels A,B and C. Each intermediate package, shipping container and unitized load shall be marked as specified in MIL-STD-129.

5.4 General.

5.4.1 Exterior container. Exterior container (see 5.2.1, 5.2.2, and 5.2.3) shall be of minimum tare and cube consistent with the protection required and shall contain equal quantities of identical stock numbered items to the greatest extent practicable.

5.4.2 Packaging inspection. The inspection of these packaging requirements shall be in accordance with 4.4.

6. NOTES

6.1 Ordering data. Procurement documents should specify the following:

(a) Title, number, and date of this specification.
(b) National Stock Number (NSN).
(c) Selection of applicable levels of packaging and packing (see 5.1 and 5.2)

6.2 Qualification. This specification does not cover all types, classes, grades or sizes of the commodity indicated by the title of this specification, or those which are commercially available, but is intended to cover the types which are normally procured to meet military requirements.

6.3 Stock listing. This specification covers the following item listed in the Federal Supply Catalog:

National Stock Number	Item Identification
6640-01-247-8225	INVESTIGATION KIT, SEXUAL ASSAULT DETERMINATION, Prepackaged.

Custodians:
Army - MD
Navy - MS
Air Force - 03

Preparing activity:

DoD-MB

Agent:

DLA-DM

CIVIL AGENCY COORDINATING ACTIVITIES:

VA-OSS
PHS
FDA-MPQAS

Project No. 6640-1442

Location: Disk # 11

APPENDIX A

NOTES TO THE INVESTIGATOR

10. SCOPE

10.1 SCOPE. This appendix details the requirements for preparing the "Notes to Investigator" service data required in 3.2.1. This appendix is a mandatory part of this specification. The requirements contained herein is intended for compliance.

20. APPLICABLE DOCUMENTS

This section is not applicable to this appendix.

30. REQUIREMENTS

30.1 Format. Shall be printed on 8-1/2 x 11 inch size paper sheet(s) with back to back printing acceptable.

30.2 Content. The service data contained herein shall apply.

NOTES TO THE INVESTIGATOR

1. RESPOND IMMEDIATELY: Your presence at the hospital is essential to the satisfactory handling, preservation, and custody of the physical evidence. Review the Medical Examination Report form to familiarize yourself with the type of evidence the medical team will collect. Discuss the examination with the medical team before and after the examination. What you know about the assault could be of benefit to them in adjusting the protocol, and debriefing them after the examination could benefit you in preparing for interviews and crime scene processing. You should receive the evidence specimens and are responsible for handling them as detailed in the Evidence Checklist.

2. ESCORT: Accompany the victim to the examining facility if at all possible and remain there to assist the physician in evidence procedures and to accept custody of the physical evidence. Request that the examining physician carefully check for any physical evidence that might corroborate the victim's account of the alleged assault, i.e., physical force bindings, etc.

3. WAIVERS: Assist the physician in obtaining the identification data, and signatures on the patient and photographic releases on the Medical Examination Report form. Your experience may be especially helpful in explaining the nature of the releases and in overcoming any reluctance to "signing things". If examination is being "ordered", present the order or authority to the examining physician.

4. PHOTOGRAPHS: Do not allow yourself to be forced into the role of the medical photographer for obtaining photographs of trauma in intimate areas. To do so could well jeopardize the essential rapport you will need with the complainant throughout the investigation. You will also subject yourself to possible future embarrassment or unwarranted criticism. If the examining facility does not have a medical photographer on duty, take your investigative photography kit with you. A few minutes of instruction on its use to the doctor or nurse should allow them to produce quite acceptable results. If possible, use color negative film rather than slide film.

5. PHYSICAL EXAMINATION: Absent yourself from the immediate examination area during the examination, but remain in the vicinity to answer any questions that the medical team may ask. It is best to remain outside the examination room, rather than merely on the other side of a curtain, as it is likely that the medical personnel will engage you in conversation through the curtain. The victim will then associate your presence with an embarrassing experience, to the detriment of future rapport. Of course, once the examination is completed, you must be present to assist in processing the evidence, but this should be done out of the presence of the victim.

6. EVIDENCE: You must be present at the examining facility to advise the medical team on chain of custody procedures, and to receipt for the items from the examining physician. You must ensure that all items are handled in accordance with the

instructions on the Evidence Checklist. Be especially careful to see that items which require air drying are kept separate to prevent cross-contamination, and that they are not sealed until completely dry (active air drying recommended). Special items of concern are as follows:

a. Hairs/Fibers: Make sure that any material that may have fallen on the examining table is not overlooked.

b. Sperm Motility Slides: The doctor must examine these slides microscopically immediately, since the purpose is to detect movement of spermatozoa. Be sure they are labeled with the examination results (e.g. "motile sperm observed 1425, 25 Mar 86"), the examiner's initials and the victim's name. Assure that the slides are sent to the forensic laboratory even if they are determined to be negative for spermatozoa. Because of the relatively low potential for identifying motile sperm in anal and oral specimens, slides from these sites are not required. The forensic laboratory will examine swabbings for non-motile sperm.

c. Swab Tubes: These are the plastic tubes with red tops and attached swabs. They should be obtained from the physician after they have been properly identified as to origin of contents. The swabs should be actively dried at normal room temperature then refrigerated (If the shipment to the laboratory is delayed beyond 72 hours, the swabs should be frozen after they are dried.

d. Smears: All microscope slides/smears should be properly labeled with the same information as the swab tubes. Seal the slide mailer with tape after inserting the slides.

e. Bacteriology/Virology: Determine from the doctor whether the local medical facility will culture for sexually transmitted disease. If so, assist the physician in assuring that the tube is properly labeled and that proper chain of custody is established and maintained. Although ordinarily regarded as a health related issue, this specimen may have evidentiary value if a suspect denies sexual contact, but is later found to be infected with the same strain of bacteria found in the culture. If this culturing cannot be done locally, request that the specimen be sent to the nearest medical treatment facility providing this service.

f. Serology and Hematology: The physician will collect three tubes of whole blood, one of which should be forwarded to the medical laboratory to test for sexually transmitted disease. The second tube of blood, properly labeled, should be collected for evidence and refrigerated prior to shipment to the crime laboratory. A third tube of blood will be processed under proper chain of custody documents by the hospital laboratory to determine blood alcohol level.

g. Secretor Status: Make sure that the gauze is actively air dried before sealing in the provided envelope. Assure that the control gauze pad is similarly packaged.

h. Fingernail Scrapings: Assist the physician in properly labeling the evidence.

i. Clothing: What items of clothing you will collect for evidence will be dictated by the circumstances of the complaint. Prior planning and assistance to the victim is especially important to allow you custody of the clothing needed, while allowing the victim to comfortably return home. All items of clothing should be receipted from the victim on a chain of custody document. If stains on the clothing are still damp, the clothing should be allowed to thoroughly air dry before being sealed in a paper bag. All bags should be securely sealed and transferred in sealed containers to prevent cross-contamination or the loss of trace evidence.

j. Tampons/Sanitary Napkins: A zip-lock plastic bag is provided for temporarily securing a tampon or sanitary napkin if the victim is wearing one. The item should be sealed inside the bag by the medical team to prevent contamination, and the bag properly labeled. When the examination is completed, you should remove this item and thoroughly air dry both it and the interior of the bag. Then it should be preserved by sealing both it and the ziplock bag used to transport it in a paper envelope, with a label attached containing your initials and the time and date you sealed the envelope. The item should NOT be placed back inside the ziplock bag. It and the bag should be placed separately into the envelope.

7. Medical Examination Report: Review the report to ensure that all questions are answered and all blanks filled in. For all "no" responses on the protocol, determine why the procedure was not completed and place appropriate comments in the margin of the protocol. The doctor will retain one copy of the report while you retain the original, and one copy should be forwarded to the crime laboratory along with the evidence.

8. CHAIN-OF-CUSTODY DOCUMENTS: Every tube, vial, envelope, bag, and sealed microscope slide holder etc. should have a properly completed evidence document. The investigator is responsible for providing the examining team with the appropriate documents and assisting the team in filling out the documents.

9. SHIPMENT: All evidence to be processed by the crime laboratory which is collected during the examination should be forwarded by the most expeditious secure means as soon after collection as possible. It is neither necessary nor desirable to wait until evidence from a suspect is available for comparison. If evidence from a suspect is shipped in the same container as evidence from the victim, extreme care must be taken to ensure that no possibility of cross-contamination will occur.

NOTE: The requirements to refrigerate swab and blood specimens apply only to the time they are stored in the evidence repository prior to shipment to the crime laboratory. They need no special attention for mailing by registered air mail special delivery than proper packing.

10. CAUTION: To avoid cross contamination, never, under any circumstances allow a suspect to occupy an area once occupied by the victim (or vice versa) until all physical evidence has been collected from both the suspect and victim. This includes vehicles, waiting rooms, interview rooms,etc. Keep unsealed laboratory specimens and clothing in completely separate areas until the items have been completely air dried and securely sealed in their containers.

11. INITIAL INTERVIEWS: The first detailed statement will probably be taken shortly after the medical examination, when the victim is still suffering from the impact phase of the rape trauma syndrome. During this interview, she may be reluctant to provide extremely intimate or humiliating details. While the statement should be as complete as possible, some of these details may have to be obtained during later interviews. Don't risk forcing the victim to lie by pressuring her at this point for details that she may be too upset to relate. Inform her that if there are details she can't bear to talk about, it can be discussed later, when she is less upset. She should also be frankly (though sensitively) informed, however, that if she is untruthful about even the smallest detail, it will cast doubt upon her entire report. The following factors should be explored in depth during the initial interview, and thoroughly documented in the victim's statement:

a. The identity of the assailant(s) (if known to the victim)

and a complete description of each. Often, better descriptions can be obtained by asking whether an individual reminded the victim of anyone she knows, or has seen on TV. If so, what features were similar, what were different, etc.? Was anything unusual about the assailant's appearance or clothing?

b. The time, date, and location of the assault.

c. How the victim arrived at the scene. Was she kidnapped, or did she voluntarily accompany the assailant(s)? Obtain a complete description of any vehicle involved.

d. The kind of assault (vaginal, oral, and/or anal).

e. The nature of any threats or injuries made by the assailant(s). Particular attention should be paid to detailing the exact words used by the assailant(s) and in the method used to entice or entrap the victim. This information may prove invaluable in establishing a psychological profile of the assailant(s) which can facilitate identification. Did the assailant's voice remind the victim of anyone? Did he sound educated? Have an accent? Did victim injure the assailant in any way?

f. If weapons were displayed or used, obtain a full description.

g. If any bindings or restraints were used, obtain full details, and examine the victim for visible marks to corroborate her description.

h. If the assailant(s) took anything, obtain a full description.

i. Obtain details of what the assailant(s) did after the assault.

j. Find out if the victim drank any alcoholic beverages, or took any medications or other drugs after the assault.

k. Find out if the victim has ever reported a sexual assault before, or has been sexually assaulted before. If she has, obtain the details.

12. FOLLOWUP INTERVIEWS: At least one additional interview should be conducted with the victim two to three weeks after the assault. During this and any subsequent interviews, the investigator should be alert for symptoms of post-traumatic stress disorder such as recurrent intrusive recollections of the assault, recurrent frightening dreams about (or symbolizing) the attack, sleeplessness or sleep disturbance, sudden "flashbacks" to the assault, numbing of responsiveness to the outside world, feelings of detachment or estrangement from others, guilt about submissive behavior, nausea when recalling the incident, and a need for greater security by moving, obtaining an unlisted number, etc. Such symptoms may help substantiate lack of consent during the assault.

13. SUSPECT INTERVIEWS: If a suspect initially denies any sexual contact with the victim, document his denial in a signed, sworn statement. Then if he changes his story to admit sexual contact but denies force, documentary evidence exists to show that he initially lied. Otherwise, when the case is tried, the testimony may just appear to be "his word against hers."

APPENDIX B

NOTES TO THE PHYSICIAN

10. SCOPE

10.1 SCOPE. This appendix details the requirements for preparing the "Notes to the Physician" service data required in 3.2.2. This appendix is a mandatory part of this specification. The requirements contained herein is intended for compliance.

20. APPLICABLE DOCUMENTS

This section is not applicable to this appendix.

30. REQUIREMENTS

30.1 Format. Shall be printed on one side of an 8-1/2 X 11 inch size sheet of paper.

30.2 Content. The service data contained herein shall apply.

NOTES TO PHYSICIAN

In cases of alleged sexual assault, along with medical care and psychological counselling, proper collection of medicolegal evidence is a professional, legal, and ethical responsibility. Attached is a Medical Examination Report from for use in connection with such cases. The protocol is oriented towards the examination of an alleged rape victim, but it can easily be adjusted to accommodate examination of victims or suspects in any type of alleged sexual assault, providing one keeps in mind the medicolegal purpose of the examination is to collect evidence to support or refute the allegation. (Were the victim and suspect in contact as alleged?)

1. Authorizations. Included on the cover sheet of the form are all necessary consent forms for the required procedures. If the examination is to be conducted without the consent of the individual, the investigator should provide you with an "order" or "authorization" from a competent authority.

2. Talk with the investigator before proceeding with the medicolegal examination. What he knows about the circumstances of the reported assault can be helpful in determining if adjustments to the protocol are indicated. (After the examination the investigator will assist you with the establishment of the chain of custody. He will also interview you with regard to "no" responses in the examination report and any variances in procedures.)

3. History. An accurate history is essential for proper interpretation of collected evidence.

4. Photography. Photographs are especially important for transient marks on the body such as ligature marks, bruises, abrasions, bite marks, lacerations, incised wounds, etc. Photographs should be taken by a hospital staff photographer, base photographer, or a member of the medical staff using equipment supplied by the investigator.

5. Examination and Collection of Laboratory Specimens. The earliest possible examination is emphasized to minimize deterioration of evidence. Throughout the course of the examination, attention should be directed to the collection of dried stains, loose fibers and other foreign matter on the patient. The sequence of examination and collection of laboratory specimens is recommended in order to prevent inadvertent transfer and/or loss of material. Finally, ensure that each block on the printed labels is complete. (Failure to properly mark specimens could render them inadmissable in legal proceedings.)

WHETHER OR NOT RAPE OR ANY OTHER SEXUAL ASSAULT OCCURRED IS A LEGAL ISSUE, NOT A MEDICAL DIAGNOSIS. USE ONLY TERMS SUCH AS "ALLEGED RAPE" OR "REPORTED SEXUAL ASSAULT" IN YOUR RECORD ANNOTATIONS.

APPENDIX C

EVIDENCE CHECK LIST

10. SCOPE

10.1 Scope. This appendix details the requirements for preparing the "Evidence Check List" service data required in 3.2.3. This appendix is a mandatory part of this specification. The requirements contained herein is intended for compliance.

20. APPLICABLE DOCUMENTS

This section is not applicable to this appendix.

30. REQUIREMENTS

30.1 Format. Shall be printed on one side of an 8-1/2 X 11 inch size sheet of paper.

30.2 Content. The service data contained herein shall apply.

EVIDENCE CHECKLIST

TO HOSPITAL LABORATORY

1. Urine for
   (a) Toxicology
   (b) Analysis if bladder traumatized
   (c) Pregnancy test if indicated
2. Blood for blood alcohol determination
3. Blood for control STS
4. Bacteriological and viral culture (Gonorrhea and Herpes)
   (a) Vaginal
   (b) Oral
   (c) Rectal

NOTE: Examining physician should look at slides prepared from the vaginal vault and cervix for sperm motility. See physical examination.

TO FORENSIC LABORATORY

1. Clothing and paper sheets
2. Head hair combings, w/comb
3. Head hair standards
4. Oral swabs
5. Saliva sample and control gauge
6. Fingernail scrapings
7. Blood sample for typing
8. Public hair combings
9. Public hair standards
10. Sperm motility slide after examination by physician
11. Vaginal swabs and slide (smears)
12. Cervical swabs and slide (smears)
13. Rectal swabs
14. Bitemark swabs (if indicated)
15. Other stains/debris
16. Other hair/standards and combings such as beard, auxiliary, etc, as history indicate
17. Fingernail clippings, if indicated
18. Vaginal aspirate

APPENDIX D

EVIDENCE HANDLING NOTES.

10. SCOPE

10.1 Scope. This appendix details the requirements for preparing the "Evidence Handling Notes" service data required in 3.2.4. This appendix is a mandatory part of this specification. The requirements contained herein is intended for compliance.

20. APPLICABLE DOCUMENTS

This section is not applicable to this appendix.

30. REQUIREMENTS

30.1 Format. Shall be printed on one side of an 8-1/2 X 11 inch size sheet of paper.

30.2 Content. The service data contained herein shall apply.

EVIDENCE HANDLING NOTES

SAMPLE	HANDLING PROCEDURE
Clothing and paper sheets	Actively air dry damp items Keep each item in separate paper bag. NEVER USE PLASTIC BAGS
Head hair combings w/comb	
Head hair standards	
Saliva sample	Actively air dry; place in a
Saliva control (gauze)	coin envelope; refrigerate
Fingernail scrapings	
Blood samples	Refrigerate
Pubic hair combings w/comb	
Pubic hair standard	
Vaginal swabs	Actively air dry, replace in tube, refrigerate
Cervical swabs	Actively air dry, replace in tube, refrigerate
Vaginal smear/slide	Actively air dry
Cervical smear/slide	Actively air dry
Vaginal pool (aspirate)	Refrigerate
Rectal swab	Actively air dry, replace in tube, refrigerate
Oral swab	Actively air dry, replace in tube, refrigerate
Bitemark swabs (if indicated)	Actively air dry, replace in tube, refrigerate
Other stain/debris	As indicated by nature of the Specimens
Other hair standards and combings as the history may indicate	
Fingernail clippings as indicated	

a. Labeling: A sufficient quantity of evidence labels is included in each kit to label each specimen container separately, as well as for use on bags for clothing, etc. The labels are designed so that the victim's identification data can be quickly imprinted on each by running them through an addressograph using the victim's medical treatment card. If this card isn't in the victim's possession or in her medical records, one should be made immediately by the medical facility's AOD. Otherwise, the victim's ID data will have to be handprinted on each label. Ensure that each specimen container is properly labeled, and all labels are properly filled out prior to receipting for them as evidence.

b. Active air drying: Be especially careful to see that items which require air drying are kept separate to prevent cross-contamination, and that they are not sealed until completely dry. The best procedure for air drying specimens is to place them in a closed dust-free area through which air is circulated at room temperature. Air on the specimens should be kept moving, but they should not be subjected to direct drafts, as in being placed in front of a fan. Do not use heated air from a hair dryer, hot air vent, etc. If shipment to the laboratory is to be delayed beyond 72 hours, swabs should be frozen.

APPENDIX E

MEDICAL EXAMINATION REPORT

10. SCOPE

10.1 Scope. This appendix details the requirements for preparing the "Medical Examination Report" service data required in 3.2.5. This appendix is a mandatory part of this specification. The requirements contained herein is intended for compliance.

20 APPLICABLE DOCUMENTS

This section is not applicable to this appendix.

30. REQUIREMENTS

30.1 Format. Shall be printed on one side only in three part copy of NCR paper. The pages shall be in a packet form, which includes a cover that can be placed between each three part segment. Each three part segment shall be detachable from the packet (e.g. perforations or score lines). The detached pages shall be 8-1/2 X 11 inches in size.

30.2 Content. The service data contained herein shall apply.

MEDICAL EXAMINATION REPORT

For Reported Sexual Assault

NAME AND LOCATION OF
EXAMINING FACILITY: _____

DATE OF ADMISSION: _____ TIME: _____

HOSPITAL ID NUMBER/SSAN: _____

NAME OF PATIENT: _____

DATE OF BIRTH: _____ PLACE OF BIRTH: _____

ADDRESS: _____

BROUGHT IN BY: _____

AGENCY OR RELATIONSHIP OF ESCORT: _____

INVESTIGATOR(S) PRESENT: _____

OTHERS PRESENT: _____

PATIENT RELEASE STATEMENT

I, _____hereby request and authorize the staff of (name of examining facility) _____ to conduct such medicolegal examinations and clinical procedures, including the collection and examinations of specimens as are necessary for diagnosis, and treatment, as well as investigation. Furthermore, I hereby authorize and request the medical staff to supply all items of evidence and copies of medical and laboratory reports to the appropriate investigative agency for use in the investigation and any resulting legal proceedings.

_____
Person Examined

_____
Parent or Guardian (if patient is a minor dependent)

DATE: _____

WITNESS: _____

PHOTOGRAPHIC RELEASE

I, _____ hereby request and authorize the staff of (examining facility)_____ to take and reproduce photographs of evidence relating to the assault which occurred (date and time) _____ . I authorize the criminal investigative agency to assume and maintain custody of these photographs. The release of these photographs is conditioned upon them being viewed only by those persons officially involved in the investigation or legal proceedings which may be initiated as a result of this assault.

_____
Person Photographed

_____
Parent or Guardian (if patient is a minor)

DATE: _____

WITNESS: _____

PATIENT'S NAME: _____

HISTORY

1. Summary of patient's description of assault: _____

_____

_____

2. Age: _____ 3. Gravidity: _____ 4. Parity: _____

5. List prior admissions to hospital:_____

_____

6. When did last period begin? _____ Normal? Yes _____ No
When did period end? _____

7. When did last pregnancy end? _____

8. How did last pregnancy end? _____

9. Most recent coitus prior to alleged assault: Date: _____
Time: _____ Where did activity take place? _____
Condom Used? ( ) Yes ( ) No

10. Current mode of contraception used by patient, if any: _____

11. Vaginal tampons used? ( ) Yes ( ) No Age begun?

a. Used at time of assault? ( ) Yes ( ) No
(advise investigator)

b. Used subsequent to assault? ( ) Yes ( ) No

c. Other sanitary devices used: ( ) Yes ( ) No

d. Collect sanitary device if present.

12. Douching practiced? ( ) Yes ( ) No Most recent: _____

13. During reported assault:

Did penis penetrate vulva? ( ) Yes ( ) No Don't know
Assailant experience orgasm? ( ) Yes ( ) No Don't know
If so, where?
Did assailant wear a condom? ( ) Yes ( ) No Don't know

Did assailant attempt/consumate:

( ) fellatio ( ) anal intercourse ( ) cunnilingus
( ) not applicable

14. Since reported assault has patient:

Douched	( ) Yes	( ) No
Bathed or showered	( ) Yes	( ) No
Defecated	( ) Yes	( ) No
Urinated	( ) Yes	( ) No
Brushed teeth/gargled, etc.	( ) Yes	( ) No

15. Has patient knowledge of:

Any present medical problems	( ) Yes	( ) No
Any current medications	( ) Yes	( ) No
Any allergy (penicillin or other)	( ) Yes	( ) No

16. In 24 hours immediately prior to the exam, did patient use alcohol or other drugs? If so, type of drug, as well as time and amount of ingestion. ( ) Yes ( ) No

PHYSICAL EXAMINATION AND COLLECTION OF LABORATORY SPECIMENS

The examination outline has been designed to facilitate evidence collection by minimizing the potential for cross contamination of anatomical sites and loss of trace evidence, while at the same time providing a tool to access medical and psychological needs of the patient. Variations should be well considered. The investigator will ask for an explanation of "no" responses.

Indicate if procedure was done

1. Blood Pressure:_____( ) Yes ( ) No
   Pulse:_____( ) Yes ( ) No
   Respiration:_____( ) Yes ( ) No
   Temperature:_____( ) Yes ( ) No

2. Mental Status (describe):_____( ) Yes ( ) No

_____

_____

_____

3. General appearance of patient and clothing (Describe, then photograph using color negative film:

_____

_____

_____

4. Collection of Clothing: Was this worn at time of assault? If no advise Investigator. ( ) Yes ( ) No

   a. Have patient disrobe while standing on the large paper sheet.

   b. Place each clothing item in a separate paper bag. Don't use plastic, clothing will mold.

   c. Fold paper sheet; tape it shut and place it in a paper bag.

   d. Label each bag.

5. Body Surface Examination: Locate, describe and photograph (with and without a scale) any evidence of injury or adherent foreign matter. (Examine with the aid of a Wood's lamp (UV light) as well as normal room lighting.) ( ) Yes ( ) No

a. Annotate any such evidence on body diagram chart (attached).

b. Bite Marks: If found or suspected, ( ) Yes ( ) No seek the assistance of a dentist and discuss documentation requirements with the investigator.

(1) Photograph with and without scale.

(2) Swab area inside dental arch marks with a swab moistened with 2-3 drops of sterile water.

(3) Prepare a control swab by swabbing the area adjacent to the bitten area with a swab moistened in sterile water.

(4) Place swabs in separate tube and label.

(5) Ensure that castings are made of any impressions.

c. Blood or Semen Stains: ( ) Yes ( ) No
Collect suspected stains as follows: (Semen will fluoresce under UV light.)

(1) On skin, if stained area is caked, scrape the dried material with edge of slide into a coin envelope or use a sterile water moistened swab. If swabbed, place swab in tube. Label container.

(2) Prepare control swab by swabbing area adjacent to the stained area with 2-3 drops of sterile water. Place swab in a tube and label.

(3) In hair, clip the entire area of stain and place in a coin envelope after air drying. Label envelope.

d. Other Stains or Debris: Depending on ( ) Yes ( ) No the matter involved, pick with tweezers, scrape, or swab as necessary to remove. (If solvent must be used try water, alcohol, or acetone in that order, providing control samples of whatever is used.

(1) Place in appropriate containers, see methods for similar specimens.

(2) Label containers.

6. Head Examination and Specimen Collection:

a. Head hair combings: ( ) Yes ( ) No

(1) Place a small paper sheet under the patient's head.

(2) Comb the head to collect all possible debris and foreign hairs.

(3) Place the comb, retrieved hair and any collected debris on the sheet.

(4) Fold up the sheet, tape (seal) it shut and place it in a paper bag.

(5) Label envelope.

b. Oral Specimens:

(1) Oral Swab: ( ) Yes ( ) No

(a) Swab gum areas and in between cheek and gum.

(b) Place swab in tube and label.

(2) Culture for gonorrhea ( ) Yes ( ) No
Herpes ( ) Yes ( ) No

(3) Secretor Status: ( ) Yes ( ) No

(a) Ensure patient has not eaten any thing for at least 30 minutes. Have patient rinse mouth with water - wait 5 minutes.

(b) Have patient thoroughly moisten (without chewing) with saliva, half of a sterile gauze pad. (Pad should be handled with tweezers only).

(c) Place 2nd (unused portion of) gauzed pad in a coin envelope marked "Control".

(d) Have patient place moistened portion of gauze pad in a ziplock bag provided for "saliva specimen."

7. Pelvic Examination and Specimen Collection: If reasonable, avoid having patient urinate at this point. Collect urine specimens after the pelvic exam. (See 12 below.) If collection of urine specimens cannot be avoided at this time, follow item 12 instructions.

NOTE: All specimens should be collected before disturbing and manipulating anatomical sites. Speculum should be lubricated with water only.

a. Pubic Hair Combings: ( ) Yes ( ) No

(1) Place a small paper sheet under the buttocks.

(2) Comb the pubic area to collect all possible debris and foreign hairs.

(3) Place comb, retrieved hair and any collected debris on the paper sheet.

(4) Fold up sheet, tape (seal) it shut, and place it in a paper bag.

(5) Label bag.

b. Documentation: Describe and document as appropriate findings in the following areas. (Use photographs and attached anatomical chart to facilitate documentation.)

VULVA:_____

INTROITUS:_____

VAGINA:_____

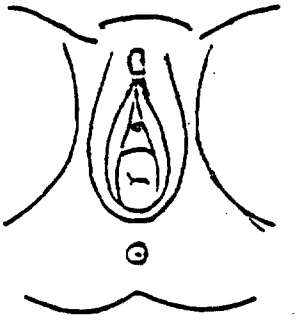
CERVIX:_____

UTERUS:_____

ADNEXA:_____

HYMEN:_____

RECTUM:_____



c. Sperm Motility: ( ) Yes ( ) No

(1) Avoiding cervix, swab vaginal canal.

(2) Prepare a slide using one drop of normal saline and moisture on a vaginal swab.

(3) Examine slide microscopically for presence of sperm.
( )Motile ( )Non-Motile ( ) None Observed

(4) Air Dry

(5) Mark slide with identifying data and place in mailer marked "Vaginal Slides".

d. Vaginal/Swab: ( ) Yes ( ) No

(1) Avoiding cervix, swab vaginal canal.

(2) Place swab in tube and label.

e. Cervical Specimens: Repeat steps 7c, 7d, using swabs from cervix. ( )Yes ( )No

f. Culture for gonorrhea: ( ) Yes ( ) No
Herpes ( ) Yes ( ) No

g. Vaginal Aspirate: ( ) Yes ( ) No

(1) Preferably, aspirate without saline. If saline is necessary, use 1-2ml.

(2) Prepare a slide using a drop of vaginal aspirate.

(3) Place remaining aspirate in tube.

(4) Examine slide microscopically for presence of sperm.
( ) motile ( ) non-motile ( ) none observed

(5) Air Dry

(6) Seal and label tube.

(7) Label slide and place in mailer.

h. Rectal/Swab: ( ) Yes ( ) No

(1) Swab rectum. (Avoid perianal area)

(2) Place swab in tube and label.

i. Culture rectum for gonorrhea. ( ) Yes ( ) No
Herpes ( ) Yes ( ) No

8. Hair standards (pubic, head and other as indicated by history): As a minimum plucked specimens should be obtained from the head and pubic areas.

a. Pubic hair standards: ( ) Yes ( ) No

(1) Pluck a representative sample of pubic hair. (Usually a total of 20 individual hairs from various places in the pubic area is sufficient.)

(2) Place in coin envelope and seal.

(3) Label envelope

b. Head hair standards: ( ) Yes ( ) No

(1) Pluck a representative sample in terms of color, length, and texture of her hair. (Usually about 20 individual hairs selected from various areas of the head will be sufficient.)

9. Fingernails

a. Scrapings:

(1) Place 3" piece of cellophane type tape, adhesive upwards, on a "zip-lock" plastic bag. Using a broken applicator stick or patient scrape the underside of all nails on one hand, depositing scraping on the tape.

(2) Stick tape to the bag.

(3) Place scraper in the bag.

(4) Label the bag to include "R" or "L" hand as appropriate.

(5) Repeat the procedure using clean scrapers for the other hand.

b. Clippings/Cuttings:

(1) If freshly broken nails are noted, attempt to cut (clip) the broken part off, preserving the broken edge.

(2) Place specimen(s) in a paper coin envelope.

10. Serology and Hematology: (three (3) vacutainers (7ml) of blood)

DO NOT USE ALCOHOL AS A PREP

a. Typing: Red top tube to Forensic Lab ( )Yes ( )No

b. Control STS & HIV ( )Yes ( )No
Red top tube

c. Blood Alcohol: Tube type per hospital ( )Yes ( )No
(Initiate chain of custody on
DD Form 1323)

11. Urinalysis and Toxicology: (two (2) urine specimens)

a. Toxicology: Urine drug screen to include THC. (Initiate chain of custody on DD Form 1323). ( )Yes ( )No

b. Urinalysis:

(1) Examine urine for hematuria ( )Yes ( )No

(2) Pregnancy ( )Yes ( )No

12. Medical Impressions

13. Treatment and Follow Up:

a. Treatment of Injury ( ) None

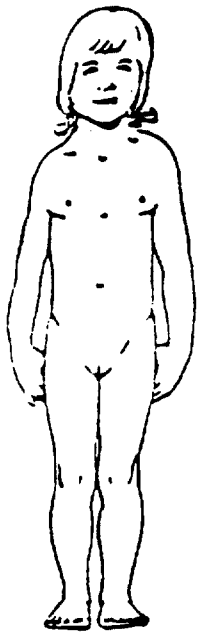
b. Management of STD Risk ( ) None

c. Management of Pregnancy Risk ( ) None

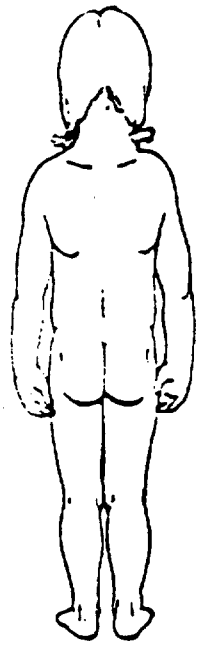
d. Psychological Support ( ) None

e. Medical/Investigative follow up: Request patient return to OB/GYN clinic 36-48 hours later. (Bruises may take that long to develop). ( ) Yes ( ) No

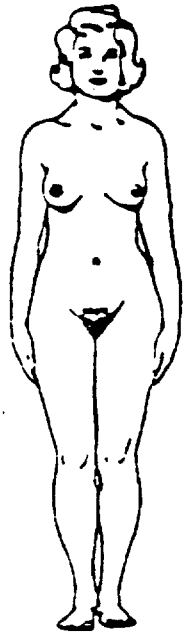
f. Other ( ) Yes ( ) No



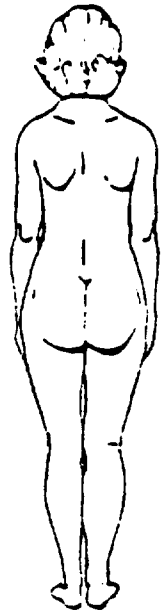
JUVENILE FEMALE (FRONT VIEW)



JUVENILE FEMALE (REAR VIEW)



ADULT FEMALE (FRONT VIEW)

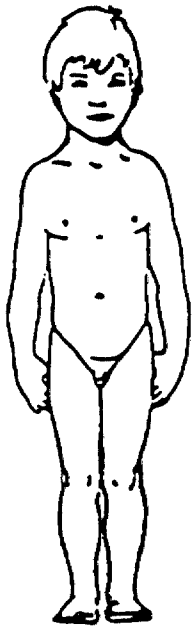


ADULT FEMALE (BACK VIEW)

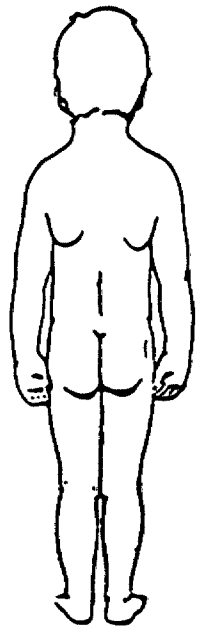
FIGURE 1 BODY DIAGRAM CHART (FEMALE)

THESE FIGURES SHOULD BE TREATED IN THE SAME MANNER AS IN THE FEMALE SEXUAL ASSAULT PROTOCOL.

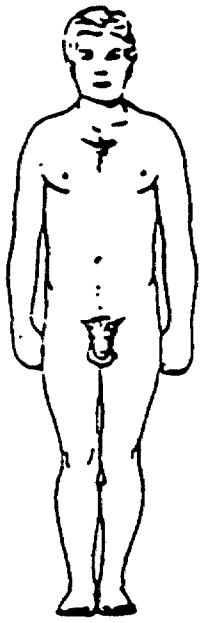
NOTE ANY TRAUMA ON MALE VICTIMS IN THE FOLLOWING DIAGRAMS.



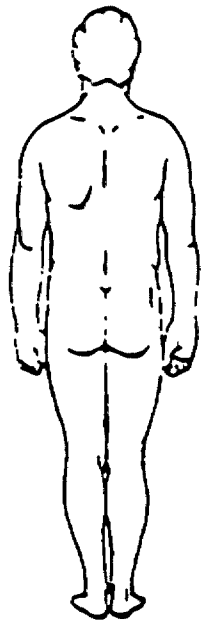
JUVENILE MALE (FRONT VIEW)



JUVENILE MALE (BACK VIEW)



ADULT MALE (FRONT VIEW)



ADULT MALE (BACK VIEW)

FIGURE 2 BODY DIAGRAM CHART (MALE)

APPENDIX F

UNIT PACKAGE MARKINGS

10. SCOPE

10.1 Scope. This appendix details the requirements for the service data required in 3.3 for the crushproof box. This appendix is a mandatory part of this specification. The requirement contained herein is intended for compliance.

20. APPLICABLE DOCUMENTS

This section is not applicable to this appendix.

30. REQUIREMENTS

30.1 Format. Shall be printed in bold print on the outside of the crushproof box. Marking secured by adhesive shall be acceptable.

30.2 Content. The service data contained herein shall apply.

SEXUAL ASSAULT EVIDENCE KIT

PLEASE READ THESE INSTRUCTIONS:

A. This kit contains instructions, report forms and specimen containers for the treatment and the orderly medicolegal examinations of victims of sexual assault and can be used to support medicolegal examinations of suspects.

B. Keep kit available at the initial points of reception of victims in your medical facility.

C. The kit may be opened, and the first page of the Medical Examination Report prepared by any responsible medical personnel. The enclosed consent forms are the only ones required.

TO THE TREATING PHYSICIAN:

D. The Medical Examination Report is also a flow sheet which will guide you through the procedure, even if you are not practiced in the medicolegal investigation. It will reinforce the accomplishment of the five objectives of your attention to your patient:

1. Treatment of physical injury
2. Protection against sexually transmitted diseases
3. Protection against pregnancy
4. Organization of psychological support
5. Collection of evidence for possible legal action

E. Equipment is complete except for a vaginal speculum, three red-topped tubes, culture mediums, and paper bags (3).

INDEX

APPENDIX A (NOTES TO THE INVESTIGATOR)

10 SCOPE

10.1 Scope

20 APPLICABLE DOCUMENTS

30 REQUIREMENTS

30.1 Format

30.2 Content

APPENDIX B (NOTES TO THE PHYSICIAN)

10 SCOPE

10.1 Scope

20 APPLICABLE DOCUMENTS

30 REQUIREMENTS

30.1 Format

30.2 Content

APPENDIX C (EVIDENCE CHECK LIST)

10 SCOPE

10.1 Scope

20 APPLICABLE DOCUMENTS

30 REQUIREMENTS

30.1 Format

30.2 Content

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STANDARDIZATION DOCUMENT IMPROVEMENT PROPOSAL

(See Instructions – Reverse Side)

1. DOCUMENT NUMBER	2. DOCUMENT TITLE

3a. NAME OF SUBMITTING ORGANIZATION	4. TYPE OF ORGANIZATION *(Mark one)*
	☐ VENDOR ☐ USER ☐ MANUFACTURER ☐ OTHER *(Specify)*: _____
b. ADDRESS *(Street, City, State, ZIP Code)*	

5. PROBLEM AREAS

a. Paragraph Number and Wording:

b. Recommended Wording:

c. Reason/Rationale for Recommendation:

6. REMARKS

7a. NAME OF SUBMITTER *(Last, First, MI)* – Optional	b. WORK TELEPHONE NUMBER *(Include Area Code)* – Optional
c. MAILING ADDRESS *(Street, City, State, ZIP Code)* – Optional	8. DATE OF SUBMISSION *(YYMMDD)*

DD FORM 82 MAR 1426

PREVIOUS EDITION IS OBSOLETE.

(TO DETACH THIS FORM, CUT ALONG THIS LINE.)