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Alleged Non-consensual Sexual Contact	ACA Standards: 4-4359M, 4-4367M, 4-4351, 4-4406		
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Management of Alleged Non-consensual Sexual Contact

This guideline is intended to provide clinical guidelines for the management of an alleged incident of non-consensual sexual contact.

I. Actions

- A. When an offender reports to medical staff that she/he has been a victim of non-consensual sexual contact, the facility head or his/her designee will be informed immediately. Incidentally, staff may notice certain indicators of sexual assault/rape in addition, e.g., depressed mood/reluctance of offender to stay in general population, injuries around the perineum, anal and vulvo-vaginal area, oral lacerations, oral herpetic lesions etc. In such cases, staff should interview the offender and, if suspicion is confirmed, notify the facility head or his/her designee. The investigative and/or security aspect of the incident will be the responsibility of the facility head or his/her designee.

- B. The facility medical provider or Qualified Health Care Professional (QHCP) will conduct a complaint focused history:
 1. Date and time of last contact (Forensic evidence may be obtained for up to 120 hours after last contact).
 2. Location
 3. Name/s of perpetrator/s if known.
 4. Mode of contact, non-consensual skin-to-skin sexual contact of any area of body; penetration of mouth, vagina, rectum. Penetration by tongue, penis, finger, other body part, or instrument. Other skin-to-skin non-consensual sexual contact.
 5. Physical and mental symptoms, including reports of any injury, bleeding, strangulation, loss of consciousness or altered level of consciousness. If contact by instrumentation, is there a retained foreign body?

6. Has the victim changed clothing since alleged assault? If the alleged victim has not changed clothes, do not remove clothes. Do prepare to send a change of clothes with alleged victim if sent for forensic examination.
 7. Has the victim been to the bathroom to shower, urinate or defecate? Discourage further urination.
- C. Is there reported or observable evidence of physical injury? Observation of injuries will be by the least invasive manner which is appropriate for the safety of the alleged victim. Injuries which require urgent care will be addressed by the facility provider or QHCP, or will be referred the local emergency department. Patients with significant injuries or history of bleeding, strangulation, retained foreign body, or loss of or altered consciousness must be evaluated by facility medical staff or emergency department staff prior to referral to a SANE Forensic examiner. The SANE Forensic examiner will not treat injuries. The Forensic examiner will offer treatment for Sexually Transmitted Diseases (STD's).

History and physical findings will be documented by Nursing Protocol, "Non-consensual Sexual Contact". Patients will be referred to the facility provider or local emergency department for treatment of significant injuries, with Forensic examination to follow. After hours, if a QHCP or medical provider is not on site at the DOC facility, history and reportable physical findings may be obtained by telephone conversation. The QHCP will notify the Correctional Health Care Administrator, who will notify the Forensic Examiner.

D. The Forensic examiner will likely offer screening and treatment for STD's and for female alleged victims will perform pregnancy screening. The Forensic examiner will make results of the examination, tests, and treatment available to the facility medical unit. Follow-up with the facility medical clinician will occur the next working day. The clinician will assure that all appropriate testing and treatment is accomplished. The Correctional Health Service Administrator will ensure that offender victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate. (PREA 115.83 f)

The victim's and perpetrator's (if known) medical records will be reviewed with attention to any previous HIV, Hepatitis, and STD test results. This review will guide appropriate testing, but in general, the following tests should to be done:

1. HIV (after required counseling) – If the victim is known to be HIV negative or status unknown, do an HIV test (CPL 3540) after pre-test counseling. Even if the perpetrator is known to be recently HIV negative, the victim should still be tested (if status is negative or unknown) because the perpetrator may be in the "window period" of acute HIV infection, pending sero-conversion.

2. Hepatitis B and C – If the victim is known to be not immune, negative for B and C or status unknown, do Hepatitis Panel (CPL 162). This will check for HB core antibody anti-HBc total), HB surface antigen (HbsAg), HB surface antibody (anti-HBs) and HC virus antibody (anti-HCV). The result for Hepatitis C is easy, it is either positive (reactive) or negative. For Hepatitis B the following table, ignoring HBeAg and anti-HBe, will help with the interpretation:

HBsAg	Total anti-HBc	IgM anti-HBc	Anti-HBs	Interpretation
-	-	-	-	Susceptible, never infected
+	-	-	-	Acute infection, early incubation period
+	+	+	-	Acute infection
-	+	+	-	Acute resolving infection
-	+	-	+	Past infection, recovered and immune
+	+	-	-	Chronic infection
-	+	-	-	False positive, past infection or low level chronic infection
-	-	-	+	Vaccinated & immune

3. Gonorrhea – Routine Neisseria Gonorrhea culture can be done from swabbing the rectum, vagina, urethra and the oro-pharynx depending on history. Use the Chlamydia/Gonococcus by DNA Probe method (CPL 275) – See below under Chlamydia for full description.
4. Chlamydia – Specimens should be taken from the urethra and, in females, endocervical canal. Use the Gen-Probe PACE Swab and transport in the Gen-Probe transport kit. The swab and transport kits are provided by CPL. Request Chlamydia/Gonococcus by DNA Probe method (CPL 275).

Urethral Specimen – The offender should not have urinated for 1hr prior to collection. Remove pus or exudate. Insert a small swab with a wire shaft 2 – 4 cm into the penis, gently rotating the swab to dislodge cells, and withdraw the swab. Place swab in transport container, snap off and seal tube with screw cap. Label the tube with offender's name and DOC#.

Endocervical Specimen – Use one swab to remove exudate or mucus from the endocervix and discard the swab. Insert 2nd swab until its tip is no longer visible, rotate the swab for 5-10 seconds and withdraw it without touching the vaginal walls. Place only the 2nd swab in the transport, making sure the cap is secure and will not leak.

5. Syphilis – Do a serum Rapid Plasma Reagin qualitative test (CPL 3503) to screen for syphilis. If reactive, then a titer and Treponema Pallidum Antibodies by indirect fluorescent antibody will be automatically done by CPL.

If there is evidence of severe injury, if the patient victim is uncooperative, if the facility provider or QHCP is not available, or if there is indication for forensic examination; then the victim may be sent to the ER or when appropriate to the nearest sexual assault assessment site (SANE) for evaluation. Victim testing as described above may be accomplished by ER or SANE evaluation and the results released to the sending facility. The perpetrator, if known, should be tested at the correctional facility as soon as possible (4-4406).

Upon return of the victim to the facility, medical will ascertain what tests were done at the ER or by SANE facility and copies of the tests obtained and filed in the medical record. If any of the above tests were not done at the ER or by SANE, the facility medical provider will order those tests.

- E. Education and Post-Exposure Prophylaxis will be offered based on the previously known test results or status of the perpetrator/s and the victim. It is not necessary to await current tests results before offering prophylaxis for the following, especially in the case of Hepatitis B and HIV.

1. HIV: If the perpetrator or victim is HIV positive or HIV status is unknown, offer preventive therapy for 30 days, using the PEP pack medications Raltegravir (Isentress) 400mg PO twice daily plus Truvada 1 PO once daily. Baseline CBC and CMP should be done before commencing therapy. If the perpetrator or victim HIV test result/s is/are negative subsequently, discontinue the prophylaxis. Refer to MSRM 140125-02 (Bloodborne Pathogen Exposure Management).
2. Hepatitis B: Refer to the above Hepatitis B test results table. Generally the following will apply:
 - a. If the perpetrator or victim is infected (HBsAg positive, Total anti-HBc positive, or IgM anti-HBc positive) and the victim or perpetrator is not immune (anti-HBs negative), start Hepatitis B Immune Globulin (HBIG) 0.06 ml/kg IM (repeat in 1 month) and vaccine 1ml IM (repeat in 1 month and 6 months) as soon as possible.

- b. If the victim is immune (anti-HBs positive) no treatment is indicated.
 - c. If the perpetrator is unknown and the victim is not immune (anti-HBs negative), offer treatment as described in "a." above.
 3. Hepatitis C: No treatment, as there are no preventive measures.
 4. Gonorrhea: Offer treatment with Ceftriaxone (Rocephin) 125mg IM as a single dose.
 5. Chlamydia: Offer treatment with Doxycycline 100mg PO bid for 7 days or Zithromax 1gm PO as a single dose.
 6. Syphilis: Treat with a single dose of 2.4 million units of benzathine penicillin (bicillin) IM. If there is a history of penicillin allergy, use doxycycline 100mg bid for two weeks. Doxycycline is contraindicated in pregnancy, however.
- F. If the perpetrator is not known, the victim will be offered prophylactic treatment for all diseases listed above pending tests results, except that if the victim is known to be Hepatitis B immune, when no treatment is indicated.
- G. Pregnancy testing will be provided for all female victims alleging rape/sexual assault by male perpetrator. (PREA 115.83 d)
- H. The above lab tests will need to be repeated in 6 weeks, 3 months and 6 months. In view of possible delay in HIV sero-conversion, consider repeating the test also in 12 months.
- I. If pregnancy results from conduct described in (g), the Correctional Health Services Administrator will ensure the offender receives timely and comprehensive information about the timely access to lawful pregnancy-related medical services. (PREA 115.83 e)

II. References

OP-140118 entitled, "Emergency Care"

OP-140106 entitled, "Medical Record System"

Morbidity and Mortality Weekly Review (8/4/2006 and 4/13/2007). Sexually Transmitted Diseases Treatment Guidelines. Retrieved 12/8/2010: www.cdc.gov/mmwr.

III. Action

The chief medical officer, Medical Services will be responsible for compliance with this procedure.

Any exceptions to this procedure will require prior written approval from the director.

This procedure will be effective as indicated.

Replaced: Medical Services Resource Manual 140118-01 entitled, "Management of Alleged Rape/Sexual Assault" dated October 25, 2013.

Distribution: Medical Services Resource Manual