Idaho Sexual Assault Response Guidelines

June 2026
Revision 4

Revision History

Revision #	Description of Changes
1	Original issue 01/21/2019
2	Eliminated testing waiver, revised Medical Exam Checklist, added option counseling, revised "VICTIM WITNESS COORDINATOR" definition, other updates per new legislation.
3	Updated contact information, updated references, included mandatory LE reporting for children, updated SAK components with new kits, updated collection instructions to new kit components, updated IKTS responsibilities of medical and LE facilities.
4	Updated Resource List, PREA contacts, added Idaho Statute Title 32 Chapter 10, Updated evidence collection technique for oral cavity,

5	**Section 2: Foundational Response Principles**
	• Added foundational framework to establish guiding principles before operational procedures.
	• Expanded emphasis on:
	  ○ Trauma-informed care
	  ○ Victim-centered response
	  ○ Patient autonomy
	  ○ Informed decision-making
	  ○ Cultural responsiveness
	  ○ Multidisciplinary collaboration
	• Clarified that medical stabilization supersedes forensic processes.
	• Added statewide flexibility language recognizing variation in local resources and capabilities.
	Section 3: Access to Care
	• Expanded discussion regarding access challenges across Idaho.
	• Added language recognizing rural, frontier, and resource-limited environments.
	• Clarified that guidelines represent best practice while allowing local adaptation.
	• Strengthened language regarding dignity, respect, patient choice, and emotional safety.
	Section 4: Trauma Response/Trauma-Informed Care
	• Expanded explanation of trauma neurobiology.
	• Added physiologic explanation of stress response.
	• Added:
	  ○ Fight
	  ○ Flight
	  ○ Freeze
	  ○ tonic immobility
	  ○ collapsed immobility
	• Expanded memory encoding discussion.

- Added practical application for responders.
- Incorporated patient-centered language throughout.
- Removed / Reduced:
    - Reduced reliance on behavioral interpretation unsupported by trauma science.

Section 5: Medical Forensic Exam Overview

- Expanded description of MFE purpose.
- Clarified distinctions between:
    - Healthcare
    - forensic evidence
    - reporting
- Added detailed reporting pathways.
- Expanded patient options.
- Clarified anonymous/non-reporting pathways.
- Expanded timing guidance.
- Added consent framework.

New Content:

- Law enforcement reporting options
- Anonymous evidence collection
- Declination pathways
- Return-to-care language

Section 6: Victim rights/advocacy/support services

- Added dedicated victim rights content.
- Expanded Idaho constitutional victim rights.
- Added victim service provider descriptions.
- Distinguished:
    - Law enforcement victim witness coordinators
    - Prosecutor victim witness coordinators
    - Community advocates
    - Added advocacy integration expectations.
- New Content:
    - Crime Victims Compensation (CVCP)
    - Application support
    - Financial assistance overview
    - Multidisciplinary roles

Section 7: Crime Victims Compensation

- Added comprehensive compensation section including:
    - Eligibility considerations
    - Covered services
    - Medical reimbursement
    - Mental health support
    - Family support
    - Fatality-related benefits
    - Application process
    - Multidisciplinary responsibilities
- Added role-specific expectations for:
    - Healthcare

- Advocacy
- Law enforcement
- Prosecutors

Section 8: Consent/Privacy/Records

- Expanded informed consent framework.
- Added photography consent.
- Expanded release-of-information discussion.
- Added documentation expectations.
- Added medical record considerations.
- Added examples of information sharing pathways.
- New Content:
  - Ongoing consent model
  - Withdrawal of consent
  - Record release examples
  - Privacy safeguards

Section 9: Mandated Reporting

- Updated reporting framework.
- Clarified:
  - pediatric reporting
  - adult reporting
  - vulnerable adult reporting
- Added transparency language for patients.
- Reduced ambiguity regarding organizational implementation.

Section 10: Special Populations

NEW

- Added dedicated guidance for:
  - Pediatric/adolescent patients
  - Vulnerable adults
  - Older adults
  - Individuals with disabilities
  - LGBTQIA+ populations
  - Tribal communities
  - Non-English-speaking individuals
  - Interpreter use
  - Incarcerated populations
  - Individuals experiencing substance use
  - Rural/frontier communities
  - Housing instability
- Added:
  - Accessibility concepts
  - Cultural responsiveness
  - Jurisdiction considerations
  - Multidisciplinary consultation expectations

Section 11:

- Expanded exam workflow from patient presentation through discharge.
- Clarified sequencing of:
  - medical stabilization

- consent
- history
- evidence collection
- treatment
- discharge

- Added patient choice language throughout.

New Content:

- Examination location guidance
- Provider qualifications
- Pause/reassess expectations
- Transfer considerations

Section 12: History collection

- Expanded guidance for obtaining patient history.
- Added objective documentation expectations.
- Added recommendation to avoid use of "alleged sexual assault."
- Added:
  - medical history
  - assault history
  - DFSA indicators
  - post-assault activity
  - consensual sexual contact documentation
- New Content:
  - Memory considerations
  - Timing considerations
  - Safety-related history

Section 13: Forensic photography

- Added dedicated forensic photography guidance.
- Added photography sequence:
  - Bookend
  - Orientation
  - close-up
  - measurement
- Added ano-genital photography guidance.
- Clarified ruler practices.
- Expanded consent discussion.
- New Content:
  - Photography workflow
  - Storage/release considerations
  - Practical image guidance

Section 14: Sexual Assault Evidence Collection

- Expanded evidence collection guidance from general overview to procedural instruction.
- Added body-site specific collection guidance.
- New Content:
  - Clothing collection
  - Bindle procedures
  - Foreign matter collection

- Pubic hair collection
- Oral evidence collection
- External genitalia collection
- Vaginal collection
- Anal collection
- Hand/fingernail collection
- Injury swabbing
- Manual contact collection
- Digital penetration collection
- Patient reference specimen

- Added operational instructions:
  - Dry vs damp swabs
  - Color coding
  - Contamination prevention
  - Packaging guidance

Section 15: Toxicology/DFSA

- Added dedicated DFSA guidance.
- Clarified collection timing.
- Added separate guidance for:
  - urine toxicology
  - blood toxicology
- New Content:
  - Dirty urine collection
  - Refrigeration requirements
  - Packaging instructions
  - Blood tube requirements
  - Collection precautions

Section 16: Chain of Custody/Packaging

- Expanded evidence security expectations.
- Added detailed handling requirements.
- Expanded wet evidence procedures.
- New Content:
  - Swab drying procedures
  - Packaging instructions
  - Peri-pad handling
  - Tampon handling
  - Documentation expectations
  - Transfer expectations
- Added:
  - Chain of custody continuity language
  - Provider transfer procedures

Section 17: Medication/Treatment/Aftercare

- Expanded post-assault treatment considerations.
- Added:
  - STI evaluation
  - prophylaxis considerations
  - pregnancy prevention

- HIV PEP considerations
- strangulation considerations

- Expanded discharge planning:
  - Safety planning
  - Follow-up timelines
  - Behavioral health referral
  - Advocacy referral
  - Evidence tracking

Section 18: Laboratory/Kit Management

- Expanded kit handling guidance.
- Added operational instructions for:
  - expiration management
  - replacement sterile water
  - kit ordering
  - toxicology kit requests
  - transfer expectations
- New Content:
  - Laboratory coordination
  - Contact structure
  - Evidence submission workflow

Section 19: IKTS

- Expanded from basic tracking concepts to full operational workflow.
- Added:
  - ISPFS responsibilities
  - Medical facility responsibilities
  - Law enforcement responsibilities
  - Prosecutor responsibilities
  - Victim responsibilities
- New Content:
  - Account setup
  - Ordering process
  - Tracking requirements
  - Submission decisions
  - Retention considerations
  - Victim access process

Section 20: PREA

- Expanded guidance for sexual assault response in correctional settings.
- Added:
  - PREA overview
  - Investigation standards
  - Uniform evidence protocol
  - Medical forensic guidance
  - Advocacy access
  - Evidence preservation
- Expanded:
  - Trauma-informed confinement response

Section 21: Training/Competency/Sustainability

NEW

- Added a dedicated statewide workforce development and sustainability section.
- New Content:
    - Training framework
    - Competency expectations
    - Continuing education concepts
    - Workforce sustainability
    - Multidisciplinary training
    - Quality improvement
    - Policy development
    - Accessibility of education
    - Responder wellness
- Added training emphasis on:
    - Trauma-informed care
    - Victim-centered response
    - Evidence collection
    - Photography competency
    - DFSA response
    - Strangulation assessment
    - Courtroom preparation
    - Cultural responsiveness
    - Special populations

Section 22: Multidisciplinary training

NEW

- Added formal recognition of coordinated education among response disciplines.
- Expanded training participation expectations for:
    - Healthcare
    - SANE/SAFE providers
    - Advocacy
    - Law enforcement
    - Prosecutors
    - Forensic scientists
    - Behavioral health
    - Tribal partners
    - Protective services
    - Community organizations
- Added:
    - Cross-disciplinary education
    - Role clarification
    - Coordinated communication
    - Systems improvement

Section 23: Quality Improvement/System review

NEW

- Changes:
    - Added ongoing quality improvement framework.
- New Content:
    - Multidisciplinary case review

	○ Peer review ○ Policy review ○ Skills validation ○ Community needs assessment ○ Training evaluation ○ Systems analysis • Added recognition of SART roles in: ○ Accountability ○ Communication ○ Coordinated community response **Section 24: Policy/Protocol Development** NEW • Added expectations for maintaining and updating policies. • Expanded organizational guidance related to: ○ Evidence collection ○ Reporting ○ Confidentiality ○ Chain of custody ○ Advocacy access ○ Interpreter services ○ Photography ○ Documentation ○ Interagency collaboration • Added expectation that policies evolve with: ○ Idaho law ○ Best practices ○ Community needs **Section 25: Education accessibility** • Added statewide education accessibility expectations. • Added delivery methods: ○ In-person learning ○ Virtual learning ○ Recorded modules ○ Skills workshops ○ Regional conferences ○ Learning collaboratives • Added expectation for routine updates. **Section 26: Responder wellness** NEW • Added organizational wellness framework. • Added recognition of: ○ Secondary traumatic stress ○ Compassion fatigue ○ Burnout ○ Vicarious trauma • Added organizational supports: ○ Peer support

	○ Debriefing ○ Mental health resources ○ Workload support ○ Trauma-informed workplace culture **Section 27: References/Endnotes/Sources** • Modernized source management and citation practices. • Changes included: ○ Expanded references ○ Conversion to standardized citation format ○ Expanded use of endnotes ○ Improved traceability ○ Improved legal/statutory citation practices ○ Reduced unsupported operational recommendations • Added: ○ National guidance ○ Idaho-specific resources ○ Operational references ○ Laboratory references **Section 28: Visuals/Supporting Materials** • Expanded educational and operational support materials. • Added / Updated: ○ Workflows ○ Visual guidance ○ Tables ○ Quick references ○ Process diagrams ○ Clinical examples ○ Evidence handling visuals ○ Supplemental resources • Formatting • Section organization • Header/footer consistency • Page organization • References structure • Appendix structure • Reduced navigation burden **Strangulation Response Guidelines** • New

Table of Contents

Introduction

The Idaho Sexual Assault Kit Initiative (ISAKI) policy advisory group was formed in 2014 with a goal of creating guidelines for a trauma informed and victim centered response to sexual assault in Idaho. The group consists of: a state legislator, state and local law enforcement, prosecutors, public defenders, a supreme court representative, a judge, victim advocacy and resource groups, victim compensation fund administrators, sexual assault nurse examiners, a physician, hospital administrators, researchers, college campus representatives and forensic laboratory personnel, all working together to improve the response to sexual assault cases in Idaho. These individuals undertook the challenge of working to improve our statewide response to sexual assault. These guidelines represent the time and dedicated efforts of many different individuals, all working toward the common goal of providing the best possible outcome for victims of sexual assault in Idaho.

We recognize that each case of sexual assault is unique, and that individual agencies and medical providers may have their own policies and procedures in place. These guidelines were developed in an effort to provide a uniform response to sexual assault statewide, and to provide a model for best practices in a multidisciplinary response to sexual assault.

For the purpose of these guidelines, the following terminology is used to reference a person who has experienced sexual violence (dependent on section):

***Patient**: Medical decisions*
***Survivor**: Trauma response*
***Victim**: Legal/criminal justice context*

Definitions

Adolescent: An individual between 12 and 18 years of age who has usually exhibited signs of physical and sexual maturation.

Alternate Light Source (ALS): A specialized forensic light source used during medical forensic examinations to assist in identifying potential areas of biological evidence, injury, bruising, trace evidence, or fluorescence that may not be visible under normal lighting conditions. Findings identified with ALS should be further evaluated, documented, photographed when appropriate, and interpreted within the context of patient history and physical examination.

Backlogged Kit: A SAECK received by the laboratory that has remained untested for greater than 30 days.

Chain of Custody: The documented process used to maintain the integrity and accountability of evidence through collection, packaging, transfer, storage, analysis, and disposition.

CODIS: Combined DNA Index System is the program and software supplied by the FBI to support criminal justice DNA databases. Eligible DNA profiles are uploaded to national, e and/or state DNA databases for comparison. The goal of the comparisons is to provide additional investigative information to law enforcement agencies.

CODIS Eligibility: A term used to describe what is allowed to be entered and searched within the CODIS system. Forensic profiles must be associated with a crime and believed to be from the perpetrator of the crime. Samples taken directly from a suspect or provided solely for comparative purposes are not eligible for entry.

Consent: Freely given, informed, reversible, and voluntary agreement to engage in a specific activity. Consent cannot be obtained through force, coercion, intimidation, manipulation, incapacitation, or inability to legally consent.

Disability: A physical or mental condition that limits a person's movement, senses, or activities.

Domestic Violence: The pattern of abusive behaviors used to gain or maintain power and control over an intimate partner or former intimate partner.

Drug-Facilitated Sexual Assault (DFSA): A sexual assault involving the use of alcohol, controlled substances, prescription medications, or other intoxicating agents to impair an individual's ability to consent, resist, recall events, or protect themselves.

Forensic Evidence: Physical, biological, trace, photographic, or digital evidence collected for potential use in a legal investigation or proceeding.

IKTS: Idaho Sexual Assault Kit Tracking Software is the tool used to track sexual assault kits in the state of Idaho in compliance with Idaho Code (67-2919). This program is used by medical, law enforcement, laboratory and legal personnel for the tracking of kits. It is also available to victims of sexual assault to track the progress of their kit.

Jurisdiction: The official legal authority to investigate, prosecute, or make judicial decisions within a defined geographic or legal area.

MAST: Medical Assessment of Specialized Trauma.

Medical Forensic Examination (MFE): A comprehensive medical assessment performed by a trained healthcare provider following a sexual assault that addresses healthcare needs, documents findings, treats injuries, provides prophylactic care, and may include forensic evidence collection.

Patient: Any individual presenting to a healthcare provider for medical evaluation following a sexual assault.

PREA: Prison Rape Elimination Act passed in 2003 supports the prevention, reduction and elimination of sexual violence in prisons.

Qualified Interpreter: A trained individual who facilitates communication between parties who do not share the same language and who is competent in medical and/or legal interpretation practices. Family members or friends should not serve as interpreters during sexual assault response whenever possible.

Re-Traumatization: The experience of being triggered emotionally, psychologically, or physiologically in ways that replicate aspects of prior trauma, often resulting from systems interactions, procedures, language, or environmental factors.

Sexual Assault Evidence Collection Kit (SAECK): A box supplied by the Idaho State Police Forensic Services laboratory for the collection of sexual assault evidence by medical professionals. The kit contains multiple envelopes for collection of swabs, foreign matter and blood reference sample from the victim.

Sexual Assault Forensic Examiner (SAFE): A SAFE may be a physician, nurse practitioner, or physician's assistant who is specially trained to provide comprehensive examination and care to sexual assault victims, including collection of forensic evidence.

Sexual Assault Nurse Examiner (SANE): A registered nurse who has been specially trained to provide comprehensive examination and care to sexual assault victims, including collection of forensic evidence.

Sexual Assault Response Team (SART): A multidisciplinary team formed to address the response to sexual assault in their community. Core members are the first responders to sexual assault and include law enforcement, healthcare professional (such as a SANE), victim advocates, and prosecutor. Other community representatives may include Adult Protection Services, Child Protection Services (depending on age of victims served), state crime lab, college or university personnel, criminal justice representative, and others as the team determines is appropriate.

TeleSANE: The use of secure telehealth technology to provide remote consultation, education, mentorship, clinical guidance, or support by trained forensic nursing professionals during a medical forensic examination.

Tonic Immobility: An involuntary neurobiological trauma response characterized by temporary physical paralysis, inability to speak, or inability to resist during an overwhelming threat.

Toxicology: The scientific analysis of biological specimens, such as blood or urine, to identify the presence of alcohol, medications, controlled substances, or other intoxicating agents. In sexual assault response, toxicology testing may assist in the evaluation of suspected drug-facilitated sexual assault (DFSA), impaired memory, altered consciousness, or unexplained intoxication. Toxicology results should be interpreted within the context of patient history, timing of specimen collection, and individual physiological response.

Trauma-Informed Care: An approach to care that recognizes the widespread impact of trauma, understands potential paths for recovery, recognizes signs and symptoms of trauma, and responds by integrating knowledge about trauma into policies, procedures, and practices to actively resist re-traumatization.

Unfounded Report: A report having no foundation or basis for fact.

Unsubmitted Kit: A SAECK in the possession of a law enforcement agency that has never been submitted to the forensic laboratory for forensic analysis.

Victim-Centered Care: An approach that prioritizes the safety, dignity, autonomy, privacy, and well-being of the victim while promoting informed decision-making and minimizing re-traumatization.

Victim/Survivor: An individual who has experienced sexual violence, abuse, exploitation, or other interpersonal violence. The terms "victim" and "survivor" may be used interchangeably throughout this document depending on legal, medical, or personal context.

Victim Witness Advocate: Community-based victim service providers who offer confidential services such as crisis intervention, safety planning, court advocacy, emotional support, counseling, and/or case management. Advocates maintain the confidentiality of the patient as allowed by law.

Victim Witness Coordinators (Law Enforcement based): Victim Advocate housed with a law enforcement agency; confidentiality is limited as the Advocate is obligated to report knowledge of the crime to the law enforcement agency with which they are associated. Advocates respond at the time of incident and continue working with the victim through the investigative process, court proceedings, sentencing hearing and parole hearing. Advocates provide court accompaniment, as well as being present for any meeting with detectives and prosecutors. Other services include victim compensation resources, crisis response, safety planning, and information about "no contact orders" and "protection orders." Advocates ensure consideration of the victim's voice during the investigative and court process, and that the victims are kept informed of the progress of the investigation and court proceedings pursuant to victim's rights legislation.

Vulnerable Adult: Any person over the age of eighteen who is unable to protect themselves from abuse, neglect, or exploitation due to a physical or mental impairment, advanced age, or because they receive care from a licensed facility or service provider

Idaho Sexual Assault Related Statutes

The following statutes may apply to sexual assault response and related practice considerations. For the most current statutory language and updates, users should access the official Idaho Legislature statutes website: https://legislature.idaho.gov/statutesrules/idstat/

- Idaho Title 18 Chapter 15 – Children and Vulnerable Adults
- Idaho Title 18 Chapter 61 – Rape
- Idaho Title 18 Chapter 66 – Sex Crimes
- Idaho Title 19 Chapter 4 – Time of Commencing Criminal Action
- Idaho Title 19 Chapter 53 – Compensation of Victims of Crimes
- Idaho Title 19 Chapter 55 – The Idaho DNA Database Act of 1996
- Idaho Title 32 Chapter 10 – Idaho Parental Rights Act
- Idaho Title 67 Chapter 29 (67-2919) – Testing and Retention of Sexual Assault Evidence Kits

Additional Resources

- Idaho Crime Victims Compensation: https://crimevictimcomp.idaho.gov
- Idaho Manual on the Rights of Victims of Crime: https://ag.idaho.gov/content/uploads/2018/04/victimsrights.pdf

Statutes and agency resources are subject to revision. Users should verify current statutory language and agency guidance through official Idaho sources prior to application.

Victim Rights, Needs, and Trauma-Informed Response

In the United States, sexual violence remains a significant public health and public safety concern. More than 1 in 5 women and 1 in 31 men have experienced completed or attempted rape during their lifetime.[1] Despite its prevalence of sexual violence, many incidents are never reported to law enforcement or medical personnel.[2] Common reasons victims identify for not reporting sexual violence to the police include fear of retaliation, belief that the police would not do anything to help, belief that it is a personal matter, and concern that they will not be believed.[3]

Considering the widespread impact of sexual violence and barriers to reporting, trauma-informed and victim-centered practices have been developed to improve survivor experiences and outcomes.[4-7] A trauma-informed approach involves recognizing and responding to the effects of trauma while understanding the physical, emotional, and behavioral impacts trauma may have on survivors. This includes recognizing survivors' rights to dignity, respect, information, and participation in decisions affecting their care.[5] include guilt, shame, embarrassment, self-blame, and minimization of the event.

Similarly, a victim-centered approach prioritizes victim safety, autonomy, and well-being by actively seeking to minimize re-traumatization, provide support, and empower informed decision-making.[5]

Under a trauma-informed and victim-centered approach, providers should:

- Create a safe environment by responding with empathy and addressing concerns.
- Provide clear explanations of all processes, procedures, and available options.
- Respect survivors' choices and support informed decision-making.[5]

When implemented effectively, trauma-informed and victim-centered practices have been associated with improved survivor engagement, reduced re-traumatization, enhanced psychological well-being, and improved multidisciplinary response outcomes.[7]

Guidelines for Victim-Centered, Trauma-Informed Care

Responding to individuals who have experienced sexual violence can feel complex and challenging. Adhering to a victim-centered, trauma-informed approach is essential to providing an appropriate and compassionate response.

Experiences of sexual violence may affect an individual's sense of safety, autonomy, trust, and control. Trauma responses vary among individuals and may influence how survivors process information, communicate, make decisions, recall events, and engage with services. The primary goals of victim-centered, trauma-informed care are to promote safety, support informed decision-making, foster empowerment, and minimize the potential for re-traumatization.[5]

The practical recommendations described below are intended to support these goals and provide guidance for effectively responding to individuals presenting with experiences or indicators of sexual violence.

Understanding the Signs of Trauma

Sexual violence can have immediate and long-term impacts that may affect a person physically, emotionally, behaviorally, and psychologically. Trauma responses vary considerably among individuals and may change over time. Common responses that victims/survivors may experience include guilt, shame, embarrassment, self-blame, and minimization of the event, confusion, numbness, anxiety, or difficulty concentrating.

Trauma can affect memory formation, information processing, communication, and emotional expression. As a result, survivors may have difficulty recounting details of the event in a chronological manner, may recall information over time, or may present with emotional responses that do not align with common expectations. Some individuals may appear visibly distressed, while others may appear calm, detached, or express little outward emotion.[6]

These responses can occur across a broad spectrum and should not be interpreted as indicators of credibility or severity. Providers should remain patient, provide opportunities for survivors to process information, and allow time for communication and decision-making.

Recognize Victim's Individual Needs

Although many survivors share common experiences, it is important to recognize that each will present with individual needs, concerns, and circumstances.

Providers should avoid assumptions and recognize that prior experiences, personal circumstances, and environmental factors may influence how victims/survivors engage with services and make decisions.

Some victims/survivors may have concerns about seeking a forensic medical examination, receiving medical care, or reporting to law enforcement. These concerns may include fear of legal consequences related to substance use, concerns regarding immigration consequences, fear of parental or caregiver reactions if the patient is a minor, privacy concerns, prior negative experiences with healthcare or criminal justice systems, or concern about how others may respond.[4]

Previous experiences of sexual violence, trauma, adversity, or system involvement may also influence emotional and behavioral responses. Providing culturally responsive, person-centered care is essential and includes consideration of language access, culture, disability and accessibility needs, developmental considerations, and individual preferences.

If communication barriers exist, providers should utilize qualified interpretation services to support informed decision-making and effective communication regarding available services and options. Family members, friends, or accompanying persons should not be used as interpreters during sensitive discussions whenever qualified interpretation services are available.[7]

Victim service providers can play an important role in supporting victims/survivors and helping address individual needs throughout care and follow-up.[8]

Respect Patient Privacy and Choice

Healthcare environments should establish a policy or process that allows the provider an opportunity to speak with their patients alone at some point in the encounter, as clinically appropriate and consistent with applicable laws and policies. This is crucial for patients presenting with concerns related to sexual violence as the perpetrator may be known to the patient or accompanying the patient.[9]

When meeting privately with your patient, ask who they would like to be in the room during the discussion, examination, treatment, and follow-up. Explain available options, limits of confidentiality, and any applicable reporting requirements so patients can make informed decisions regarding their care.[10]

If a sexual assault forensic exam is being considered, discuss available reporting and evidence collection options in accordance with state law and local protocols. Patients should receive clear information regarding available choices and be supported in making informed decisions when possible.[11]

Describe Processes, Procedures, and Options in Detail and Respect Victim's Right to Make Decision About Their Care

Healthcare providers should support their patients in making informed decisions regarding their care and explain available options in a clear, transparent, and understandable manner. Patients should understand that participation in medical treatment, forensic examination procedures, evidence collection, and reporting processes may involve separate decisions and that options may vary based on applicable laws and local protocols.[9]

For patients who choose to proceed with a sexual assault forensic examination, explain the purpose and anticipated steps of the examination before beginning. Discuss available reporting and evidence collection options, explain any applicable confidentiality or reporting requirements, and emphasize that patients may request breaks, ask questions, decline specific procedures, or stop the examination at any time.[12]

Providing a brief overview of what to expect during the examination can help reduce uncertainty and support informed decision-making. Explain the anticipated length of the visit, possible medical evaluation and treatment options, evidence collection procedures, and the possibility that portions of the examination may trigger emotional or trauma-related responses.

Continue to obtain informed consent throughout the encounter, check-in with the patient regularly, and assess whether they wish to proceed. At the conclusion of care, review discharge instructions, discuss follow-up options and referrals, and ask whether the patient has additional needs, concerns, or support requests.[11]

Offer to Contact a Victim Service Provider and Be Aware of Local Resources

Victim service providers, which are described in more detail below, may include community-based victim advocates and victim witness coordinators. One of their primary goals is to assist and support victims/survivors and respond to the individual needs throughout the sexual assault response process. Services may include emotional support, crisis intervention, assistance understanding available options, accompaniment during medical care or legal proceedings, and connection to community resources.[8]

If a victim service provider is not already present, offer to contact one on behalf of the victim/survivor as early as possible. Individuals should be informed that accepting advocacy services is voluntary and they may choose whether or not to engage with available support. If local resources are unknown in your area, refer to the resources listed in this document.[8]

For adult patients who choose a non-reporting, anonymous, or otherwise confidential forensic medical pathway, only contact community-based victim advocacy services unless the patient requests otherwise or local policy permits additional involvement. Involvement of victim witness personnel may not align with the patient's preferences and, depending on local protocols and applicable law, could affect reporting status or eligibility for anonymous processes.[11]

Understand and Describe Options for Evidence Collection and Reporting

Adults have the right to decide if they want to have a forensic medical examination, report to law enforcement, and the extent to which they want to be involved in the criminal justice process.[13] Decisions regarding medical care, forensic evidence collection, and law enforcement involvement should be discussed as separate but related options.[11]

Available pathways may include:

- Law enforcement report with evidence collection.
- Anonymous or non-reporting evidence collection.
- Medical care and treatment without evidence collection.[11]

All available options should be discussed with a survivor before decisions are made about reporting or undergoing a forensic examination.[11] Available options are listed in detail in the Medical Forensic Examination section of this guideline.

Tailor the Victim's Care to Their Experience

Ask the patient to share information regarding their experience only to the extent they are comfortable and only as necessary to guide medical evaluation, treatment, safety assessment, and forensic evidence collection. Explain why information is being requested and reassure the patient that they do not need to provide unnecessary details to receive care.[12]

The examination and evidence collection process should be individualized based on the patient's history, concerns, symptoms, reported contact, and personal goals for care. This may include tailoring

assessment, treatment, and evidence collection based on factors such as the type of contact disclosed, areas of concern, symptoms, reported injuries, timing of events, and patient preferences.[12]

Providers should avoid assumptions regarding injury patterns, emotional responses, or examination needs and should continue to seek consent throughout the encounter.[9]

Prioritize Patient Safety, Medical Needs, and Timely Care

Patients presenting following sexual violence should receive timely, patient-centered medical care consistent with clinical presentation and established triage practices. Immediate medical needs, safety concerns, and stabilization should take priority while also considering opportunities to preserve forensic evidence when appropriate.[12]

Healthcare providers may have concerns regarding balancing medical treatment with preservation of forensic evidence; however, patient health, safety, and clinical needs remain the primary priority. When medically appropriate, efforts should be made to explain available options and preserve potential evidence without delaying necessary treatment.[12]

In addition to implementing trauma-informed and victim-centered practices, providers should understand available evidence collection and reporting pathways so patients can make informed decisions regarding how they wish to proceed.[11]

Medical Forensic Examinations

Evidence Collection and Reporting Options

In Idaho, medical professionals and other mandated reporters are required to report to law enforcement any suspected incidents of abuse, abandonment, or neglect to a child under the age of 18. Thus, providers must report suspected child abuse, abandonment, neglect, or sexual abuse to the appropriate law enforcement agency or the Idaho Department of Health and Welfare, as required by Idaho law. In order to promote choice and empowerment, victims should be made aware of these mandated reporting requirements as early as possible.[14]

For victims who are 18 years of age or older, there are four main options available in terms of evidence collection and reporting. It is crucial that these options are clearly explained to victims and that they are given the opportunity to make their own decision about how to proceed. Timing considerations for evidence collection are also important. (i.e., generally up to 120 hours after the assault for adolescents and adults; up to 72 hours for children).[11]

Option 1: Medical Forensic Examination (MFE), Law Enforcement Report, and Evidence Collection

Option 1 includes a medical forensic examination to address healthcare needs, to collect biological and physical evidence that may assist a criminal investigation, and to report the assault to law enforcement for investigation. The decision to have the MFE, have evidence collected, and to report to law enforcement belongs entirely to the victim.[12]

If the adult victim makes this choice and has not notified law enforcement, the medical provider should contact the law enforcement agency of jurisdiction after the MFE is complete.[11]

The medical provider should document the name of the officer(s) who responded and the case number, if available. The Sexual Assault Evidence Collection Kit (SAECK) will be sent to the laboratory for testing except as outlined in Idaho statute 67-2919.[15]

Option 2: Anonymous Report and Evidence Collection

As per Idaho Code § 67-2919 and § 39-1390, adult victims may also choose to have evidence collected but remain anonymous to law enforcement (i.e., Jane/John Doe). This allows for the individual to receive medical care, as well as evidence preservation and the potential to make an official law enforcement report at a later date if they choose.[11]

With this option, evidence is collected and turned over to law enforcement. The victim's identifying information is kept within the sealed SAECK in the event they later decide to have it tested, but the outside of the SAECK is labeled Jane or John Doe. Due to statutory and practical limitations, the evidence will not be sent to the laboratory for testing unless the victim elects to convert to a law enforcement report within the time period specified in Idaho Statute 67-2919.[15]

Option 3: Medical Care Without Evidence Collection

Adult victims have the right to receive medical care but decline a MFE, evidence collection, or reporting to law enforcement. Medical providers should support patient autonomy by facilitating a fully informed decision-making process. The provider should inform the victim that they can return for a forensic exam and evidence collection up to 120 hours after the assault, and they can choose to report to law enforcement at any time.[13] While opting out of evidence collection now will likely preclude gathering forensic evidence for a criminal investigation in the future, victims retain the right to report the incident to law enforcement at any time, regardless of whether viable forensic evidence exists. This option allows them to receive any medical services they need.[12]

Option 4: Declination of Care

Adult victims may decline medical care, the MFE, forensic evidence collection and reporting to law enforcement. Medical providers should support patient autonomy by facilitating a fully informed decision-making process. Inform the victim that they can return for medical care at any time and encourage them to seek care for the evaluation and treatment of sexually transmitted infections, pregnancy, and mental health concerns. The victim should be informed that they can return for the MFE and evidence collection up to 120 hours after the assault, and they can choose to report to law enforcement at any time.[12]

Idaho Crime Victim's Rights

Idaho recognizes specific constitutional and statutory rights for victims of crime intended to promote dignity, participation, information, and access throughout the criminal justice process. In November 1994, Idaho voters approved the Crime Victims' Rights Amendment, codified in Article I, Section 22 of the Idaho Constitution.[13]

Under Idaho law, crime victims are afforded rights that include, but are not limited to:

- Being treated with fairness, respect, dignity, and privacy throughout the criminal justice process
- Receiving timely disposition of criminal proceedings
- Receiving notice of proceedings and information regarding case status and offender disposition, as permitted by law
- Being present at court proceedings, as authorized by law
- Communicating with prosecuting authorities
- Being heard at proceedings involving pleas, sentencing, release, probation, or other qualifying events
- Seeking restitution as provided by law
- Refusing interviews or contact initiated by the defendant or persons acting on the defendant's behalf, unless otherwise authorized by law
- Accessing information and participating in the justice process as permitted by statute[13]

These rights are further implemented and expanded through Idaho Code § 19-5306 and related victim rights statutes. Medical providers, forensic examiners, advocates, and other multidisciplinary response

personnel should maintain awareness of these rights and support victims in understanding available options and accessing appropriate resources.[13]

Victim service providers can play an important role in explaining victims' rights, facilitating access to services, and helping survivors navigate healthcare and criminal justice systems.[8]

Victim Service Providers

Victim service providers can include both victim witness coordinators and victim advocates. Victim Witness Coordinators work in a law enforcement agency or prosecuting attorney's office whereas Victim Advocates work in community- or tribal-based, social service agencies. Victim witness coordinators and victim advocates both provide a variety of services such as emotional support, crisis intervention, and accompaniment during medical exams and criminal justice proceedings, assistance with safety planning, and referral to community resources. While there are many commonalities among the services they provide, there are some differences as well which are listed below:[8]

Law Enforcement Victim Witness Coordinator

- Accompanies detectives to the scene
- Serves as liaison during the investigation process
- Assists with Crime Victims Compensation
- Is not bound by confidentiality (may be required to disclose certain information)

Prosecutor's Office Victim Witness Coordinator

- Attends criminal court with the victim
- Serves as liaison with the prosecutor
- Explains legal terminology
- Is not bound by confidentiality[8] (may be required to disclose certain information)

Victim Advocate

- Assists with Civil Protection Orders and safety planning
- May provide individual counseling and support groups within their agency
- May assist with housing and transportation
- May attend criminal and civil court proceedings with the victim
- Provides assistance regardless of whether the incident is reported
- Is bound by confidentiality

It is important that individuals are given the option to have a victim service provider present before, during, and after any medical care or evidence collection. These providers can help survivors understand available options and support informed decision-making throughout the medical and criminal justice process.[8]

Idaho Crime Victims Compensation

Purpose

The Idaho Crime Victims Compensation Program (CVCP) plays an important role in supporting victims of sexual violence and other violent crimes by reducing financial barriers associated with medical care, counseling, lost wages, and other crime-related expenses.[16]

Victims of sexual assault may experience significant physical, emotional, psychological, financial, and social impacts following victimization. Access to compensation resources may assist victims in obtaining necessary healthcare, behavioral health services, forensic examinations, and supportive services during recovery.[16]

Healthcare professionals, advocates, law enforcement personnel, prosecutors, forensic examiners, and multidisciplinary response partners should be familiar with available compensation resources and assist victims in accessing information regarding the Idaho Crime Victims Compensation Program whenever appropriate.[16]

Incorporating crime victim compensation education into multidisciplinary response supports:

- Victim stabilization and recovery.
- Access to medical and behavioral healthcare.
- Reduction of financial stressors.
- Coordinated trauma-informed response.[16]

Idaho Crime Victims Compensation Program (CVCP)

The Idaho Crime Victims Compensation Program (CVCP) provides financial assistance to eligible victims of violent crime for certain crime-related expenses not covered by other payment sources.[16]

CVCP may provide reimbursement or direct payment for qualifying expenses related to:

- Medical treatment
- Counseling and behavioral health services
- Wage loss
- Travel expenses
- Funeral and burial costs
- Sexual assault forensic and medical examinations[16]

The program is intended to reduce financial barriers that may interfere with victim safety, healing, recovery, and access to care.[16]

Additional information regarding the CVCP may be obtained through:

- Website: https://crimevictimcomp.idaho.gov/

- Telephone: 208-334-6050
- Email: cvcp.admin@iic.idaho.gov
- Mailing address: Idaho Crime Victims Compensation Program
  PO Box 83720
  Boise, ID 83720

Multidisciplinary Responsibilities

All multidisciplinary responders play an important role in informing victims about available compensation resources.[16]

Whenever appropriate, multidisciplinary professionals should:

- Provide victims with information regarding CVCP
- Explain available application options
- Assist with referrals and resource connection
- Document crime-related injuries and treatment
- Encourage victims to ask questions regarding eligibility and benefits

Victims may be overwhelmed, emotionally distressed, medically unstable, or unfamiliar with available resources following sexual assault. Victims may benefit from repeated opportunities to receive information and follow-up regarding compensation resources may be beneficial.[9]

Healthcare Providers and Forensic Examiners

Healthcare providers and forensic examiners should:

- Document injuries and treatment thoroughly
- Inform patients of available compensation resources
- Provide application materials when available
- Explain that certain forensic examination costs may be covered through CVCP[16]

Whenever possible, patients should receive information regarding:

- Sexual assault forensic examination reimbursement
- Medical expense coverage
- Counseling benefits
- Additional crime-related support resources[16]

Healthcare providers should recognize that victims may:

- Decline immediate law enforcement involvement
- Require time before completing applications
- Initially feel overwhelmed by financial or legal concerns[9]

Advocates

Advocates may assist victims by:

- Explaining compensation resources
- Assisting with applications
- Helping gather documentation
- Coordinating referrals
- Supporting victims throughout the compensation process[8]

Advocates may also assist victims in understanding:

- Eligibility requirements
- Reporting considerations
- Confidentiality concerns
- Available community resources[8]

Law Enforcement

Law enforcement personnel should:

- Provide victims with information regarding compensation resources
- Complete reports in a timely manner
- Document injuries and evidence appropriately
- Support multidisciplinary coordination when compensation documentation is needed[16]

Law enforcement reports may assist CVCP in determining eligibility and verifying criminally injurious conduct.[16]

Trauma-informed communication regarding compensation resources is encouraged.[9]

Prosecutor and Victim Witness Coordinators

Victim witness coordinators and prosecutors may assist victims by:

- Providing information regarding compensation eligibility
- Assisting with documentation needs
- Coordinating communication regarding criminal case status
- Supporting access to victim services throughout the criminal justice process[16]

Victim witness personnel should recognize that compensation-related needs may continue long after the initial response.[9]

Eligibility Considerations

Eligibility requirements for the CVCP are determined by Idaho law and program policy.[17]

General eligibility considerations may include:

- The crime occurred in Idaho.
- The crime was reported to law enforcement within required timeframes or good cause exists for delayed reporting.
- Cooperation with investigation and prosecution efforts when applicable.

- Timely submission of applications.
- Documentation supporting criminally injurious conduct.[16]

Eligibility determinations are made by CVCP according to applicable statutes, rules, and program requirements.[17]

Multidisciplinary responders should avoid making definitive statements regarding eligibility and instead encourage victims to contact CVCP directly for individualized guidance.[9]

Sexual Assault Forensic and Medical Examination Costs

Under Idaho law, costs associated with adult sexual assault forensic and medical examinations may be reimbursed through the Idaho Crime Victims Compensation Program.[16]

Covered costs may include:

- Examiner fees
- Facility fees
- Laboratory fees
- Evidence collection costs
- Medications associated with sexual assault care
- Follow-up forensic-related treatment as allowed by program policy[16]

Healthcare providers should follow current Idaho statutes, billing guidance, and organizational protocols regarding sexual assault forensic examination reimbursement procedures.[16]

Victims should not be billed directly for qualifying sexual assault forensic examination costs covered under Idaho law.[17]

Non-Reported Sexual Assault Examinations

Adult victims may choose to receive medical forensic care without immediate participation in law enforcement reporting.[11]

Victims who elect non-reported or anonymous evidence collection may still qualify for reimbursement of sexual assault forensic examination costs through designated CVCP application processes.[16]

Patients should receive clear information regarding:

- Available reporting options
- Reimbursement applications
- Limitations of coverage
- How future law enforcement reporting may impact available benefits[16]

Medical and Mental Health Benefits

CVCP may assist eligible victims with expenses related to:

- Emergency medical care
- Hospital treatment
- Imaging
- Medications
- Behavioral health treatment
- Counseling services
- Other qualifying medical expenses related to the crime[16]

Mental health services may play an important role in recovery following sexual violence.[9]

Victims may experience:

- Anxiety
- Depression
- Post-traumatic stress symptoms
- Sleep disturbance
- Fear
- Emotional distress
- Other trauma-related effects following assault[6]

Access to counseling and behavioral health services may significantly support long-term healing and recovery.[16]

Family Member Support

The impact of sexual violence frequently extends beyond the immediate victim.[9]

Under certain circumstances, CVCP may provide counseling-related support for qualifying family members affected by violent crime.[16]

Multidisciplinary responders should recognize the potential impact of sexual violence on:

- Children
- Caregivers
- Intimate partners
- Other household members[9]

Intimate Partner Violence, Strangulation, and Sexual Violence

Sexual assault may occur in the context of:

- Intimate partner violence
- Domestic violence
- Coercive control
- Stalking
- Strangulation[9]

Victims experiencing interpersonal violence may face additional barriers related to:

- Safety concerns
- Financial dependence
- Housing instability
- Fear of retaliation
- Childcare concerns
- Ongoing contact with the offender[9]

CVCP may assist eligible victims with expenses associated with injuries and treatment related to interpersonal violence, including strangulation-related medical evaluation when applicable under program guidelines.[16]

History of non-fatal strangulation is a significant risk factor for future homicide and should be taken seriously regardless of visible injury findings.

Fatality Cases

In fatality cases, eligible dependents or authorized representatives may apply for compensation benefits associated with:

- Funeral expenses
- Burial expenses
- Crime-related medical treatment
- Other qualifying expenses[16]

Multidisciplinary responders should provide surviving family members with information regarding available victim compensation resources whenever appropriate.[16]

Limitations and Other Payment Sources

CVCP is generally considered a payer of last resort.[16]

Other payment sources, including:

- Private insurance,
- Medicaid,
- Medicare,
- Workers compensation,
- Other available benefits may be utilized prior to CVCP payment depending on statutory requirements and service type.[16]

CVCP does not typically reimburse:

- Property damage
- Stolen property
- Non-qualifying expenses[16]

However, certain medically necessary items damaged during the crime may qualify for reimbursement according to program policy.[16]

Application Process

Victims may apply for compensation by:

- Completing a CVCP application
- Submitting supporting documentation when requested
- Cooperating with any additional program requirements[16]

Applications and additional information may be accessed through:

Idaho Crime Victims Compensation Program Application Information

Multidisciplinary responders should recognize that victims may:

- Require assistance completing applications
- Need repeated information
- Delay application completion due to trauma-related responses[9]

Multidisciplinary Collaboration

Coordinated multidisciplinary response improves victim access to compensation resources and supportive services.[9]

Collaboration among:

- Healthcare providers
- Forensic examiners
- Advocates
- Law enforcement
- Prosecutors
- Victim witness coordinators
- Community organizations supports continuity of care and reduces barriers to recovery[9]

Sexual Assault Response Teams (SARTs) are encouraged to incorporate victim compensation education and resource coordination into multidisciplinary response planning and training initiatives.[9]

Access to Care

Idaho includes diverse rural, frontier, and urban communities with varying levels of healthcare access and forensic response resources. This document provides recommended best practices and procedures; however, implementation may vary based on available personnel, infrastructure, and local capabilities. These guidelines are intended to support consistent responses to reported sexual assault while allowing flexibility based on site-specific resources and patient needs. [9]

The primary focus of care is the patient's physical, psychological, emotional, and, when desired by the patient, spiritual well-being. Patients should be treated with dignity, respect, and compassion and receive trauma-informed, victim-centered care that supports safety, autonomy, and informed decision-making.[9] Applicable national, state, county, tribal, and local reporting requirements and policies should be followed.[14]

Medical assessment, stabilization, and treatment take priority over forensic considerations. Medical needs may require urgent or emergent intervention. Once the patient is medically stable, a medical forensic examination (MFE) may proceed to address healthcare needs and, if desired by the patient and clinically appropriate, facilitate forensic evidence collection and documentation.[12]

The Trauma Response and Use of Trauma-Informed Approaches to Care

The patient who has experienced a sexual assault has been traumatized; all control of their self and body has been stripped from them, and they have experienced intense fear, and even terror. These emotions trigger a physiological stress response, activating a hormonal cascade that changes the way the brain functions during the assault and for several hours/days after the assault. As those who care for these patients, providers must be cognizant of how the stress response alters a person's emotional presentation and responses.[6]

When the brain recognizes a threat, the logical center, (the frontal cortex), usually in control, is shut down and the amygdala, (which controls emotional processing), signals the hypothalamus to initiate the stress response, flooding the body with hormones needed to act to protect the body from danger. This response focuses on Fight or Flight, but a third component, much more likely in sexual assault, is the Freeze response. The freeze response is initiated when the brain, completely automatically and not under conscious control, decides that neither fighting nor fleeing will best protect the body.[6]

In simplified terms, hormones released, and their effects, include:

- Catecholamines – natural adrenaline that triggers the fight, flight, or freeze response.
- Corticosteroids – controls energy levels: high, if needed to fight or flee, but it will also decrease energy if the brain determines that freezing is a safer response.
- Endogenous opioid – an endogenous opioid-like compound to decrease physical pain and may create a flat affect, or "out of it" demeanor.
- Endogenous oxytocin – a "feel good" hormone that assists in blocking pain, but also may produce emotions seen as inappropriate to the situation

    - The Freeze response may progress (often seen with restraint) to Tonic Immobility (a true muscular paralysis during which the brain remains fully aware of what is happening, but the body is rigidly immobile) or Collapsed Immobility (in which the patient may lose consciousness and the body remains paralyzed, but "floppy"). With an immobility response the patient has no control over the body and has no ability to speak.[6] This response explains why the patient "just laid there" or didn't call for help, even if help was nearby.
    - The hormones involved in the stress response alter the way memories are captured and encoded; memories are no longer captured in a linear fashion, but as sensory inputs (improving memory of what is seen, heard, touched, tasted, or smelled). Encoding (or 'filing' for later recall) memories is delayed; the encoding will occur after one to two sleep cycles have occurred.[6]
- The hormonal effects of the stress response are responsible for the unexpected trauma responses we see; demeanor that is very calm, or very angry; poor eye contact, difficulty remembering what happened, and unable to recall memory in a linear or logical sense. High oxytocin levels contribute to poor or impaired decision-making – perhaps the patient calls the assailant and makes plan to meet up shortly after the assault, leaving those around to wonder how on earth the report of assault could be true.[6]
    - When we see these 'unexpected' responses, we need to recognize that the patient has been severely traumatized
        - "In the midst of assault, the brain's fear circuitry takes over while other key parts are impaired or even effectively shut down. This is the brain reacting to a life-threatening situation just the way it is supposed to" (Hopper and Lisak, 2014).
- The goal of intervention with the patient is to prevent re-traumatization; we do this by shifting our thoughts/approach from "what is wrong with you" to "what happened to you". Being patient-centered means returning control to the patient and using trauma-informed techniques, including:[9]
    - Safety – creating an environment of both physical and emotional safety, where the provider's integrity, sincerity, non-judgmental demeanor and honesty will foster the ability for the patient to feel safer in talking openly with us.[9]
    - Empowerment – taking the patient's history at face value, demonstrating sincerity ("I am sorry this happened to you"), careful listening to understand, and demonstrating an accepting body language sends the message that they are believed and can be open with the provider.[9]
    - Choice – giving the patient total control for all that happens during the examination, restoring the ability to make choices for their own care, is the beginning of recovery. Giving enough information for the patient to make informed choices and respecting those choices (even if we feel the choice isn't the best one) restores the patient's sense of self-control, which is vital to begin the healing process.[9]
    - Collaboration – collaborating with other providers, such as Advocates or Law Enforcement to ensure the patient's needs are met after a provider's time with them is over reinforces the patient's feeling that others care about them and that their needs are important and respected.[17], [9]
    - Trustworthiness – being honest about what the provider can and cannot do fosters the belief that what is being said can be trusted; even if the provider cannot give what the patient is looking for ("I know it's frightening to wake up and not remember what may

have happened; you need to understand the examination may not provide those answers for you").[9]

- While sexual assault is a terrifying event that carries fear, anxiety, and depression that may advance to PTSD and suicidal ideation, there can be healing and recovery with a positive and joyful life afterward if the patient is not re-traumatized by unbelief and receives care in a patient-centered, trauma-informed manner while providing referrals for on-going care after the immediate healthcare examination is complete.[9]

Where Medical Forensic Examinations May Be Performed

Sexual assault medical forensic examinations (MFE) should be performed in an appropriate healthcare setting or designated examination location established by local jurisdiction, facility policy, and available resources, consistent with the patient's clinical condition and care needs.[12]

Prior to initiation of the medical forensic examination, the patient should receive an appropriate medical evaluation and be determined to be clinically stable to participate in the examination.[12]

Emergent or urgent medical conditions should be identified and treated before proceeding with forensic examination activities.[12]

Best practice is for medical forensic examinations to be conducted by healthcare professionals with education, training, and demonstrated competency in sexual assault evaluation and response. This may include Sexual Assault Nurse Examiners (SANE), Sexual Assault Forensic Examiners (SAFE), Forensic Nurse Examiners (FNE), Pediatric SANE/SAFE providers, Medical Assessment of Specialized Trauma (MAST) providers, physicians, advanced practice providers, or other qualified clinicians operating within scope of practice and facility protocol.[12]

If the patient's medical condition changes during the medical forensic examination, the examination should pause while appropriate medical evaluation and treatment occur. If services are provided outside an Emergency Department (ED), transfer or transport to a higher level of care may be necessary.[12]

Mandated Reporting

Healthcare providers should understand and comply with all applicable federal, state, tribal, and local mandatory reporting requirements, as well as organizational policies. Reporting obligations may differ depending on patient age, vulnerability status, circumstances of presentation, and applicable law.[14]

For patients younger than 18 years of age, suspected abuse, neglect, abandonment, exploitation, or assault should be reported in accordance with Idaho mandatory reporting requirements and organizational policy. Patients and caregivers should be informed of applicable reporting obligations as early as practical to support transparency and trauma-informed care.[14]

Adult patients generally retain the ability to decide whether to report sexual assault to law enforcement unless another mandatory reporting obligation applies under state law.[11]

When concerns exist regarding abuse, neglect, exploitation, or mistreatment of a vulnerable adult, providers should follow Idaho mandatory reporting requirements and applicable organizational procedures regarding notification and referral.

Mandatory reporting is dependent on individual hospital policy and procedures that meet Idaho statute.[14]

Patient Consent and Decision to Collect Evidence

Informed consent should be obtained prior to initiating medical evaluation, forensic examination activities, photography, specimen collection, evidence collection, or release of information. Consent discussions should occur in a manner that supports informed decision-making and allows opportunities for questions throughout the encounter.[10]

Components of consent may include:

- Consent for medical evaluation and treatment, which may include:
    - Physical examination
    - Diagnostic testing
    - Collection of blood and/or urine for medical or toxicology purposes
    - Pelvic, genital, speculum, anoscopic, or other clinically indicated examination
    - Medication administration and treatment recommendations
- Consent for medical forensic examination activities, which may include:
    - Forensic evidence collection
    - Collection and storage of specimens
    - Injury assessment and documentation
    - Forensic photography[12]
- Consent discussions regarding photography should address:
    - Whether photographs become part of the medical record according to organizational policy
    - Potential uses of photographs for healthcare, legal, quality improvement, education, peer review, or investigative purposes as permitted by law and policy
    - Conditions under which photographs may be released to law enforcement, prosecutors, or other authorized entities
    - Limits of confidentiality and retention practices[10]
- Consent discussions should include:
    - What information may be collected
    - How information may be documented
    - How records may be stored, accessed, and released consistent with law and organizational policy[10]
- Refusal to participate in all or portions of forensic evidence collection should not delay or prevent access to medically indicated evaluation or treatment.[12]
- Patients should receive information regarding how and when medical records may be released and any processes required for authorization, subpoena, court order, or lawful disclosure.[10]
- Healthcare organizations, in collaboration with local multidisciplinary response teams and applicable laws, should establish procedures that protect patient privacy while supporting lawful access to medical forensic information when appropriate.[10]
- Programs may utilize different processes for sharing information with law enforcement consistent with patient authorization, legal requirements, and local protocol.[10]

- Examples may include:
    - A law enforcement summary or investigative summary derived from the medical record, where permitted
    - Release of designated portions of the medical record. Examples may include:
        - patient demographics
        - patient impairment and any toxicology samples collected
        - date/time/location of assault
        - trauma response behaviors observed
        - patient's verbal history of assault
        - methods of violence
        - acts of assault (checklist)
        - injury documentation: body maps and narrative descriptions
        - evidence collected
        - strangulation addendum, if pertinent
        - Release of the complete medical record when authorized or otherwise permitted by law[10]

- Consent is an ongoing process and may be withdrawn or modified, in whole or in part, at any time to the extent permitted by law and clinical circumstances.[12] Patients should be informed of any implications related to withdrawal of consent after evidence has already been collected or released.[10]

Anonymous Kits

- Anonymous/Jane Doe exam option is available to adult patients (18 years of age or older).[11]
- Identifying information is managed in a manner intended to preserve patient confidentiality while allowing medical care and forensic evidence preservation.[10]
    - No patient identification information is given to law enforcement.
    - Sexual Assault Evidence Collection Kits (SAECK) will have the patient's name on internal documentation and evidence envelopes inside the kit, but the front of the kit will be labeled as "Jane or John Doe."[11]

Anonymous kits should be transferred, stored, retained, and managed in accordance with Idaho Code § 67-2919 and applicable jurisdictional procedures. Patients should receive information regarding available timelines, retention practices, and options for converting to law enforcement reporting if desired.[11]

- Particularly in small or rural communities, providers should consider operational practices that support privacy and reduce the potential for unintended contact or identification. Examples may include coordinating timing of notification, patient discharge processes, and evidence transfer procedures consistent with local protocol.[9]
    - Example:
        - Especially in small communities, the provider should ensure the patient has left the building before notifying law enforcement so no accidental contact between the patient and officer occurs.
        - System-based advocates cannot be utilized for these patients.[8]

Law Enforcement Notification (Adults)

- Facilitate notification to Law Enforcement (LE) in the jurisdiction where the assault was reported to have occurred, if requested by the patient.[11]
- If the adult patient does not wish to report to LE, should facilitate contact a community-based victim advocate and provide information regarding available support services and reporting options.[11],[8]
- Reports of pediatric assault are always reported to LE, as indicated by Idaho mandatory reporting laws.[14]

Advocacy

- Providers should call in victim advocacy at the beginning of the response, so a patient can make the decision to proceed with advocacy services or not.[8]
- Explain the role of the advocacy service. Examples of support may include:
    - Emotional support
    - Crisis intervention
    - Information regarding community resources
    - Assistance navigating healthcare and criminal justice systems
    - Safety planning
    - Follow-up support after discharge[8]
- Patients should be informed that advocates may also provide information, and assist with applying for, available financial assistance programs, such as Crime Victims Compensation (CVCP).[8],[16]
- Patients should be reassured that accepting advocacy services is voluntary. If a patient chooses not to engage with an advocate after contact is initiated or information is provided, that decision should be respected.[9]
- Written advocacy contact information and resource materials should be offered at discharge even if advocacy services are initially declined, as patients may choose to seek support at a later time.[8]

Timeframe for Evidence Collection

- Idaho recommendations for sexual assault evidence collection generally support collection up to 120 hours following the assault; however, timing considerations, laboratory acceptance criteria, patient circumstances, and evidence potential should be considered in accordance with current Idaho protocol.[12]
- Healthcare providers may determine that evidence collection beyond recommended collection windows remains clinically or forensically appropriate. When evidence collection occurs outside standard timeframes, the provider should document the rationale within the Patient Information and History section of the Sexual Assault Evidence Collection Kit (SAECK). Examples of rationale may include:

    - Significant patient distress regarding missed collection opportunities
    - Multiple assaults or repeated contact over time
    - Multiple perpetrators
    - Delayed disclosure with continued potential for evidentiary value
    - Clinical findings supporting continued collection[12]
- For suspected drug-facilitated sexual assault (DFSA), blood samples for forensic toxicology are generally most useful within approximately 24 hours following suspected ingestion when collection is indicated. When forensic toxicology samples are collected, urine collection should also be considered when appropriate.[12]
- Urine specimens for forensic toxicology may remain useful for a longer collection period than blood and may be considered up to approximately 120 hours following suspected ingestion depending on the substance involved.[13]
- Toxicology specimens intended for forensic analysis should be collected, packaged, documented, stored, and submitted according to current Idaho State Crime Laboratory procedures. Clinical toxicology testing performed by healthcare facilities may differ from forensic toxicology testing capabilities.[12]
- When collecting urine or other forensic specimens, providers should explain collection procedures and take reasonable measures to preserve potential biological evidence (collect the initial urine specimen prior to cleansing whenever feasible and avoid wiping after urination) while minimizing patient burden and maintaining dignity.[9],[13]

Medical Forensic Examination General Considerations

- Preservation of forensic evidence could be considered during medical evaluation and treatment. However, patient safety, medical assessment, stabilization, and treatment remain the priority.[12]
- Medical forensic documentation should be thorough and include appropriate history, review of systems, medications, allergies, patient-reported events as applicable, and physical findings relevant to medical and forensic care. Document observed injuries – or absence of findings – using narrative description, body diagrams, and photographic documentation when consented and appropriate.[12] Injury documentation should include location, size, shape, color, and appearance.[12]
- Patients presenting following sexual violence should be screened for possible strangulation using patient-centered language.[9] Examples may include asking whether the patient experienced difficulty breathing, pressure to the neck, voice changes, difficulty swallowing, dizziness, loss of consciousness, or other related symptoms. If strangulation concerns are identified, further medical assessment and imaging should be considered as clinically indicated.

Provider Considerations

Providers should use practices that reduce the potential for contamination of forensic evidence collection

- Secure facial hair and minimize shedding risks where applicable
- Wear clean protective coverings as appropriate (such as masks)
- Wear gloves and change gloves between evidence collection sites

- Minimize talking directly over evidence collection areas
- Follow evidence handling and packaging procedures to reduce contamination risk[12]
- Minimize unnecessary movement around evidence

Swabs should be dried in a protected, low-traffic environment for a minimum of 60 minutes.[12]

All examiners should use contamination prevention practices regardless of sex or gender to reduce introduction of extraneous DNA. If both patient and suspect examinations are performed, use separate examiners whenever feasible. If this is not possible, additional precautions should be taken to reduce contamination risk between examinations.[12]

Separate examination spaces should be used whenever feasible to reduce the possibility of cross-contamination.[12]

Room Considerations

Examination spaces should support privacy, safety, and trauma-informed care while accommodating the patient, support persons as desired, advocates, and clinical staff.[9],[12]

The environment should be designed to promote comfort, privacy, and patient-centered care whenever possible.[9]

Rooms and equipment should be cleaned and prepared between patients according to organizational infection prevention and evidence contamination prevention procedures.[12]

History

- Document patient's chief complaint and presenting concerns.[12]
- Avoid the term "alleged sexual assault" in medical documentation
    - "Alleged" is a legal term and is generally not used in the medical documentation of patient-reported events.[12] Documentation should reflect objective findings and the patient's statements.

Medical History

Assess and document

- Medical and surgical history
- Medications, allergies, and immunization status
- Vital signs
- Menstrual history (if applicable), birth control method(s), and recent sexually transmitted infection (STI) history
- Prior ano-genital surgery, injury, or conditions that may affect examination findings
- Existing injuries present before the assault[12]
- Document consensual sexual contact within the previous 5 days (including contact type and timing if known).[18]

- It is vital that consensual partners be identified to ensure exclusion from the CODIS database.[18]

Possible Drug-Facilitated Sexual Assault (DFSA)

Assess for symptoms or history suggestive of possible drug or alcohol-facilitated assault (because many substances used in suspected DFSA have relatively short detection windows, collect toxicology samples immediately after obtaining consent)[15]

Examples may include:

- Memory loss or gaps in recall
- Loss of consciousness or altered awareness (evaluate carefully, as the patient is not always aware that loss of consciousness occurred.)
- Unexpected intoxication relative to reported voluntary substance ingestion
- Extreme fatigue or sleepiness
- Vomiting
- Dizziness or confusion[15], [12]

Assault History

Obtain history sufficient to guide medical evaluation and forensic evidence collection.[12]

Type of contact:

- Oral, digital, genital, or other contact to areas of the patient's body (specify)
- Vaginal, anal, and/or oral penetration
- Non-genital contact (kissing, licking, sucking, biting, manual contact)[12]
  - Identification of areas may be enhanced with the use of an alternate light source[12]
- Use of foreign objects
- Ejaculation history and location of possible biological evidence
  - Patients may not know whether ejaculation occurred
- Use of a condom
- Use of lubricant (including saliva or other substance(s))[12]
- Date and time of assault
  - This may assist with timing of medications, toxicology, and evidence collection[12]
- General location of assault such as (not address):
  - "My bedroom"
  - "In the car"
    - May assist with injury interpretation and possible environmental exposure(s)[12]
- Identification of assailant(s) if known
  - This helps to assist in safety planning and forensic processes[9]
- Threats, coercion, restraint, or weapons used
  - Assists in determining the level of emotional trauma and safety evaluation

    - Assist with injury assessment[9]
- Physical violence and associated injuries
    - Type
    - Location
    - Patient description of events
- Patient actions during the event such as:
    - Scratching
    - Pushing away
    - Striking
        - This may inform evidence collection planning[12],[18]

Post-Assault Activity

Document activities that occurred after the event, including:

- Voiding
- Bathing/showering
- Changing clothes or underwear (including bras)
- Brushing teeth
- Eating/drinking
- Washing hands
- Wiping or cleansing body[12]

The activities do not preclude evidence collection, but should be documented in the "patient information" and "history" section of the SAECK to inform forensic scientists.[12]

Clothing Collection

Collect clothing worn during the assault, if possible. The patient must consent to collection. Let the patient know clothing items provided will not be returned.[12]

Collection and packaging

- Prepare a clean collection area using a protective barrier beneath the bindle sheet to reduce contamination.
- Place open evidence bags around the collection area before clothing removal. Avoid placing hands or arms inside evidence bags whenever possible to reduce potential transfer of examiner DNA.
- Ask the patient, when able and comfortable, to remove and place each article of clothing directly onto the bindle sheet or directly into the evidence bags.
- Package one clothing item per evidence bag, including socks, stockings, and undergarments.
- Label paired items separately when indicated (e.g., left and right socks).
- After collection is complete, carefully fold and package the bindle sheet in a separate evidence bag[15], [12]

- If the patient chooses to retain clothing but visible areas of concern exist (e.g., possible biological material), consider photographic documentation and/or swabbing as clinically and forensically appropriate. Use similar collection considerations for jewelry or personal items that may contain biological material.[12]

Consider collection of underwear worn after the event when clinically indicated, as transfer of biological material may still occur.[15], [12]

Documentation

Label clothing evidence. Documentation may include:

- Patient identifier (medical record number, patient number, case number, etc)
- Description of clothing item ("intact black sock from left foot")
- Observed staining or damage ("red shirt with 4cm x 7cm dark stain on lower portion near hem")
- Date and item collected
- Collector identification
- Chain of custody documentation[15], [12]

Patient Comfort and Discharge

- Protect patient dignity throughout clothing collection by offering privacy, gowns, coverings, and assistance as desired.[9],[12]
- Patients should be provided with replacement clothing prior to discharge whenever possible.[9]
    - Avoid sending patients home in scrubs, disposable clothing, etc.[9]
- Programs performing medical forensic examinations should maintain access to clean replacement clothing in a range of sizes.[12]
- Community advocacy organizations and community partners may assist with replacement clothing and basic needs when available.[9],[8]

Clothing Collection Visual Aid

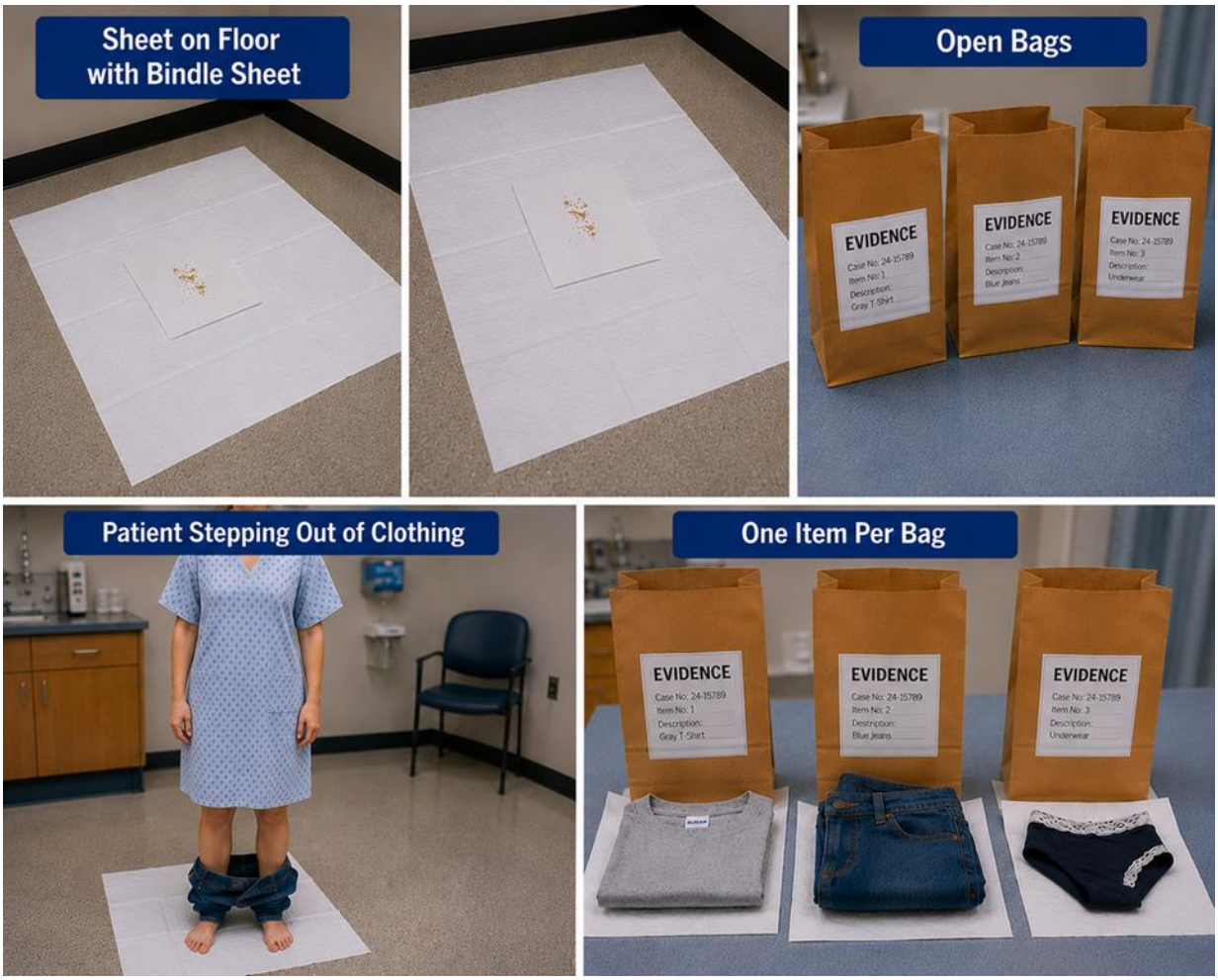


Figure 1: Clothing collection visual aid. Illustrated using AI and reviewed for accuracy by ISPFS

Examination

Following clothing collection (when performed), conduct a medical forensic examination guided by patient consent, clinical findings, reported history, and evidence collection goals.[10],[12] Examination should occur in conjunction with documentation, forensic photography (when consented), and evidence collection.[12]

Perform a systematic examination. A common approach is assessment from scalp to waist, posterior body assessment as indicated, lower extremities, and completion with the ano-genital examination.[12]

When injuries or areas of concern are identified, document findings, obtain forensic photographs (when consented), and collect evidence swabs as indicated (see "Swabbing").[12],[15]

Examination procedures should be explained before initiation and consent should be confirmed throughout the encounter.[9],[10]

* Special consideration should be given to adults who have never previously undergone a speculum examination. Avoid unnecessary speculum examinations and perform them only when clinically indicated and with patient consent.[10],[12]

Inspect for Injury

- Photograph injuries and findings:
    - Photograph injury and non-injury body areas per your organization's policy/protocol
    - Refer to forensic photograph recommendations in following section[10],[12]
- Collect evidence swabs from appropriate injuries and areas of concern. (See "swabbing" section.)[15]
- Assess posterior body surfaces, including back, buttocks, and posterior lower extremities.[12]
- Perform systematic examination of:
    - Scalp and hair
    - Head and face (including oral cavity, ears (including the canals and postauricular areas), and conjunctivae
    - Neck, shoulders, and chest
    - Upper and lower extremities
    - Ano-genital region
    - Recognize that biological material may be present on the inner thighs[12]
- Consider assessment of inner thighs and surrounding skin for possible transfer of biological material.[15]
- Swab areas identified by the patient as feeling "wet", "sticky", "painful", or otherwise concerning, even when no visible findings are present.[9],[15]

Ano-Genital Examination Considerations

- Internal examination procedures should be guided by patient consent, developmental considerations, symptoms, injury assessment, and clinical indication[10],[12]
- Speculum examinations should occur when medically or forensically indicated and appropriate for the patient[12]
    - Routine insertion of instruments (speculum, swabs, etc.) into the vagina of a prepubertal child **is not recommended**. When an internal examination is clinically indicated, consultation with an appropriately trained pediatric specialist should occur[12]
- If examination findings suggest internal injury requiring additional evaluation or treatment, consider patient comfort, prior examination history, developmental status, and consultation as clinically indicated[9],[12]
- Patients with non-estrogenized genital tissue (including many prepubertal and post-menopausal patients) may experience increased discomfort or tissue sensitivity and should be examined using age- and condition-appropriate techniques[12]
- Patients with gender-diverse anatomy, surgical reconstruction, hormone-related tissue changes, or increased tissue fragility may require individualized examination approaches[9],[12]
- When clinically indicated and consented, obtain photographic documentation of external genital findings before internal examination procedures when possible[10],[12]

Forensic Photography

- Obtain written informed consent before obtaining forensic photographs. Consent discussions should include intended use, storage, release procedures, and organizational policy regarding photography[10,12]
- When photographs are obtained for forensic purposes, complete photography before evidence swabbing whenever possible[12]

General Photography Sequence

Follow patient consent and organizational protocol(s).[10,12]

- Bookend photograph (picture of patient ID)
    - Full-body and facial photographs for identification are no longer recommended[12]
- Photograph clothing findings when clinically or forensically indicated, including visible tears, staining, damage, or other relevant findings[12,15]
- Injury photography
    - Photograph injuries systematically
        - Orientation photograph: capture sufficient surrounding anatomy to identify injury location and laterality
        - Close up photograph: fill the frame with the injury while maintaining focus and image quality
        - Measurement photograph: obtain an additional image with an approved forensic measurement scale (ABFO ruler)[12]
            - Position the ruler adjacent to – not covering – the injury
- Ano-genital photography
    - Obtain orientation photograph sufficient to document anatomy and location
    - Use visualization techniques (separation and traction) to assess and document findings
    - Photograph genital injuries using focused close-up images
        - Routine ruler photographs for genital findings are not recommended
    - Internal photographs (including cervical images) should be taken through the speculum for optimal visualization[10,12]
- Complete photo series with second bookend photograph (same as beginning bookend photo)[12]

Photography Storage

Programs are encouraged to establish standardized procedures for obtaining, storing, securing, retaining, and releasing forensic photographs obtained during Sexual Assault Medical Forensic Examinations.

Sample Photography Policy

This sample policy is intended as a template. Organizations should review and adapt it in consultation with legal counsel, health information management, information technology, and local multidisciplinary partners to ensure compliance with organizational practices and applicable law.

1. Consent for Photography

The patient shall be offered forensic photography as a component of the medical forensic examination.

Written consent should be obtained specifically for:

- Medical forensic photography
- Storage of images
- Release of images
- Use for peer review/quality improvement (if applicable)
- Separate authorization for education/training use

Patients may:

- Decline all photography
- Limit photography to certain body areas
- Withdraw consent prior to image transfer if allowed by law/policy

Photography decisions should not affect access to medical care or evidence collection.

2. Image Capture Standards

Images should:

- Be captured only using facility-approved forensic equipment
- Never be stored on personal devices
- Include patient identifier and date according to facility protocol
- Follow orientation → mid-range → close-up → close-up with scale methodology
- Be documented in the medical record

Programs often require multiple views and scale use for injury documentation.

3. Storage and Security

All forensic photographs shall be uploaded immediately to an approved secure storage platform and removed from the capture device following successful upload verification.

Storage controls:

- Encrypted storage
- Access restricted to authorized personnel
- Audit logs enabled
- No storage on:
    - personal phones
    - removable drives
    - email
    - unsecured folders

- cloud services not approved by the organization

Photographs generally become part of the medical forensic documentation and should be retained according to medical record retention requirements and applicable state law.

4. Release to Law Enforcement

Reported Adult/Adolescent Cases

Forensic photographs may be released:

- with written patient authorization
- as permitted under applicable law
- through established evidence transfer procedures
- or pursuant to legal process

Transfer should be documented using:

- date/time
- receiving agency/person
- method of transfer
- image inventory
- signatures

Non-Reported / Anonymous / Information-Only Exams

Forensic photographs shall not be released to law enforcement without:

- patient authorization
- mandatory reporting obligation; or
- legal order

Pediatric / Mandatory Reporting Cases

Release and access shall follow:

- mandatory reporting statutes
- child protection requirements
- organizational policy

Original photos must be maintained with the original patient chart and stored per policy outlined in section 3 above.

5. Chain of Custody

If photographs are transferred outside the electronic medical record, or other storage device containing original photos:

Maintain documentation of:

- who captured images
- storage location
- transfer dates
- recipient
- method of transfer
- access history

6. Quality Improvement and Education

Images used for:

- peer review
- competency assessment
- education
- presentations
- publications

must be separately authorized or de-identified according to policy.

Supporting Standard 1: This sample policy was developed using nationally recognized evidence-informed guidance and evidence-informed practices for sexual assault medical forensic examinations. Individual organizations should adapt this policy to align with applicable federal and state law, organizational procedures, medical record requirements, and evidence retention practices.

• U.S. Department of Justice Office on Violence Against Women. A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents, Second Edition.

• U.S. Department of Justice Office on Violence Against Women. Sexual Assault Medical Forensic Examination (SAFE) Program information and implementation resources.

• Organizational medical record retention and release policies.

• Organizational evidence handling and chain-of-custody procedures.

• Applicable federal and state privacy, disclosure, and records requirements.

• Applicable sexual assault evidence collection, storage, and transfer requirements.

Photography Visual Aid

Figure 2: Forensic photography guide: Illustration generated using AI and reviewed for content accuracy by ISPFS

Sexual Assault Evidence Collection Kits (SAECK)

Idaho State Police Forensic Services (ISPFS) provides standardized evidence collection kits to support medical forensic examinations. Instructions are included within each kit and should be followed in conjunction with current Idaho protocols.[15]

Available kits may include:

- Sexual Assault Evidence Collection Kit (SAECK)
- Urine toxicology kit
- Blood toxicology kit[15]

Sexual Assault Evidence Collection Kit

- Verify kit integrity and all applicable expiration dates before opening.[15]
- Open the sealed kit immediately prior to use
    - If sterile water vial has expired, replace it with one from stock or hospital supply. Document that you have done this, and proceed using the kit[15]
    - Document kit number in the medical record. Once opened, maintain chain of custody throughout collection, storage, transfer, and disposition[15]
- Verify kit contents according to current kit instructions, which may include:
    - Patient Information and History Form
    - Victim Notification and Tracking Form
    - Collection Instructions
    - Blue FDA insert discussing expiration date (keep insert in box)
    - Evidence envelopes:
        - Foreign Matter Collection
        - Pubic Hair Combings
        - Other Swabs (x2)
        - Vaginal Swabs
        - Anal Swabs
        - Oral Swabs
        - External Genitalia Swabs
        - Known Blood Sample (patient reference bloodspot card)
    - Sterile water vial (verify expiration)
    - Two evidence tape labels[15]

Urine Toxicology Kit

Generally may remain useful up to approximately 120 hours following suspected ingestion depending on substance and protocol[15]

- Collect first voided urine, if possible
    - Sample should be the initial urine specimen collected prior to cleansing
    - Obtain a minimum of 30 mL, if possible[15]

- Place on ice or refrigerate
    - When given to law enforcement, remind them to keep specimen refrigerated or frozen[15]
- Patient should avoid wiping after voiding
    - If patient must wipe, have them use a 4x4 gauze to pat genitalia dry and package the gauze in an evidence envelope from the SAECK
        - Do not package the gauze with the urine kit or submit for toxicology testing[12,15]

Blood Toxicology Kit

Collect if suspected ingestion has occurred within 24 hours[15]

- Use kit supplies and follow included instructions
- Clean collection site using the approved non-alcohol prep contained in the SAECK, or an approved alternative if an allergy exists
    - Document any substitutions[15]
- Use the provided 10 mL grey-topped tubes
    - Check expiration date(s)
    - Do not substitute a hospital grey-top tube, as they do not contain the correct preservatives
    - Fill tubes fully
    - Gently invert according to manufacturer recommendations[15]
- Label with the patient's name, birthdate, collectors name, and date and time of collection[15]
- Place tube(s) in biohazard bag (leave absorbent sheet in bag) and zip shut
- Place biohazard bag in kit box, close, and seal with evidence tape[15]
- Always submit a urine sample when a blood sample is collected for toxicology[15]
- Keep tube refrigerated, or on ice until ready to give to law enforcement (LE). Remind LE to keep blood refrigerated – Not frozen[15]

Collection of Evidence

Evidence collection should be guided by:

- Patient history
- Reported contact
- Clinical findings
- Patient goals and consent
- Potential evidentiary value[10,12]

Collect evidence from anatomical sites where body contact, transfer of biological material, injury, or environmental transfer may reasonably have occurred.[15]

When history is limited or memory is incomplete, providers may consider collection from commonly involved evidence sites.[9,12]

Examples may include:

- Oral (mouth)
- Perioral area (possible saliva from kissing, sucking, or biting)
- Neck (possible saliva from kissing, sucking, or biting)
- Chest and breasts (possible saliva from kissing, sucking, or biting)
- Inner thighs (possible saliva from kissing, sucking, or biting and/or semen from possible ejaculation)
- External genitalia (possible saliva from kissing, sucking, or biting and/or semen from possible ejaculation)
- Vagina/cervix (one specimen)
- Any injury that may have been created by aggressive skin-to-skin contact (apparent finger pad marks on the neck, slap marks anywhere) and any suspected bite injury.
- Collect any foreign debris seen
- Collect pubic hair combing if pubic hair is present
- Patient reference sample[15],[18]

SAECK Visual Aid

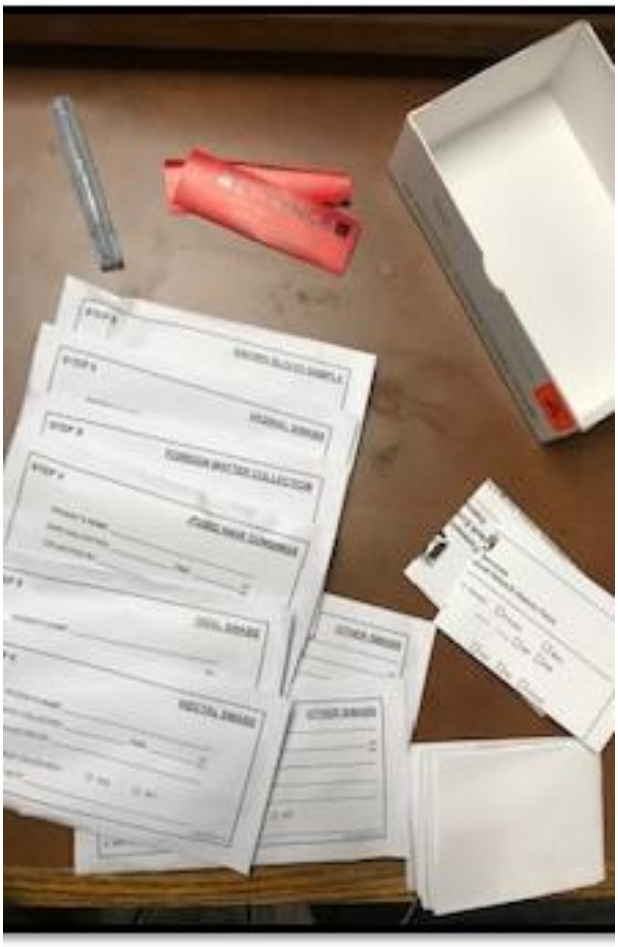


Figure 3: Photo of SAECK contents provided by ISPFS

Toxicology Collection Visual Aid

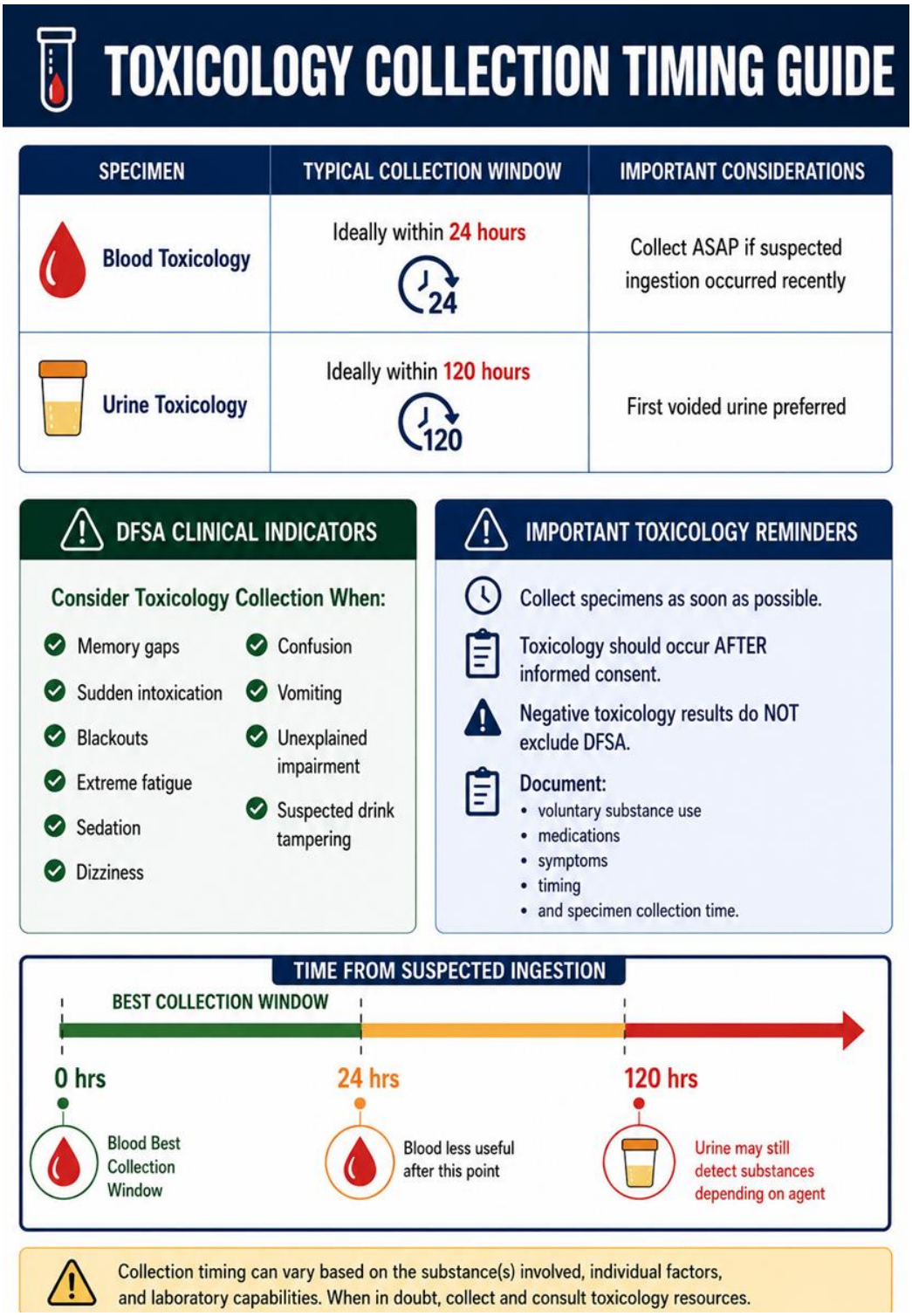


Figure 4: Toxicology Collection Timing Guide: Illustration generated using AI and reviewed for content accuracy by ISPFS

Swabbing & Other Evidence Collection

General Principles

Evidence collection should follow current Sexual Assault Evidence Collection Kit (SAECK) instructions and be guided by patient history, consent, examination findings, and potential evidentiary value.[10],[12],[15]

- Use four (4) dry swabs when collecting specimens from body cavities
    - Do not use more than four swabs in any body cavity
    - Collect 2 swabs at a time
- Two (2) damp swabs are to be used for non-cavity site collections
    - To dampen swabs, apply one to two drops of sterile water to the swab – using more may wash DNA away
    - Do not use fewer than two swabs for non-cavity areas
- Open only the evidence collection envelope for the site currently being collected, do not open all envelopes at one time
    - Open the swab package and use markers to color code the handles of the swabs about one inch from end of swab; make a swipe of color with the marker on the envelope
    - When reassembling the SAECK ensure the correctly colored handles are placed in the envelope with the same swipe of color – this ensures the correct swabs are placed in the correct envelopes
- Use two (2) swabs at a time, held a slight distance apart
    - Swab over the area to be collected using light pressure and a twirling motion to ensure all sides and the tip of each swab makes contact with the area being swabbed.
    - Do not "scrub" the area being swabbed.
        - Light pressure is all that is needed to collect DNA. Too much pressure will collect excessive amounts of the patient's DNA, which may overwhelm the assailant's DNA, making identification difficult or impossible.[15]
- Oral swabs
    - Use one (1) swab at a time, gently trace gumline at top of each tooth
        - swab every tooth in the mouth: front and back of top and bottom teeth
            - secretions migrate to crevices
            - be gentle and do not cause bleeding or discomfort while swabbing
    - Swab under tongue and over hard palate
        - Do not swab soft palate (may cause gagging)
    - Repeat swabbing of the same areas with three (3) additional swabs (one at a time)[15]
- Foreign matter
    - Collect any material present on the patient's body and place in evidence envelope, labeling envelope with name of material ("fiber", "hair", etc.) and the location where the foreign matter was found.
        - If two pieces of the same evidence (example: 2 or more pieces of hair) are found, collect each in a separate bindle sheet (can use clean white copy paper and fold into a bindle)
            - Label bindles as #1, #2, etc
            - Place each bindle sheet in the "foreign matter" envelope and note:
                - #1: hair from breast

        - #2: Hair from external genitalia
            - Differing pieces of foreign matter (twig, grass, etc) may be placed in the same bindle sheet[15]
- Pubic hair
    - If the patient has pubic hair use the bindle sheet/comb in the evidence envelope and collect any loose debris that may be present by placing the bindle sheet under the patient's buttocks and combing through the pubic hair. Return bindle sheet and comb to evidence envelope.[15]
- External genitalia (without penis and scrotum)
    - Swab if there is any reported contact (digital or penile)
    - Use two (2) damp swabs to swab the following:
        - Mons – to – anus, including clitoral hood, labia majora and minora, fossa navicularis, posterior fourchette, perineum
- External genitalia (with penis and scrotum)
    - Two (2) damp swabs:
        - Glans and shaft of penis
            - Ensure evidence envelope is labelled as penile (you may need to cross out "vaginal" envelope and write "penile" or you may need to circle "penile" depending on the date of your kit
    - Two (2) new damp swabs:
        - Entire scrotum
            - Use "other" envelope and relabel as "scrotum"[12,15]
- Vaginal cavity
    - Use four (4) dry swabs:
        - Walls of vagina
        - Place tip of swab at cervical os for about 10 seconds to wick up secretions. Do not insert into cervical os
        - If injury is noted, continue to use the same swabs
    - Speculum exam
        - Small amount of lubricant can be used
            - Document type of lubricant used
        - Use caution in individuals who have never had a speculum exam
        - Never to be done on prepubescent females
        - If speculum exam is not tolerated, or if patient declines, blind swabbing of the vaginal cavity is acceptable[10,12,15]
- External anal
    - Use two (2) damp swabs to swab around the anal opening and on around anal folds
    - Label as external anal swabs

- Internal anal
    - If anal penetration is reported, use four (4) swabs to collect internal anus specimens to the line of dentate
    - Use traction until anal sphincter relaxes
        - Gently insert two (2) swabs at a time, no more than 1 inch into the anus.
        - Rotate gently within the anal canal at the level of the dentate line
            - Repeat with other 2 swabs[15]
- Hands and fingernails

    - Use two (2) damp swabs to swab entire palm of hand including all surfaces of each finger and under each fingernail
    - Each hand will be swabbed as one body site
    - Label evidence envelopes as "left hand and fingernails" and "right hand and fingernails"[15]
- Other
    - Additional areas for swabbing will be dependent on patient history
    - Swab any injury or body area that had oral (sucking, biting) or ejaculate contact[15]

- Manual Contact Swabs
    - Swab any area of aggressive, prolonged, or vigorous skin-to-skin contact (strangulation, manual restraint of wrists or heels, an injury from a slap or fist, etc.); use a "other" envelope and label as "manual contact" and note area swabbed.[9,15]

- Digital penetration
    - If there was no genital-to-genital contact, or oral-genital contact, but digital touch/penetration was reported, swab the external genitalia and vagina (as noted above), or the penis/scrotum. Using a "other" envelope, label it "digital penetration" and note location of collection.[15]
- Patient reference sample
    - Use the lancet to collect the Bloodspot Card, let dry completely
    - You may use a butterfly instead of the lancet, if preferred
    - If labs are being drawn ask the phlebotomist to give you 2ml for the Bloodspot Card
    - Do NOT use buccal swabs for the patient reference sample; the lab considers ALL swabs submitted in the SAECK as evidence swabs
    - Mark front of SAECK indicating whether or not this sample was collected[15,18]

Adjuncts to Collection

- Alternate light source (ALS)
    - ALS may be used to assist identification of areas for further evaluation or evidence collection
    - Areas identified may be documented and swabbed
    - Lack of fluorescence does not exclude evidence. The provider may choose to swab areas without use of ALS[12,15]
- Toluidine blue dye (TBD)
    - May be used at the discretion of the provider to increase visibility of an injury that is present but difficult to see/photograph with the naked eye
    - Photo documentation and external swabs of genitalia need to be completed prior to TBD application and speculum insertion
        - Additional photo documentation is recommended following the TBD application
            - Photograph, apply, photograph, remove dye, photograph[10,12]
- Foley catheter for hymenal visualization
    - If it is difficult to visualize the edges of the hymen, insert a foley about three inches into the vagina, inflate the balloon according to current clinical guidance and catheter

manufacturer recommendations; the hymen will drape on the foley bulb, and its margins will be easily visible[12]

Reassembling Kit

Swabs

- After swabbing, swabs must be air-dried (in a protected environment without forced airflow– do not use swab dryer fan) for a minimum of 60 minutes[15]
- Document the time each set of swabs is collected on the evidence envelope and document time of packaging swabs in the medical record[15]
- After drying, place swabs in corresponding evidence envelope. Swabs should be completely dry before packaging[15]
- Ensure each envelope is labeled with the body site that was swabbed (some pre-printed envelopes are included in the SAECK) and fill out ALL requested information on the envelope. Marking "yes" to 'was sample collected?' assures the forensic scientist that even though the swabs may appear unused, the evidence has been collected. Unused envelopes are not to be returned to the Crime Lab. Sign or initial across sealed flap[15]

Peri-pads

- Do not fold in on itself
- Place sticky side on plain piece of paper, air dried for at least 60 minutes, then place in a small, paper evidence bag (do not place in SAECK)
- Label as "wet"
    - Inform law enforcement of wet contents when they pick up the evidence kit.[15]

Tampons

- Place in a plastic urine cup with holes punched in the lid
- Place in a small, paper evidence bag (do not place in SAECK)
- Label as "wet"
    - Inform law enforcement of wet contents when they pick up the evidence kit.[15]

Paperwork

- Complete the patient information and history form that is included in the Sexual Assault Evidence Collection Kit, providing enough detail about all body contact that the forensic scientists can determine probative value.[15]

Kit

- Return all sealed evidence envelopes, blood stain card and completed patient information and history form back into kit
- Label, date, time, seal with provided evidence tape and initial
- Complete chain of custody information located on the outside of the kit.[15]

Packaging Wet Evidence Visual Aid

Figure 5: Packaging Wet Evidence Visual Aid: Illustration generated using AI and reviewed for content accuracy by ISPFS

Swab Drying and Packaging Workflow Visual Aid

Figure 6: Swab drying and packaging workflow: Illustration generated using AI and reviewed for content accuracy by ISPFS

Color-Coded Swabs Visual Aid

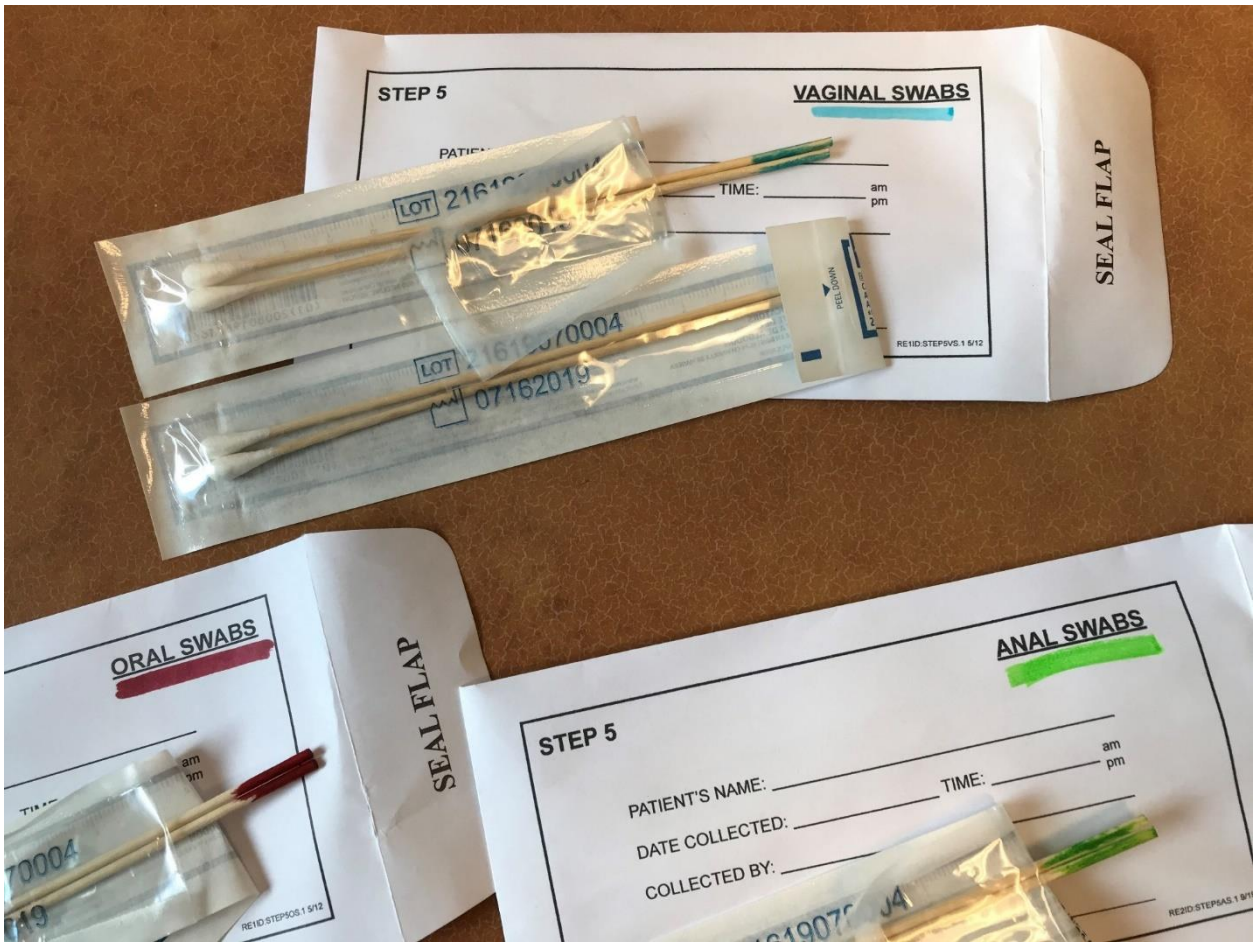


Figure 7: Color-coded swabs visual aid: Provided by ISPFS

Chain of Custody

- Maintain chain of custody for all specimens in accordance with established protocols governing sexual assault forensic evidence collection and handling. Attention must be paid to cautious handling of any material collected for potential evidence. The examiner collecting the evidence should maintain continuous custody of the evidence until responsibility is formally transferred to the receiving law enforcement agency or another authorized individual, with documentation of the transfer.[15]
- Once opened, the evidence collection kit and collected evidence should remain under the continuous control of the examiner or other authorized healthcare provider until collection is complete and custody is formally transferred. Evidence should not be left unattended.[15]
- If patient care is transferred to another qualified examiner, custody of all collected evidence should be formally transferred at the same time. The chain-of-custody documentation should include the date, time, individuals involved in the transfer, and required signatures in accordance with kit instructions and organizational policy.[15]

Any unexplained break in documented chain of custody may affect the evidentiary value of collected specimens. Examiners should document all transfers promptly, completely, and accurately.

Chain of Custody Visual Aid

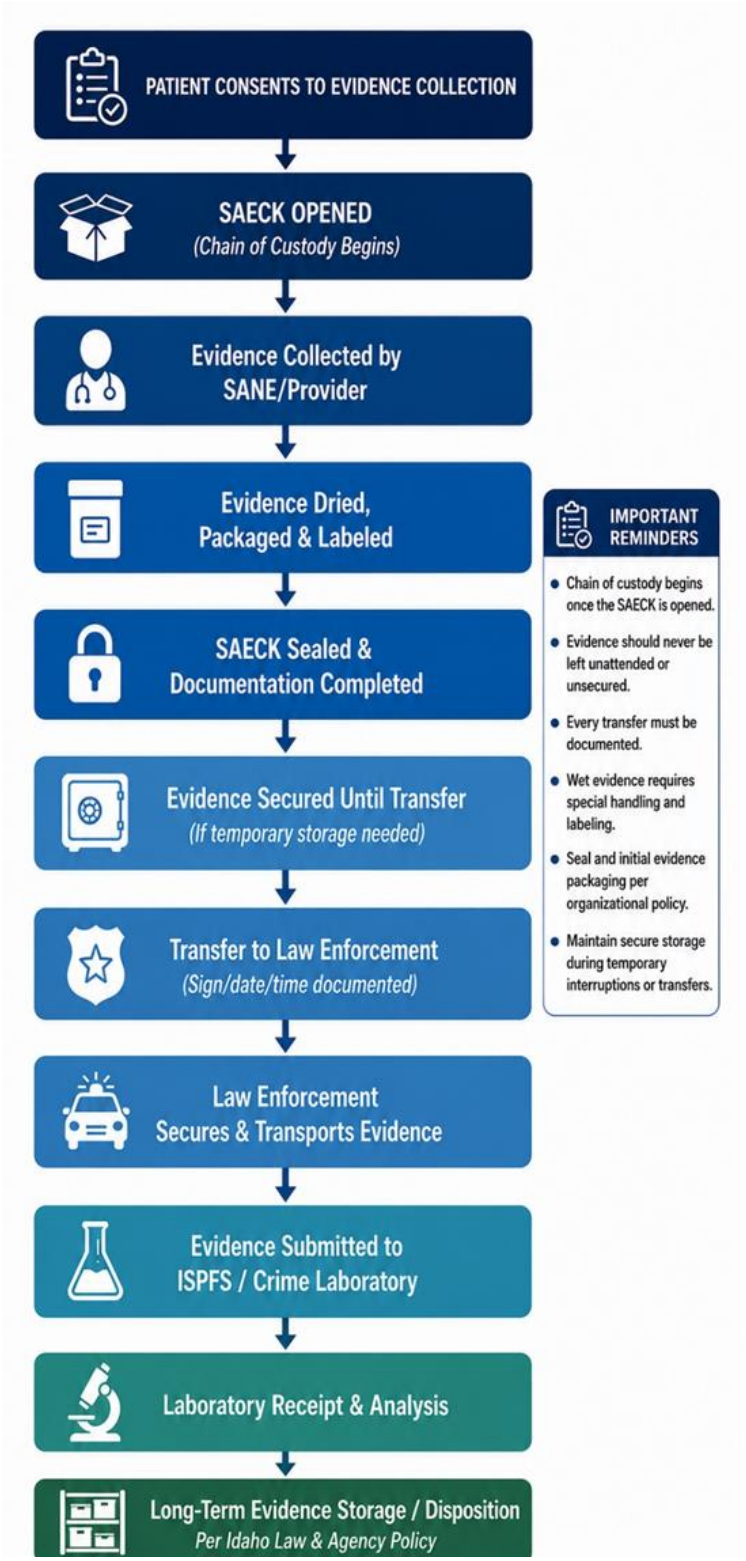


Figure 8: Chain of custody visual aid: Illustration generated using AI and reviewed for content accuracy by ISPFS

Medication and Treatment Considerations

Medical treatment should be individualized based on patient history, clinical findings, timing of presentation, patient goals, consent, pregnancy risk, exposure concerns, and applicable clinical recommendations.[9],[10],[17]

Depending on patient presentation and clinical judgment, treatment considerations may include:

- Tetanus immunization assessment and update when indicated
- Hepatitis B vaccination and/or follow-up recommendations when indicated
- Symptom management (e.g., nausea, pain, psychological support, as appropriate)
- Sexually transmitted infection (STI) evaluation and prophylactic treatment when indicated
- Pregnancy assessment and emergency contraception when indicated
- HIV exposure assessment and consideration of post-exposure prophylaxis (PEP) when indicated
- Medical evaluation and imaging for strangulation or other traumatic injury when clinically indicated
- Referral and follow-up planning for ongoing medical, mental health, and supportive care needs[17]

Risks, benefits, alternatives, and follow-up recommendations should be discussed with the patient prior to treatment whenever possible.[9],[10]

Medication administration, patient decisions, declined treatment, and discharge instructions should be documented in the medical record.[10],[12]

Follow current CDC recommendations, applicable organizational policies, and local protocols regarding treatment recommendations, STI prophylaxis, HIV post-exposure management, and pregnancy prevention.[17]

Discharge and Aftercare

Review discharge instructions directly with the patient whenever possible. Family members, support persons, or caregivers should only participate in discharge discussions with patient permission or as otherwise required by law.[9],[10]

Consider individualized discharge and communication planning for patients experiencing intimate partner violence, domestic violence, stalking, trafficking, coercive control, or other safety concerns. Discuss safe methods for follow-up communication and determine whether written materials, voicemail, text messaging, mail, or electronic communication create safety concerns.[9],[8]

Provide discharge instructions in accordance with organizational policy and patient needs. When available and appropriate, provide sexual assault-specific discharge instructions and additional instructions related to identified injuries or conditions[17] (e.g., strangulation).

Assess for ongoing safety concerns and complete lethality, danger, or violence risk assessment according to organizational policy and available tools (e.g., IRAD or local assessment processes). Advocacy personnel may assist with this process where available.[9],[8]

Screen for suicide risk, emotional distress, and behavioral health concerns according to organizational policy. Patients with identified concerns should receive appropriate intervention, referral, crisis resources, or emergent evaluation as indicated.[9],[17]

Recommend follow-up with a healthcare provider, clinic, or primary care provider within approximately 2–3 weeks, or sooner if symptoms, injuries, or concerns develop.[17]

Follow-up considerations may include:

- Evaluation for sexually transmitted infections (STIs)
- Pregnancy testing and follow-up
- Medication review and adverse effects
- HIV follow-up and monitoring when indicated
- Review of healing and injury progression
- Ongoing behavioral health support[17]

Referral to public health, infectious disease, HIV, or specialty services as indicated.[17]

Provide referrals for counseling services, victim advocacy, community resources, and other supportive services as available.[9],[8]

Provide patients with applicable victim notification materials, evidence tracking information, and instructions for accessing kit status information when available.[15]

Provide information regarding law enforcement follow-up and reporting options when applicable and desired by the patient.[9],[11]

Sample Discharge Instructions

The following sample discharge instructions are provided as a template. Healthcare organizations should modify the content to align with current clinical guidelines, organizational policies, local resources, and patient-specific needs.

Today's visit included:

☐Medical evaluation
☐Forensic examination
☐Evidence collection
☐Photography
☐STI prophylaxis
☐Emergency contraception
☐HIV PEP counseling
☐Advocacy services offered
☐Safety planning discussed

Medications provided today:

Antibiotics / STI Prevention	Emergency Contraception	HIV Post-Exposure Prophylaxis
☐Ceftriaxone ☐Doxycycline ☐Azithromycin ☐Metronidazole ☐ Other:_____	☐Levonorgestrel	☐HIV PEP started today ☐HIV PEP declined ☐Referral provided

Other Medications

_____

_____

Important Medication Information

- Take medications exactly as prescribed.
- Complete all antibiotics even if symptoms improve.
- Avoid alcohol while taking metronidazole and for at least 24 hours after completion.
- Doxycycline may increase sun sensitivity.
- Contact your healthcare provider if severe side effects occur.

Follow-Up Recommendations

Please follow up with your healthcare provider or clinic for:

☐STI testing/follow-up
☐Repeat pregnancy testing
☐HIV testing
☐Injury reassessment
☐Behavioral health/counseling
☐Primary care follow-up
☐Additional forensic follow-up needed

Other/Comments:

_____
_____
_____

Seek immediate medical care if you experience:

- difficulty breathing
- chest pain
- worsening neck swelling
- difficulty swallowing
- severe abdominal pain
- heavy vaginal bleeding
- severe allergic reaction
- suicidal thoughts
- worsening emotional distress
- or any concerning new symptoms

Important Reminders:

- It is common to experience emotional reactions after trauma
- Healing may take time
- You are not responsible for the assault
- Support services are available even if you choose not to report to law enforcement

Resources/Contacts

Advocate/Crisis Services	
Law enforcement contact	
Medical Follow-up	

Crime Victims Compensation Program	https://crimevictimcomp.idaho.gov/ Phone: 208-334-6080

Patient Acknowledgement

Patient received:

☐Verbal discharge instructions

☐Written discharge instructions

☐Medication education

☐Follow-up recommendations

☐Resource information

Provider Signature: _____

Date: _____

Pediatric Considerations

All suspected cases of sexual or physical assault of a minor (under 18 years of age) must be reported to Law Enforcement and/or CPS, regardless of the wishes of the minor or parent/guardian.[14],[12]

Except as otherwise permitted by law, informed consent for medical forensic examination and treatment of a minor should be obtained from the minor's parent or legal guardian in accordance with Idaho law and organizational policy[12]

Preferred personnel to be involved in pediatric cases include:

- Provider experienced in medical care of the pediatric patient
- Law Enforcement and CPS (mandated reports)
- Advocacy – for both the child and parent/guardian
- Pediatric forensic interviewer
- This may require transfer to a site that specializes in this care, such as CARES, or a Child Advocacy Center; organizations should have a referral pattern established to care for these patients.[12],[8],[14]

Consent for the MFE must be obtained from the minor's parent or guardian.[12]

A medical screening examination will be completed prior to a forensic interview or exam to ensure the child is medically stable.[12]

If any evidence is collected at the medical center prior to the forensic interview/examination, it shall be properly preserved and protected under the Chain of Custody.[15],[15]

Forensic interviews may be performed by the CARES team (Children at Risk Evaluation Services, Boise) or other Child Advocacy Center, Law Enforcement, and/or Child Protective Services by specifically trained personnel.[12]

- Forensic interviews are not usually considered emergent and should be scheduled for family convenience and with respect for the child's physical and emotional well-being. Whenever feasible, the forensic interview should occur before the medical forensic examination when this will not delay necessary medical evaluation or treatment.[12]

The pediatric patient must assent to all portions of the procedure to prevent re-traumatization.
Organizations may use age-appropriate child abuse screening tools. Assessment for violence within the child's household or caregiving environment should follow organizational policy when appropriate. Identified concerns will be reported to the proper agency according to law.[9],[12]

If a patient makes a disclosure of sexual abuse or is discovered to be a victim of sexual abuse while admitted to the hospital, the social worker or designated staff will notify Child Protective Services and Law Enforcement. Collaboration with a SANE is highly recommended.[12],[14]

In general, triage of pediatric victims of reported sexual abuse or assault should be performed as follows:

- Emergent evaluation may be indicated for:

- Acute sexual contact within recommended evidence collection windows
- Active bleeding
- Significant pain
- Concern about injury
- Medical instability
- Safety concerns requiring immediate intervention[12]

Scheduled or outpatient evaluation may be appropriate for:

- Delayed disclosure
- Concerns outside acute evidence collection windows
- Follow-up assessment and support services[12]

Organizations, preferably in collaboration with local SART and pediatric partners, should establish age-specific referral and response pathways.[12]

Providers with questions regarding pediatric sexual abuse or assault response should consult local pediatric forensic resources, pediatric specialists, established referral centers, or state consultation resources according to organizational protocol.[12]

Prison Rape Elimination Act (PREA)

Prison Rape Elimination Act & Confinement Settings Sexual Assault

General Information

The Prison Rape Elimination Act (PREA), enacted in 2003, established national standards to prevent, detect, and respond to sexual abuse and sexual harassment in confinement settings.[19]

Idaho Department of Correction facilities and Idaho county jails implement PREA standards. In order to certify, law enforcement, victim service providers, and medical staff must adhere to the Prison Rape Elimination Act standards when responding and/or investigating sexual assault in Idaho's confinement settings.[19]

Standards relating to the Official Response following an Inmate report §115.61- §115.68, Investigations §115.71-§115.73 and Medical and Mental Care §115.81-§115.83 can be found on the National PREA Resource Center website www.prearesourcecenter.org.[19]

The purpose of this chapter is to ensure law enforcement, victim service providers, and medical staff are knowledgeable and compliant with PREA standards which are designed to deliver the same level of trauma-informed care to victims in custody as those who are not. The standards take into consideration the unique obstacles victims in custody experience which include but are not limited to being exposed daily to their abuser and/or location of abuse. Victims not in custody may have similar obstacles, however confinement limits a victim's ability to avoid these triggers of sexual trauma symptoms. Additional information and resources on PREA are listed below.[9],[19]

Uniform Evidence Protocol for Examination and Investigation

All correction agencies or facilities in Idaho shall report any potentially criminal conduct to the appropriate law enforcement agency and**,** if an external agency is requested for investigation**,** shall inform that agency of the requirement to use a uniform evidence protocol in the investigation.[15],[19] The investigation shall ensure the healthcare needs of the victim are met and evidence is collected in a manner to properly preserve it, through a coordinated, multi-disciplinary response that is victim-centered, trauma-informed, and that considers the impact of neurobiology of trauma on the victim. The coordinated response will allow the needs of the victim to be met, while promoting the criminal justice system response.[9],[12],[19] The following recommendations are from *A National Standard Protocol for Medical Forensic Examinations, 2nd ed., April 2013*.

Investigation

The investigation of a reported sexual assault must be commenced in a timely fashion, i.e., as soon as logistically possible to preserve evidence from the scene, the victim, and the possible perpetrator. Care should be taken to prevent any alterations in the scene of assault with collection of physical evidence by prevention of access to the scene by anyone until law enforcement/trained investigator is able to process the scene and collect physical evidence.[15], [19] The investigator will determine the interviews

necessary to collect all possible evidence related to the assault; those shall be completed in a trauma-informed manner and with regard for the neurobiological effects of trauma.[9],[12], [19]

Every effort is to be made to prevent the victim and suspect from engaging in any hygiene activities that could degrade DNA, such as bathing, douching, handwashing, using enemas, using mouthwash or brushing teeth, or washing clothing/bedding. If a urine sample is needed attempt to have specimen collected before victim voids. *If hygiene activities have taken place post-assault evidence swabs should still be taken.*[12]

Medical Forensic Examinations

Medical forensic examinations will be offered to all residents/inmates who report sexual assault/abuse; those examinations will be performed by healthcare providers with specialized training in the care of sexual assault patients and may be a SANE (Sexual Assault Nurse Examiner) or SAFE (Sexual Assault Forensic Examiner). When a resident/inmate is a pediatric victim, healthcare providers trained in the provision of pediatric medical forensic care will be utilized, if possible.[12],[19]

The medical forensic examination consists of obtaining a forensic medical history which will guide the healthcare provider to assess and treat acute medical needs after sexual assault, including treatment for possible sexually transmitted infections and possible pregnancy risk (as indicated). The healthcare provider will provide education related to care after the assault, including medical follow-up and referrals for mental and emotional well-being.[9],[12]

Once all immediate healthcare concerns are addressed the SANE/SAFE will collect and preserve forensic evidence if consent for the same is given by the resident/inmate.[10],[9], [12]

Suspect exams will be performed by healthcare providers with specialized training in the care of sexual assault patients and may be a SANE (Sexual Assault Nurse Examiner) or SAFE (Sexual Assault Forensic Examiner) or trained investigator. It is highly preferable that separate examiners conduct the exams on victim and suspect; when that is not possible every effort will be made to ensure the victim and suspect exams are conducted in separate spaces so no possibility of cross-contamination can occur. [12],[15], [19] At no time should the victim and suspect be in contact with one another, whether under supervision or not.[9], [19]

Advocacy

The resident/inmate will be offered the services of a victim advocate who has experience in assisting victims of sexual assault; the advocate will be allowed to accompany the resident/inmate for the medical forensic examination and the forensic interview to offer advocacy, support during the crisis period and afterward, and to ensure appropriate referrals for on-going support are initiated, as requested or consented to by the resident/inmate.[9],[10],[8], [19], [8]

Evidence Collection and Preservation

Scheduling should balance timely evidence collection with the patient's medical needs, rest, and trauma-informed care.[6],[12], [19] The medical history and forensic examination will guide the collection of evidence from the scene**,** perpetrator, and from the resident/inmate's body.[12]

Dependent upon the history/interview evidence to be collected may include:

- Bedding
- Clothing, especially underwear
- Condoms, if used and available
- Any objects used in assault/penetration
- Foreign matter at scene or on resident/inmate's body
- Evidence swabs, including:
    - Oral swabs (for reported oral or genital contact)
    - External genitalia swabs
    - External anal swabs
    - Internal anal swabs for reported anal penetration
    - Vaginal swabs for female resident/inmates who report vaginal penetration
    - Injury and stain swabs
        - Bites, licked areas, or suck marks
        - Any site where ejaculate may have been
        - Any injuries that occurred during the assault
            - Lacerations, cuts, tears, abrasions, redness, irritation or swelling [12]

Evidence to be obtained from a suspect may include:

- Clothing, especially underwear
- Evidence swabs, including:
    - oral swabs (for reported oral or genital contact)
    - external genitalia swabs
    - hand swabs
    - anal swabs if there was digital, penile, or object penetration
    - vaginal swabs, if there was digital, penile, or object penetration
    - Injury or stain swabs
        - Any scratches or other injury present
            - Lacerations, cuts, tears, abrasions, redness, irritation, or swelling, and any areas of reported oral or ejaculate contact[12]

Evidence will be properly collected and handled (including drying and packaging, as appropriate) and the Chain of Custody appropriately initiated and maintained. Photographic documentation of all injuries is recommended, if the resident/inmate consents; photographic documentation should be performed by trained personnel according to organizational policy.[10],[12],[15]

Law Enforcement

Sexual Assault Investigation

The medical forensic examination is, above all, a medical examination and, as such,

the decision to have, or not to have, the exam, belongs exclusively to the victim of assault. Evidence collection during this examination is part of the medical process done to promote the return of personal autonomy to begin healing. The healthcare provider is not an extension of law enforcement, although they are trained to ensure that evidence collected during the medical exam is properly done and viable for use by law enforcement, if needed.[12]

Assign a tracking number for every reported sexual assault offense and document each report in writing

Even if an incident does not meet the elements of a sexual offense, a written report should be saved as an information report. Preserving information reports affords potential pattern identification with serial offenders, a return to cases as more information develops, and promotes supervisory review.

All victims deserve to be treated as victims and not suspects when reporting a sexual assault

- Start by believing as you would other crimes, conduct a thorough investigation before making a decision.
- Consider the interview environment (a soft interview room vs. a suspect interview/interrogation room
- Utilize victim interview skills (FETI (forensic experiential trauma informed interviewing) or Enhanced Cognitive Interviewing, not suspect interview and interrogation methods (Reid or Wicklander and Zulaski methods).
- Utilize advocates, victim witness coordinators or a support person of the victims choosing
- Recognize trauma responses that can look like deception in a suspect.
- When possible, utilize those with specific training and/or experience working with sexual assault victims in a trauma informed, victim centered manner.[20]

All reports should be taken as valid unless evidence proves otherwise

- Do not rush to decide if a report is an information or crime report. This decision should be based on evidence collected through the investigation.
- A report should not be labeled “false” or unfounded as a result of the initial victim interview or perceived victim reaction to the sexual assault.
- Victims of sexual assault may recant or decline prosecution for various reasons (e.g. fear of retaliation by the offender, concern about not being believed, hesitancy regarding the criminal justice system, and loss of privacy).

- A victim's reluctance to participate is neither indicative of a false report nor reason to forgo a strong, evidence-based investigation.
- Case coding and clearance decisions should be based on careful analysis of evidence identified through an investigation. When closing cases, the National Incident Based Reporting System (NIBRS) should be utilized.[21]

Ask the victim to describe the assault in a trauma informed manner, listing as many details and feelings as possible

Begin with open-ended questions that allow the victim to describe their experience without leading the direction of the interview.

Example: "What are you able to tell me about the experience?"
"What are you able to tell me about why you came in?"[20]

- It is critical to capture the details necessary to establish elements such as premeditation/grooming behavior by the perpetrator, coercion, threats and/or force, and traumatic reaction during and after the incident (e.g. demeanor, emotional response, changes in routines or habits).
- Document the elements of the crime by asking the victim to tell you what they thought, felt, and feared at the time of the assault.
    - What was the victim experiencing before, during, and after the sexual assault?
    - What did the victim see, smell, taste, hear, or touch during the incident?
- Document the victim's condition as observed.
- Fully document fear by recording all trauma response reactions the victim exhibited. For example, the victim may describe feeling unable to move.
- Silence is not consent. "No" or resistance is communicated through more than just words. Detail and corroborate what "No" looked or felt like for the individual victim in your report (e.g. looking away, closing eyes, positioning or moving body).
- Submission and Negotiation are not consent. When the victim as made attempts to stop the assault and now are submitting because they are trying to survive the event (I know my kids need me to survive) or negotiating a lesser harm (knowing sexual assault is going to continue so they ask the offender to at least put on a condom), that is not consent.
- Create a timeline to show trauma/post-assault behavior of the victim in context of previous behavior. For example, document dramatic physical changes such as weight loss/gain or reported changes in daily routines and/or work performance.[6]

Document all information given by the victim, even if it does not cast them in the best light

- The reality is that victims who may be judged as unreliable witnesses may have been chosen by the perpetrator for that reason.
- Use the victim's exact words and place those words in quotations. Do not sanitize or "clean-up" the language used by the victim. Altered language may be used against the victim or officer in court.
- Every effort should be made to exclude officer opinion in the written report and to avoid asking leading questions. This can compromise the integrity of the entire report and the credibility of the victim and officer. It is normal for a victim to not know or remember complete details; do not try to fill in the gaps for them.[22]
- If the victim was incapacitated as a result of voluntary alcohol or drug use, show why this is an issue of increased vulnerability rather than culpability

Report Writing Considerations and Potential Suspect Defenses

The following are four common sexual assault defenses and strategies to counter these defenses in the written case report.[23]

- **Denial:** Collect and document evidence to establish that (nonconsensual) sexual contact did occur
- **Identity:** Collect and preserve DNA samples from the victim and suspect, and other physical evidence from the crime scene(s); document witness statements
- **Consent:** Document fear, force, threat, coercion and/or inability to consent
- **Impeachment by Contradiction:** Document any changes in victim/witness statements, especially as additional details are recalled following the initial trauma/shock of the assault

Note: Because the majority of sexual assaults are perpetrated by someone the victim knows (even if just briefly or casually), the difficulties in prosecution are not based upon whether the correct suspect has been identified or sexual contact occurred. The burden for the prosecution is proving that the act was nonconsensual (i.e. the perpetrator claims that the contact was consensual)

If the facts obtained from the investigation indicate use of force by the perpetrator, document using language that reflects this

- **Document evidence of trauma response, like immobility and dissociation that could explain lack of resistance, but do not equal consent.**
- If at some point a consensual encounter turned nonconsensual, ask the victim to describe details about how and when the perpetrator's behavior changed.
- Documentation should reflect a lack of consent. Avoid wording that implies consent. For instance, "he forced his penis into her vagina" denotes lack of consent while "he had sex with her" implies consensual intercourse.
- In documenting force, be specific. "He threatened me" is vague. List the specific threats that were made, tones used, gestures and/or looks given.
- Victims may not be able to resist physically. This may be an indicator of force or fear and should be documented.
- Perpetrators of sexual assault generally use only as much violence as needed to attain submission. Force or violence may not be overt if the perpetrator can commit the crime by using lesser means (i.e. a weapon isn't needed when you can use threats, alcohol, etc.)
- The mere presence of a perpetrator and/or the verbal tactics they employ can be seen as force and should be documented as such.[24] An example of this is the Use of Force Continuum utilized by law enforcement that starts with the mere presence of an officer, followed by verbal commands. Should an individual comply with either of these, no additional force would be needed or justified.

If your department has specialized investigators:

- The first responder should conduct a preliminary interview gathering just enough information to determine whether the elements of a crime have been met and by whom.
- The in-depth trauma-informed interviews should be left to the investigator (when available in an agency) in order to decrease account repetition and reduce the possibility of inconsistent information that could be used against the victim's credibility in court.[20]

Victim Interview

Due to the particularly intimate and intrusive nature of sexual assault, the interview process may be difficult both for the victim and the officer. Recognize the significance the victim's initial contact with first responders and investigators will have on their trust in the criminal justice system. The treatment the victim receives during the interview may impact the victim's decision to go forward with the case.[20]

Respect the victim's immediate priorities

- Attend to the victim's immediate health and safety concerns and questions about reporting and the criminal justice process before beginning the interview.
- Victims have a right to accept or decline all services. This does not mean that a thorough investigation should not be conducted.
- Help victims gain back a sense of control by involving them in the decision of when and where to hold the interview.

Build a rapport with the victim

- Victims may know little about the investigative process and may find the criminal justice system confusing, intimidating, or even frightening. Explain all processes during each step of the interview and investigation. This creates transparency and trust for the victim while helping to restore the victim's sense of control.
- Assure the victim that they will not be judged and that the information reported is being taken seriously.
- Victims of sexual assault often blame themselves. Reassure victims that, regardless of their behavior, no one has the right to sexually assault them.

Ask the victim if they would like to have a support person present for the interview

- It is best practice to allow victims to have an advocate or a support person of their choosing present during the medical exam and/or law enforcement interview. Ask the victim privately who they would like present and take action to support their wishes.
    - This ensures that the victim can speak freely; at times, it may be the assailant who is with the victim, or the victim may not wish to share parts of the experience with a significant other/support person.
- While victims are entitled to have someone with them during the interview, look for signs of:
    - Hesitation from the victim in revealing all of the details of the assault in front of someone with whom they are close, like a spouse or parent.
    - Controlling or intimidating behavior by the support person towards the victim.
- Provide victims with written contact information for community referrals.[20]

Recognize the impact of trauma and how this affects an individual's behavior.

- People react differently to trauma. Lack of emotion or the presence of emotion is not an indicator of the legitimacy of the assault, and either is common.
- Research shows that most victims of sexual assault never make a report to law enforcement. Of the victims who report, the majority do so after some delay. A delay in reporting should never deter a thorough investigation. A skillful prosecutor will be able to overcome any disadvantage a delay in reporting might cause when making the case in court.
- Most victims experience continuing trauma which may affect their physical, emotional, social, and economic state of being.

- Victims may experience difficulty remembering all the details of the sexual assault due to traumatic response. This does not mean they are lying or leaving out details intentionally. Often with time and as trauma recedes, details will emerge.
- After sufficient time to conduct a thorough investigation, schedule a follow-up interview to gather any information the victim may have missed or not recalled earlier and to ask about or clarify additional information learned.
    - Unless there are exigent circumstances requiring an arrest or identification, delaying the follow-up interview will generally enhance the investigation and the quality of information obtained.[6]

Do not polygraph victims

The practice of submitting victims of sexual assault to a polygraph exam intimidates victims and destroys the trust victims and the community have with law enforcement. Polygraphing negatively affects law enforcement's chance to successfully investigate sexual assault crimes.[25]

Do not pressure the victim to make any decisions regarding participation in the investigation or prosecution during the initial interview or initial stages of the investigation

- Sexual assault victims are often reluctant to actively participate with case proceedings. Document any information the victim shares, as this may aid in the identification and apprehension of a serial offender.
- A victim's right to change their mind regarding moving forward with the investigation and prosecution should only be constrained by the statute of limitations. Even then, the victim may serve as a witness in another case involving the same suspect, so an interview and investigation should always be conducted.
- Pressuring a reluctant victim to sign a form stating that they are not interested in prosecution and will not hold the agency accountable for stopping the investigation is poor practice and is potentially damaging to an agency.
- Victim follow-up builds trust with victims and sends a message to the community about the seriousness with which an agency handles sexual assault crimes.

Provide victims with information on how to obtain medical treatment and undergo a forensic exam

- Sexual assault examinations will be provided to victims at no cost. The Crime Victims Compensation Program can be contacted by law enforcement to cover the cost of the examination.
- Explain the medical significance of a sexual assault forensic examination, including testing for sexually transmitted infections and HIV.
- Notify the victim of locations where a sexual assault forensic examination is available in the community. If department policy allows, transport the victim to the local rape crisis center or hospital.
- Should a victim initially decline a forensic medical examination, provide information as to where the victim may obtain an exam at a later time.
- Physical evidence can be collected up to 120 hours (adult victims) following a sexual assault. The victim should be advised, however, that critical physical evidence and documentation of injuries may be lost with a delayed exam.[26]

Idaho Kit Tracking System (IKTS)

Sexual Assault Evidence Collection Kit (SAECK)

- Medical provider (SANE Nurse, Nurse Practitioner, Physician's Assistant, MD, etc.) collects evidence from the victim's body and seals that evidence into the SAECK box. Standard chain of custody procedures should be followed for sealing and signing seals as would be done with other evidence.
- Medical provider hands off the sealed SAECK to the Law Enforcement (LE) officer. Chain of custody should be known and recorded throughout this process so that a kit is never outside someone's physical custody.
- SANE or medical provider logs into IKTS (https://www.isp.idaho.gov/SexualAssaultKitTracking/) and "sends" the SAECK from the medical entity to the LE agency.
- LE officer either books SAECK into property/evidence of their agency, where the kit is packaged and mailed to Idaho State Police Forensic Services (ISPFS) Lab, or the LE officer can transport the kit directly to the lab if proximity allows.
    - For kits **being** submitted to ISPFS (per IC § 67-2919), the LE officer needs to complete the "pre-log" (https://ilims.isp.idaho.gov/prelog/LIMSPrelog/) through ISPFS's ILIMS system and that paperwork needs to accompany the SAECK to the ISPFS Lab.
        - Please contact ISPFS for information on adding pre-log users
    - For kits **not being** submitted to ISPFS at that time (per IC § 67-2919), the LE officer will need to book the SAECK into property/evidence and update IKTS documenting reason for non-submission
    - Once the destination of the kit is known, the LE officer must "send" the SAECK in IKTS (https://www.isp.idaho.gov/SexualAssaultKitTracking/) by tracking number to property/evidence or ISPFS.[15]

Note: Other evidentiary items related to the investigation, but not included in the SAECK (i.e. clothing, reference sample buccal swabs from suspects or consensual partners, etc.) are not regulated by IC § 67-2919, but still need to be collected and packaged per your agency's evidence protocol. Reference samples from suspects and any consensual partners are to be submitted along with SAECK to ISPFS. The LE officer should contact lab personnel to seek guidance prior to submission if other types of evidence may need to be submitted (i.e. clothing, bedding, etc.), or if a required reference sample cannot be obtained within the IC § 67-2919 submission requirement.[11]

Testing and Retention of Sexual Assault Evidence Collection Kits (IC § 67-2919)

***Except as provided in Title 67-2919, evidence obtained in a sexual assault evidence collection kit shall be tested by the Idaho State Police Forensic Services Laboratory according to the current sampling protocols and procedures established by the laboratory.**[11]

Important Highlights:

- Sexual Assault Kits are provided to victims at no charge. Kits are provided by ISPFS.
- Kits will be forwarded to ISPFS no later than 30 days from the collection date. A DNA reference sample should be collected from any named suspect(s) and/or consensual partner(s) and submitted along with the kit. If extenuating circumstances prevent collection of a required reference sample ISPFS should be contacted prior to submitting the kit.

- Law Enforcement agencies holding completed kits for another agency must notify that agency within 7 days. The notified agency must retrieve the kit within 7 days.
- All SAECKs collected in this state that are eligible for testing per IC § 67-2919 shall be processed by ISPFS[15],[11]

Retention of Sexual Assault Kits

Following analysis by ISPFS, sexual assault evidence collection kits and any remaining DNA extracts shall be returned to and retained by the investigating agency in accordance with agency evidence standards and for the durations outlined in IC § 67-2919:

- For death penalty cases, until the sentence in the case has been carried out and no un-apprehended persons associated with the offense exist.
- For felony cases, including anonymous sexual assault kits collected under the violence against women act, fifty-five (55) years from the collection of the kit during the medical examination or until the sentence in the case is completed, whichever occurs first.
- For cases before July 1, 2019, where there is no evidence to support a crime being committed, when it is no longer being investigated as a crime or when an adult victim expressly indicates that no further forensic examination or testing occur, ten (10) years from collection of the kit during the medical examination.
- For cases on and after July 1, 2019, where a crime is alleged and the allegation has been determined to be unfounded, ten (10) years from collection of the kit during the medical examination.[11]

Victim Notification

Per IC § 67-2919 a law enforcement agency holding a SAECK shall, upon written request, notify a victim of sexual assault, a parent or guardian if the victim is a minor at the time of notification, or a relative if the victim is deceased, of the following ("notify" shall include updates to the IKTS website used by ISPFS for tracking of sexual assault evidence collection kits):[11]

- When the sexual assault evidence collection kit is submitted to ISPFS (information available in IKTS)
- When any evidence sample DNA profile is entered into the Idaho DNA database (information available in IKTS)
- When a DNA match occurs; provided however, that such notification shall state only that a match has occurred and shall not contain any genetic or other identifying information (information available in IKTS)
- When there is any change in the status of their case or reopening of the case

CODIS Match Follow-Up

If you are notified of a CODIS match the case investigator will receive a report from ISPFS through ILIMS stating a match occurred with either an offender or another forensic evidence sample.

- In the event of a match with an offender sample the report will contain the offender's name and a request for submission of a reference sample from the offender for confirmation of the match. ISPFS will follow-up with a phone call or e-mail to the investigator with additional information.
    - The investigator will need to locate the subject and obtain a DNA reference sample from them either with consent or with a detention warrant. Offender samples are not

considered evidentiary because they do not have a chain of custody. The second sample is necessary to confirm the match.
    - The case investigator will need to submit the reference sample to ISPFS for confirmation of the match.
    - If you do not intend to collect a reference sample from the subject for verification of the match you must contact ISPFS.
- In the event of a match with a sample from another case (forensic match), case information for that sample will be listed. ISPFS will follow-up with a phone call or e-mail to the investigator with additional information.
    - The investigator should follow-up with the other law enforcement agency to determine if additional information is available.

Suspect Interrogation

While investigative emphasis has historically focused on the victim's behavior, the reality of this type of crime is that the suspect is often known to the victim and thus can be identified easily. An effective investigation will concentrate on gathering as much evidence as possible on the suspect.

Focus the investigation on the suspect rather than the victim
As with other crimes, focus should remain on the suspect, not on the victim's character, behavior, or credibility.

If the suspect invokes the constitutional right to remain silent, investigating officers must still evaluate the circumstances of the assault in order to anticipate the suspect's defense strategy

Allow the suspect ample opportunity to give an account of the incident

- Many perpetrators of sexual assault will provide information in an attempt to justify their actions.
- Pretext phone calls are a strong tool to be considered when the victim and suspect know each other. The transcript from a monitored call can provide useful evidence as facts are corroborated and the suspect makes admissions or gives improbable statements.

Obtain consent, acquire a court order, or act under exigent circumstances to secure evidence from the suspect's person

- Like the victim, the suspect's body carries evidence and can potentially confirm aspects of the victim's account (e.g. identifying marks, injuries, DNA material).
- In some jurisdictions, a suspect forensic exam can be done incident to arrest or by requesting a court order for non-testimonial evidence.
- Have a working relationship with your prosecutor's office to know when it is appropriate to seize evidence from the body of a suspect under exigent circumstances to ensure the evidence is not destroyed or degraded.

Investigation

Strong sexual assault investigations are supported by physical evidence and do not rely solely on the victim or the perceived credibility of the victim. Remember, the overall intent of any investigation is to be fair, balanced, and thorough. Gather all physical and testimonial evidence.[27]

Build trust by partnering with the victim, showing respect, and remaining nonjudgmental

- A victim-centered approach will aid the interview process and allow for as much evidence to be gathered as possible.
- In most cases the suspect is familiar to the victim, so the victim may be able provide corroborating details and evidence.
- Remind the victim that, due to the nature of trauma, it is typical not to remember all of the details of the sexual assault. Think out loud with the victim to identify new information in the victim's account that may be used as evidence. This process may help jog additional memories.[9]

Thoroughly investigate and document the suspect's conduct prior to the assault

- Grooming behavior which may be indicative of premeditation is often used to test, select, and isolate victims and to make the potential victim feel comfortable and able to trust the perpetrator.[28]
    - Why did the suspect choose this victim? What might make her/him less credible and/or more vulnerable?
    - How did the suspect create a situation to build trust?
    - Did the suspect monitor the victim physically or through electronic means?
    - What was the role of alcohol and/or drugs?
    - Did the suspect isolate or attempt to isolate the victim?
    - Why was the specific location for the assault chosen?

- Sexual assault cases are typically portrayed as "he said/she said" but in reality are often "he said/they said" cases. Perpetrators of this crime frequently have a history of acts of sexual violence. Previously unreported offenses may be found by interviewing the suspect's social circles, current and former partners.[29]
- Evidence of a trauma response is powerful evidence in an investigation and should be documented to demonstrate the impact of the assault on the victim. This often takes the "he said/she said" assumption to a case with additional evidence.[30]
- Prior victims should be interviewed and their statements included in the current investigation.

Do not overlook the importance of witness statements/testimony29

- Victims will often confide in someone (e.g. a close friend). These individuals are considered "outcry witnesses" and their statement can provide powerful corroboration.
- Suspects often boast or brag about their sexual encounters to a friend or friends. These individuals are also considered "outcry witness" and their statement(s) can provide powerful corroboration of the details of the assault.

Keep in mind the co-occurring nature of violence crimes and what other crimes may have been committed

- Sexual assault may occur in the context of domestic violence.
- Monitoring and surveillance are often pre-cursors to sexual assault. Look to see if stalking charges may apply.
- Remain open to the possibility of drug-facilitated sexual assault. Victims of a drug-facilitated assault may report black-outs, gaps in time and memory, and a general uncertainty as to whether or not an assault occurred.

- Additional crimes to look for include: theft, property damage, false imprisonment, human trafficking, kidnapping, abduction, administering an illegal substance, poisoning, witness tampering, etc.

Ensure every report, including every information report, is reviewed

- Establish and train officers on guidelines and procedures adopted by the agency.
- Create a system to review the coding and clearing of sexual assault cases with particular attention to reports determined to be false or unfounded.

Working with Vulnerable Populations

Predators prey upon the vulnerabilities of others; therefore, victimization is often higher among certain populations. When investigating a sexual assault, be aware of particular issues that may face certain populations (i.e. age, culture, disabilities, gender, language) and how this might affect the way a victim makes decisions and responds to law enforcement.

Forensic Laboratory

Sexual Assault Evidence Collection Kits (SAECK) are analyzed by the laboratory first to determine if a body fluid or male DNA (female victim kits) is present. If either are indicated on an item(s) from the kit the laboratory may proceed with DNA testing of that item, with the purpose of generating a DNA profile suitable for comparison and/or Combined DNA Index System (CODIS) entry. DNA analysis is a comparative process. Without reference samples from the victim, known suspect(s) and consensual partner meaningful comparisons may not be possible. A lack of necessary reference samples may also prevent CODIS entry.[27]

SAECKs meeting the requirements of Idaho Code 67-2919 that are accompanied by the required reference sample(s) will be accepted by the Idaho State Police Forensic Services (ISPFS) laboratory for testing.[11] Any kits lacking the required references may be returned to the agency unless prior discussion/notification has occurred as to why the reference sample(s) are not available. If a suspect(s) has been identified a reference sample from that individual is required for analysis. In addition, if the victim had a consensual partner within 96 hours of the assault a reference sample from that individual is also required. Evidence must be pre-logged (https://ilims.isp.idaho.gov/prelog/LIMSPrelog/) prior to submission to the laboratory. Submitted SAECKs will be worked in the order in which they are received into the laboratory unless the laboratory is notified of a public safety issue, extenuating circumstances, or pending jury trial date necessitating rush analysis.

The ISPFS laboratory is accredited under ISO 17025 accreditation standards. All biology screening and DNA analysis of SAECKs shall be done according to the laboratory's current ISO 17025 compliant analytical methods and in accordance with the current FBI Quality Assurance Standards for Forensic DNA Testing Laboratories. Once analysis has been completed a report will be issued and available through the ISPFS pre-log system.

All CODIS eligible profiles generated by ISPFS will be uploaded to the National (NDIS) and/or State (SDIS) DNA index system. In order for a profile to be eligible for CODIS entry it must be related to a crime, believed to be from the perpetrator of that crime, and cannot be generated from an item directly associated with the suspect (i.e. his/her clothing, body swabs, etc.). It must also meet Idaho's and/or the FBI's current completeness definitions. Profiles entered into the database are routinely searched against new profile uploads. They are compared against both the convicted offender index (convicted offender sample profiles) as well as the forensic index (profiles generated from items of evidence). In the event of a match with a convicted offender profile or a forensic profile the agency will be notified by the laboratory and a Database Search report will be generated and available through the ISPFS pre-log system. It is the agency's responsibility to follow-up on all CODIS matches or notify ISPFS as to why follow-up will not be completed.

Legal

The primary role of prosecution is to see that justice is accomplished. In cases of sexual assault, this means protecting the safety and rights of the victim and community by holding the offender accountable. To accomplish this goal, prosecutors must work in a coordinated and collaborative fashion with the victim, law enforcement, advocates, medical professionals and crime labs. Prosecutors are responsible for assessing reports of sexual assault to determine if enough evidence exists or could be obtained to file criminal charges. Prosecutors must also consider the ethical issues of whether or not to file criminal charges.[31]

Please note, these guidelines do not advocate altering the level of discretion entrusted to the prosecutor; however, it does endorse consideration of the victim's needs in exercising that prosecutorial discretion. A sexual assault victim deserves to be informed about the reasons that motivate decisions about the case, especially when those decisions might appear to be contrary to his/her expressed interests.

Vertical Prosecution

Vertical prosecution is recommended in all sexual assault cases. Vertical prosecution means the same prosecutor, who has specialized training and/or experience in sexual assault cases, is assigned to the case from beginning to end.[32] With vertical prosecution, victims are able to work with the same prosecutor and investigator from the time potential charges are first reviewed through the sentencing of the offender.

Meeting With the Victim

It is recommended that prosecutors meet with the victim prior to making a determination about whether or not to charge the defendant. Meeting with the victim gives prosecutors increased insight not available through written reports. Meeting with the victim is also part of being victim-centered; it demonstrates to the victim that the prosecution is taking the case seriously and provides an opportunity to build trust between the victim and the prosecutor. A victim-witness coordinator should be present during meetings with the victim whenever possible.[33]

When meeting with a victim, if the prosecutor plans on discussing the facts of the case, it is recommended that the investigating officer or other law enforcement personnel be present. In the event the victim provides new or different information, law enforcement can document the information in a report and, if necessary, testify at trial. Failure to have a witness present could result in the prosecutor becoming a witness.

Meeting with the victim also provides an opportunity to review the case from the victim's perspective, explain the process, uncover details that may have been overlooked in the initial investigation, and determine what outcome the victim is seeking. Creating a safe environment for the victim to discuss all relevant facts and offer them a perspective regarding the sexual assault is essential to obtaining a full

picture of the case. In order to do this, a prosecutor, along with the victim witness coordinator, should attempt to establish rapport by:

- Conducting the meeting in a place where the victim feels safe and is able to speak freely.
- Allowing adequate time for the meeting.
- Answering the victim's questions as fully and accurately as possible.
- Adopting a non-judgmental and "seeking to understand" perspective in speaking with the victim.
- Explaining the legal process associated with the prosecution of a sexual assault, and the prosecutor's discovery obligations, including the accumulation of relevant materials and the disclosure and admissibility of sensitive and potentially privileged information concerning the victim (e.g., medical records).[34]
- Reminding the victim that what they share with family and friends is not privileged information and is subject to subpoena; explaining the right of privilege held by social workers and counselors.
- Reviewing the victim's rights and explaining the victim's role throughout the prosecution process.
- Inquiring about any threats defendants have made toward victims and respecting and supporting the victim's efforts to maintain their safety.

Victims Who Choose Not to Participate in Prosecution

A victim-centered approach also means that prosecutors should support victims who choose not to cooperate in moving the case forward. There are a variety of reasons why a victim may not wish to pursue a prosecution including:

- Lengthy timeframes associated with the investigation and prosecution of the case.
- Feeling uninformed about, and uninvolved in, the decision making or prosecution process.
- Not initially realizing the toll that a criminal investigation and trial can take on them mentally, emotionally and physically.
- Pressure from family, friends and the community to not participate in prosecuting the defendant.[35]

The prosecutor should attempt to understand the reasoning behind a victim's desire to not pursue a prosecution. In some instances, addressing the victim's concerns may allow a prosecution to proceed forward. However, when victims are unable to, or choose not to, participate in a prosecution, they should be treated with the same dignity and respect as victims who are able to fully participate in the prosecution of their case. In such circumstances, consider asking the victim to sign a release from prosecution so they understand that the prosecutor may be able to bring the charge back if the statute of limitations allows.

Collaboration With Law Enforcement

Prosecutors should review the investigative file early in the process to identify incomplete information or gaps in the evidence. Working closely with law enforcement ensures the collection of important evidence. The sooner this process begins, the more likely that evidence will be preserved and/or obtained.

Decisions Not to Charge

A victim-centered response to sexual assault takes into account the potentially lifelong impact that charging decisions have on victims. Victims of sexual assaults whose cases are not charged may feel re-traumatized because the pathway to achieve closure through the justice system has been closed to them.[31]

It is the responsibility of the prosecutor's office to notify a victim of sexual assault that a decision has been made not to charge the case. The notification should occur promptly and, if possible, before anyone else

outside of the criminal justice system is notified. This will prevent the victim from hearing the disposition from the alleged perpetrator or other people first. Best practice is to make notification in person or by phone whenever possible. In addition, as a courtesy to the investigating agency, the agency should be consulted and informed of the prosecutor's decision prior to disclosure to the victim. Notification of the victim should include an honest explanation of the reasons for the decision not to charge.

Preparing the Victim and Family in Charged Cases

The victim-centered approach recognizes that the victim is the center of the investigation. The victim is the person most affected by the crime and in the majority of sexual assaults, the only witness to the assault. Providing information, education and respect to victims and their families promotes cooperation and helps to build the strongest case possible. When a decision is made to charge the offender, prosecutors must prepare victims and family members for the next steps in the justice process.[36] [33]
Prosecutors can do this by:

- Educating victims about the steps in the process of the investigation and prosecution.
- Educating victims about attendance at court proceedings.
- Educating victims on the estimated timeline of the case.
- Preparing victims for testimony and estimating the amount of time they will be spending on the stand while acknowledging and understand the impact the victim's trauma will have in this process.
- Preparing victims and family members for disclosure of traumatic information in the trial (e.g., 911 tapes, photos, etc.).
- Informing victims about media coverage, including the possibility of the presence of media in the courtroom.
- Cautioning victims about potential consequences of discussing the case with others outside the criminal justice system.
- Preparing victims, family members or other loved ones on how to respond to inquiries from defense attorneys, investigators and the media.

Protecting Victim Safety

Ensuring the physical and emotional safety of victims during the prosecution phase is critical.[37] In some cases, victims may be subject to intense pressure and harassment from others. To promote victim safety, prosecutors should:

- Advocate for bail conditions that consider the safety of the victim and the community.
- Ensure that criminal no contact orders are written rather than oral.
- Inform victims about the terms of bail conditions for the offender.
- Assist victims to develop a safety plan in the event of retaliation or harassment, this may involve referring the victim to a community or campus-based sexual assault programs who have experience safety planning in cases of gender-based violence.
- Be mindful of the need to separate victims and defendants during any proceedings at the courthouse.

Initial Court Appearances or Pre-Trial Hearings

A victim's attendance at court may be a difficult experience. In some cases, it may be the first time the victim and defendant meet face to face after the assault. Undoubtedly, it will be an affirmation that the defendant is being held accountable for their actions.

Because of this, it is not uncommon for defendants to attempt to intimidate the victim. A victim-centered response recognizes that court appearances are a critical emotional juncture for the victim.[38] When working with victims, the prosecutor and/or victim witness coordinator should:

- Discuss the advantages and disadvantages of victim attendance at court proceedings.
- Consider whether efforts should be made to quash a subpoena should the defendant subpoena a victim to testify at an initial court appearance or pre-trial hearing.
- Plan where the victim will be waiting prior to and during all court proceedings to limit the victim's exposure to the defendant, their family or their supporters.
- Attempt to ensure the victim and the defendant do not enter the courtroom at the same time.

Plea Negotiations

A victim's input should always be sought before plea discussions. Explain the rationale for offering a negotiated plea and ask victims for their feedback. Minimally, the prosecutor should:

- Never present a plea without first attempting to contact the victim.
- Educate the victim about the process of plea negotiations and sentencing options.
- Make sure the victim is informed of the disposition being offered to the defendant.

Trial Preparation

A victim-centered approach recognizes the need to fully prepare victims for the realities of the trial process. Involving victims in preparing the prosecution's case will empower them and improve their testimony. To prepare victims for trial, the prosecutor or victim witness coordinator should:

- Provide a courtroom tour.
- Prepare the victim for all testimony and anticipated cross examination.
- Caution the victim about speaking about the case with others in a public place such as a courthouse restroom or any other place where potential jury members or others may be present before, during and after the trial.
- Advise the victim who is allowed to be present in the courtroom.
- Discuss with the victim the benefits and challenges of attending certain phases of the trial.
- Prepare the victim for the various possible outcomes of the trial.
- In addition to victim preparation, additional witnesses in the case, including medical personnel, should be fully prepared prior to depositions and/or trial testimony.

Jury Selection

Jury selection, as in any other criminal case, is critical to the outcome of a sexual assault trial. Potential jurors bring with them their own personal experiences and beliefs. Jurors are also exposed to dramatized and/or wholly fictional accounts of sexual assaults in various media which often bear no relationship to reality. The questions asked of potential jurors during the selection process can expose myths and prejudices that they may hold about sexual assault.[33]

Sentencing

Sentencing hearings can be an empowering and/or traumatic experience for victims and their family members.[38] To prepare victims for the sentencing hearing, the prosecutor's office should:

- Notify the victim that in the event the court orders a pre-sentence investigation, someone from

the system may request to speak to the victim directly or through the victim witness coordinator to form an opinion as to the impact of the crime and what the victim feels is an appropriate sentence.

- Review with the victim the possibility that the reading of the charges and sentencing arguments made by prosecution and defense may be potentially upsetting. Victims should be informed that the defendant may speak at the hearing and may address their statements directly at the victim. Victims should be aware it is entirely up to them if they want to acknowledge the defendant's comments.
- Inform the victim of their right to speak at sentencing. Victims who do not wish to speak at the hearing should be offered the option of providing a written Impact Statement directly to the court with copies provided to the defense and prosecution ahead of the hearing.
- A sentencing hearing can be an emotionally charged event. Giving an oral Victim Impact Statement can be overwhelming. Assisting the victim in preparing the statement beforehand can be very helpful in assuring that a victim does not miss saying something they felt was important. It also prepares the advocate or support person for reading the statement in the event the victim is unable to do so.
- If the court permits, victims should be offered the option of sitting or standing when giving their statement.
- Advise the victim that family members and friends may be present to support them.
- Request that a "no contact order" is included in sentencing, if desired by the victim. Victims should be reminded that restraining orders should not be dropped in reliance on the criminal case "no contact" order.
- Encourage the victim to be clear in their Victim Impact Statement whether they are in support of the sentencing proposal.

Idaho Sexual Assault Kit Tracking (IKTS)

General Information

The Idaho Sexual Assault Kit Tracking System (IKTS) is the web-based program used to track all Sexual Assault Evidence Collection Kits (SAECK) in Idaho. https://isp.idaho.gov/SexualAssaultKitTracking/[26]

Idaho State Police Forensic Services (ISPFS) provides Sexual Assault Evidence Collection Kits for the collection of evidence from victims of sexual assault. Every SAECK in Idaho shall be labeled with a serial number and be entered in IKTS. The tracking will begin with receipt of the kit by ISPFS from the manufacturer and will track the kit throughout its lifecycle, including final disposition or destruction, as applicable. All kits in possession of law enforcement lacking a serial number must have a serial number assigned by ISPFS for entry into IKTS.

Victims may access the timeline and current status of their kit by utilizing the website listed above and entering their kit serial number.[15]

Sexual Assault Evidence Collection Kit Tracking

Idaho State Police Forensic Services

- Receive SAECK from manufacturer, create kit in IKTS
- Receive request for SAECK from medical facility:
    - Send requested kits to medical facility
    - Send each kit to the medical facility in IKTS
- Receiving SAECK from Law Enforcement Agency
    - Receive each kit in IKTS and enter Laboratory Case Number
    - At completion of all laboratory analysis complete Lab Data Fields in IKTS
    - If there is a DNA database match, enter that information in IKTS
    - Return SAECK to law enforcement agency and send kit in IKTS[15]

Medical Facility

- Addressing an expired kit:
    - Only the ampule of sterile water expires
    - Remove and discard expired ampule
    - Replace ampule with sterile water from organization
    - Document that expired ampule was discarded
    - Document expiration date of new sterile water
    - Use SAECK per protocol[15]
- Returning unused kit(s) to ISPFS:
    - Physically return kit(s) to ISPFS
    - Send each kit in IKTS to ISPFS[15]
- Kit utilized for purpose other than collecting evidence from a victim of sexual assault:
    - Mark kit as repurposed in IKTS[15]
- Kit used to collect evidence from a victim of sexual assault:

- Provide Victim Notification Form to victim
- Complete Medical Data fields in IKTS
- Turn over custody of kit to appropriate law enforcement agency
- Mark as sent in IKTS to appropriate law enforcement agency[15]

Law Enforcement Agency

- Receive SAECK from medical facility
  - Pick up kit from facility
  - Mark kit as received in IKTS
  - Complete Law Enforcement Data fields, including planned destruction date
  - Determine if per IC § 67-2919 the kit must be submitted to the laboratory:
    - If the kit SHOULD be submitted to the laboratory
      - Click "yes" under "meets submission requirements" drop down
      - Deliver or ship kit to ISP Forensic Services
      - Mark kit as "sent" in IKTS
    - If the kit should not be submitted to the laboratory
      - Click "no" under "meets submission requirements" and select non-submission reason from drop down[11],[15]
- Receiving SAECK from ISPFS after analysis
  - Mark kit as "received" in IKTS and enter planned destruction date
  - Maintain custody of kit per IC § 67-2919[11],[15]
- Transferring SAECK to another agency
  - Turn over custody to that agency and document transfer on chain of custody
  - Mark as "sent" in IKTS, indicating agency kit was given to[15]

Prosecutor

- Monitor IKTS for kits requiring review (those noted as Not Meeting Submission Requirements)
- Review listed kits, complete Prosecuting Attorney Review fields[15]

Victim

- Access website
- Enter kit number in Serial Number field (upper right corner)
- View kit timeline
- Contact law enforcement handling the investigation (information on timeline) for questions related to kit status[15]

IKTS Organization Set-Up

Organizations beginning a SANE/MFE program must notify the following entities for program support, IKTS access, and laboratory coordination:[15]

Contact	Purpose	Email
ISPFS Meridian Laboratory	Biology/DNA evidence submission questions	R3lab@isp.idaho.gov

IKTS Administrator	IKTS account setup and access	IKTS@isp.idaho.gov
State Coordinator	Statewide SANE program support and resources	forensic.nursing@isp.idaho.gov

How to Order Kits

ISPFS provides SAECKs at no cost to healthcare organizations performing SANE examinations.

To request kits, email the following information to R3lab@isp.idaho.gov:

- Name of organization
- Organization address
- Contact person receiving kits
- Number of kits requested

Toxicology Kits

Blood and urine toxicology kits may be requested from the ISPFS laboratory serving your region:

Region	Email
Coeur d'Alene	R1lab@isp.idaho.gov
Meridian	R3lab@isp.idaho.gov
Pocatello	R5lab@isp.idaho.gov

Forensic Services Victim Notification Form

Forensic Services
Victim Notification Form

SEXUAL ASSAULT EVIDENCE KIT TRACKING #_____

Notification of victim's rights pursuant to Idaho Code Chapter 29, Title 67, Section 67-2919 regarding sexual assault evidence kit* testing and notification:

Sexual assault evidence kit testing

As an adult victim you have the right to decline collection of a sexual assault evidence kit or to request an anonymous kit collection. You must expressly indicate your request for an anonymous kit collection; otherwise, the sexual assault evidence kit will be submitted by law enforcement to the Idaho State Police Forensic Services laboratory for testing (except as provided in Idaho Code Chapter 29, Title 67, Section 67-2919, Subsection 6).

Victim Notification

As an adult victim (or parent/legal guardian of a minor victim) you have the right to receive notification of the following events upon written request to the law enforcement agency that submitted the sexual assault evidence kit for testing:

- When the sexual assault evidence kit is submitted to the Idaho State Police Forensic Services laboratory
- When any evidence sample DNA profile is entered into the Idaho DNA database
- When a DNA match occurs
- When there is any change in the status or reopening of the case
- When there is any planned destruction of the sexual assault evidence kit or any other sexual assault case evidence

A website has been developed to assist in tracking the status of sexual assault evidence kits in the state of Idaho. To view the current status of the sexual assault evidence kit please visit the following website and enter the sexual assault evidence kit tracking # listed at the top of this page:

https://isp.idaho.gov/SexualAssaultKitTracking

**"Sexual assault evidence kit" means a set of materials, such as swabs and tools for collecting blood samples, used to gather forensic evidence from a victim of reported sexual assault and the evidence obtained with such materials.*

Figure 9: Forensic services victim notification form: Provided by ISPFS

Special Population Considerations

Purpose

Individuals impacted by sexual violence may have unique medical, psychological, developmental, cultural, communication, legal, accessibility, or safety-related needs that influence how they experience trauma, access services, interact with systems, and participate in care or investigations.[4,9,12]

A trauma-informed, victim-centered response requires recognition that sexual assault affects individuals across all ages, identities, backgrounds, cultures, abilities, and living environments. Multidisciplinary responders should provide equitable, accessible, respectful, and culturally responsive care tailored to the individual needs of each patient or victim.[4,7,9,12]

Special population considerations are intended to enhance—not replace—standard trauma-informed response principles.[9]

General Principles

Responders should:

- Avoid assumptions or stereotypes
- Recognize potential barriers to disclosure and access to care
- Provide individualized and culturally responsive services
- Assess communication and accessibility needs
- Promote patient autonomy whenever legally permissible
- Collaborate with appropriate multidisciplinary and community resources[4,7,9,12]

All individuals should be treated with dignity, respect, compassion, and professionalism regardless of:

- Age
- Race
- Ethnicity
- Religion
- Disability
- Gender identity
- Sexual orientation
- Socioeconomic status
- Immigration status
- Incarceration status
- Housing status
- or reporting choice[4,9,12]

Pediatric and Adolescent Patients

Comprehensive pediatric-specific sexual assault response guidance is currently being further developed as part of ongoing statewide multidisciplinary response initiatives. While these guidelines include pediatric considerations throughout applicable sections, responders should continue to follow existing organizational policies, pediatric forensic protocols, Child Advocacy Center procedures, mandatory reporting requirements, and current evidence-informed pediatric best practices when responding to children and adolescents impacted by sexual violence.[4,9,12,14]

Future guideline development may include expanded pediatric-specific guidance regarding:

- Pediatric medical forensic examinations
- Transfer pathways
- Forensic interviewing coordination
- Child Advocacy Center collaboration
- Pediatric evidence collection considerations
- Developmental communication approaches
- Specialized multidisciplinary response protocols[12]

Children and adolescents who experience sexual violence require developmentally appropriate, trauma-informed care and coordinated multidisciplinary response.[4,9,12]

Responders should:

- Utilize age-appropriate communication
- Explain procedures in developmentally understandable language
- Minimize repeated interviewing
- Involve trained pediatric professionals whenever possible
- Recognize that behavioral responses to trauma may differ significantly from adults[4,9,12]

Mandatory reporting requirements apply to all suspected abuse or assault involving minors in accordance with Idaho law.[14]

Whenever available, pediatric sexual assault examinations should be conducted by providers with specialized pediatric forensic training.[12]

Special consideration should be given to:

- Caregiver involvement
- Mandated reporting transparency
- Forensic interviewing coordination
- Safety planning
- Minimizing additional trauma during medical and investigative processes[9,12,8,14]

Vulnerable Adults and Older Adults

Vulnerable adults and older adults may face increased risk of abuse, exploitation, dependency-related coercion, social isolation, cognitive impairment, communication barriers, or physical limitations.[4,9,12]

Responders should:

- Assess for caregiver-related abuse or neglect
- Evaluate decision-making capacity in accordance with law and policy
- Provide accommodations for communication or mobility needs
- Ensure privacy during interviews and examinations whenever possible[4,9,12]

Healthcare providers and other mandated reporters must comply with Idaho reporting requirements regarding abuse, neglect, or exploitation of vulnerable adults.[14]

Individuals With Disabilities

Individuals with physical, sensory, intellectual, developmental, cognitive, or communication disabilities experience disproportionately high rates of sexual violence and may encounter barriers to reporting, healthcare access, communication, and system participation.[4,7,9,12]

Responders should:

- Provide reasonable accommodations
- Use accessible communication methods
- Assess the need for assistive devices or support services
- Avoid assumptions regarding credibility, consent capacity, or comprehension[4,7,9,12]

Whenever possible:

- Qualified interpreters should be utilized
- Support persons should be identified according to patient preference
- Communication should occur directly with the patient rather than through caregivers or companions[7,9]

Family members or caregivers should not automatically be assumed to be safe support persons.[9]

LGBTQIA+

LGBTQIA+ individuals may experience barriers to care related to stigma, discrimination, prior negative system interactions, fear of mistreatment, or lack of culturally responsive services.[4,9,12]

Responders should:

- Use respectful and inclusive language
- Utilize the individual's affirmed name and pronouns
- Avoid assumptions regarding anatomy, relationships, sexual practices, or gender identity

- Provide care based on anatomy and reported assault history rather than assumptions about identity[4,9,12]

Multidisciplinary responders should recognize that fear of discrimination may impact disclosure, reporting, and participation in services.[4,9,12]

Tribal Communities and American Indian/Alaskan Native Individuals

Sexual violence disproportionately impacts tribal communities, including American Indian and Alaska Native populations.[4,9,12]

Responders should recognize the importance of:

- Tribal sovereignty
- Jurisdictional considerations
- Culturally responsive care
- Historical trauma
- Collaboration with tribal advocacy, healthcare, law enforcement, and community resources[4,9,12]

Whenever possible, patients should be offered access to tribal advocacy or culturally specific support services if desired.[9,8]

Multidisciplinary response involving tribal jurisdictions should prioritize respectful communication, collaboration, and understanding of applicable legal and jurisdictional processes.[9,12,8]

Non-English-Speaking Individuals and Interpreter Services

Language barriers should never prevent access to medical care, advocacy services, reporting options, or participation in response processes.[7,9,10,12]

Qualified interpreters should be utilized whenever language barriers exist.[7]

Whenever possible:

- Professional medical or legal interpreters should be used
- Interpretation should occur in a manner that protects privacy and confidentiality
- Family members, friends, children, or accompanying individuals should not serve as interpreters except in emergencies when no alternative exists[7,10,12]

Responders should recognize that communication barriers may affect:

- Understanding of rights and options
- Informed consent
- Safety planning
- Engagement with multidisciplinary systems[7,9,10,12]

Incarcerated Individuals and PREA Considerations

Individuals who are incarcerated or detained retain the right to timely, trauma-informed medical care and sexual assault response services.[9,19,19]

Response to sexual assault within correctional settings should comply with:

- The Prison Rape Elimination Act (PREA)
- Applicable correctional policies
- Patient confidentiality and safety standards whenever possible[10,19,19]

Responders should recognize potential concerns related to:

- Retaliation
- Coercion
- Confidentiality limitations
- Fear of reporting
- Restricted access to advocacy or support services[9,10,8,19]

Collaboration between healthcare, advocacy, correctional personnel, and law enforcement should prioritize patient safety and evidence integrity.[9,12,8,19]

Individuals Experiencing Substance Use or Intoxication

Substance use or intoxication does not negate the need for compassionate, trauma-informed response or thorough investigation.[5,9,12,17]

Responders should:

- Avoid judgmental language
- Assess for possible drug-facilitated sexual assault
- Provide appropriate medical stabilization
- Recognize that intoxication may affect memory, communication, consent capacity, and recall[6,9,12,17]

Victims may fear blame, criminal consequences, or disbelief related to substance use. These concerns may contribute to delayed disclosure or reluctance to seek care.[5,9,12]

Rural and Frontier Communities

Individuals living in rural or frontier communities may experience barriers related to:

- Geographic isolation
- Limited healthcare access
- Transportation challenges
- Reduced anonymity
- Limited advocacy resources

- Lack of specialized forensic services[4,9,12,17]

Response systems should promote:

- Coordinated multidisciplinary collaboration
- Cross-jurisdictional partnerships
- Equitable access to trauma-informed services throughout Idaho[9,12,8,17]

Special consideration should be given to protecting patient confidentiality in small or close-knit communities.[4,9,10]

Individuals Experiencing Homelessness or Housing Instability

Individuals experiencing homelessness or unstable housing may face increased vulnerability to sexual violence and additional barriers to healthcare, safety planning, transportation, communication, and follow-up care.[4,9,8,17]

Responders should:

- Assess immediate safety and basic needs
- Provide referrals to housing and community resources
- Recognize the impact of survival behaviors, trauma history, and systemic barriers on reporting and service engagement[4,9,8,17]

Lack of stable housing should never diminish the quality or seriousness of response provided.[4,9,12]

Multidisciplinary Considerations

Effective response to special populations requires ongoing multidisciplinary collaboration among:

- Healthcare providers
- Advocates
- Law enforcement
- Prosecutors
- Child and adult protective services
- Correctional systems
- Tribal agencies
- Behavioral health providers
- Interpreters
- Community organizations[4,9,12,8,17]

Whenever possible, multidisciplinary teams should seek specialized consultation, training, and culturally specific resources to support individualized care and improve system responsiveness.[4,9,12,17]

Training, Competency, and System Sustainability

Purpose

Sustainable, trauma-informed, multidisciplinary sexual assault response systems require ongoing education, competency development, collaboration, quality improvement, and workforce support.[5],[4],[9],[12],[17]

The purpose of this section is to promote statewide consistency, evidence-informed practice, multidisciplinary collaboration, and long-term sustainability of Idaho's sexual assault response systems through ongoing training, professional development, mentorship, and system coordination.[4],[9],[12],[17]

Effective response to sexual violence depends upon skilled professionals who receive ongoing education in trauma-informed care, forensic practices, victim-centered response, multidisciplinary collaboration, and emerging best practices. [5],[4],[9],[12],[17]

Guiding Principles

Training and system development efforts should:

- Promote victim-centered, trauma-informed care
- Support evidence-informed practices
- Encourage multidisciplinary collaboration
- Improve accessibility to services statewide
- Strengthen workforce recruitment and retention
- Support rural and frontier response systems
- Promote cultural responsiveness
- Encourage continuous quality improvement [5],[4],[9],[12],[17]

Training initiatives should recognize that competency development is an ongoing process requiring education, mentorship, skills practice, peer collaboration, and periodic reassessment.[4],[9],[12],[17]

Multidisciplinary Training

Sexual assault response is strengthened through coordinated multidisciplinary education involving:

- Healthcare providers
- SANEs and SAFEs
- Advocates
- Law enforcement
- Prosecutors
- Forensic scientists
- Correctional personnel
- Dispatch personnel
- Behavioral health providers

- Child and adult protective services
- Tribal partners
- Community organizations[4,9,12,8,17]

Whenever possible, multidisciplinary trainings should:

- Encourage cross-disciplinary understanding of roles
- Improve communication and collaboration
- Reduce systems fragmentation
- Strengthen coordinated response
- Promote consistency in trauma-informed practices[4,9,12,17]

Training topics may include:

- Neurobiology of trauma
- Victim-centered response
- Trauma-informed interviewing
- Forensic evidence collection
- Strangulation assessment
- Photography competency
- Courtroom testimony
- DFSA considerations
- Vulnerable populations
- Cultural responsiveness
- LGBTQIA+ considerations
- Child abuse response
- PREA response
- Multidisciplinary case coordination[6,4,9,12,17,19]

Quality Improvement and System Review

Multidisciplinary response systems should engage in ongoing quality improvement efforts to strengthen services, identify gaps, and improve statewide consistency.[4,9,12,8,17]

Quality improvement activities may include:

- Multidisciplinary case review
- Peer review
- Policy review
- Skills validation
- Community needs assessments
- Patient feedback
- Training evaluations
- Systems response analysis[4,9,12,17]

Sexual Assault Response Teams (SARTs) play an important role in:

- Identifying system strengths and barriers
- Improving communication
- Supporting accountability
- Promoting coordinated community response[9,12,8,17]

Policy and Protocol Development

Agencies and organizations responding to sexual violence should maintain current policies and procedures consistent with:

- Idaho law
- National best practices
- Trauma-informed principles
- Multidisciplinary response standards[4,9,12,14,17]

Policies should address:

- Evidence collection
- Reporting procedures
- Confidentiality
- Chain of custody
- Advocacy access
- Interpreter services
- Vulnerable populations
- Photography
- Documentation

- Interagency collaboration[7,9,10,12,14,17]

Policies should be reviewed periodically and updated as practices, laws, and community needs evolve.[4,9,12,17]

Accessibility of Education and Resources

Whenever possible, statewide education and resource materials should be accessible through:

- In-person training
- Virtual learning
- Recorded educational modules
- Skills-based workshops
- Regional conferences
- Multidisciplinary learning collaboratives[4,7,9,12,17]

Educational materials should be regularly updated to reflect current evidence-informed practices and evolving legal or forensic standards.[4,9,12,17]

Secondary Traumatic Stress and Wellness

Professionals responding to sexual violence may experience secondary traumatic stress, compassion fatigue, burnout, or vicarious trauma.[4,9,17]

Organizations are encouraged to support responder wellness through:

- Peer support
- Debriefing opportunities
- Mental health resources
- Workload support
- Healthy workplace practices
- Trauma-informed organizational culture[4,9,17]

Supporting responder wellness strengthens workforce sustainability and improves long-term system effectiveness.[4,9,17]

Resource Directory

The following resources are provided to support individuals impacted by sexual violence and the multidisciplinary professionals responding to sexual assault in Idaho. Inclusion does not constitute endorsement. Contact information and availability may change over time; organizations should verify current information periodically.

National Resources

- Futures Without Violence
  Purpose: Education, prevention, policy, and training resources related to violence prevention.

- National Sexual Assault Hotline (RAINN)
  Phone: 800-656-HOPE (4673)
  Purpose: 24-hour confidential crisis support, information, and connection to local services.

Statewide Resources

- Attorney General's Office
  Purpose: Victim rights information and statewide legal resources.

- Idaho CareLine (211)
  Phone: 211
  Purpose: Community resource referral and support services.

- Idaho Coalition Against Sexual & Domestic Violence
  Phone: (208) 384-0419
  Purpose: Statewide advocacy, training, and program coordination.

- Idaho Council on Domestic Violence and Victim Assistance
  Phone: (208) 332-1540
  Purpose: Victim assistance funding and statewide coordination.

- Idaho Crime Victims Compensation Program
  Phone: (208) 334-6080
  Toll Free: (800) 950-2110
  Purpose: Financial assistance for eligible victims.

- Idaho Department of Health and Welfare – Sexual Violence Prevention Program
  Purpose: Prevention resources and public health information.

- Idaho Legal Aid Services
  Phone: (208) 746-7541
  Purpose: Civil legal services and legal support.

- Idaho Parole Commission – Victim Services

Phone: (208) 334-2520
Purpose: Victim notification and parole participation resources.

- Idaho Volunteer Lawyers Program
  Phone: (208) 334-4500
  Purpose: Civil legal assistance.

- Victim Information and Notification Everyday (VINE)
  Phone: (866) 984-6343
  Purpose: Custody and case status notification.

Northern Idaho Resources (District 1)

- Boundary County Youth Crisis and DV Hotline — Bonners Ferry
  https://www2.boundarycountyid.org/prosecutor/Boundary%20County%20Victim%20Services%20Page.htm

- Coeur d'Alene Tribal STOP Violence Program — Plummer
  https://www.cdatribe-nsn.gov/ss/stopviolence/

- LillyBrooke — Sandpoint
  https://www.lillybrookefjc.org/

- Priest River Ministries — Priest River
  https://www.prmafw.org/

- Safe Passage — Coeur d'Alene
  https://www.safepassageid.org/

Central Idaho Resources (District 2)

- Alternatives to Violence of the Palouse — Moscow
  https://atvp.org/

- University of Idaho Family Justice Clinic — Moscow
  https://www.uidaho.edu/law/legal-clinics-and-support/family-justice

- Mini Cassia Shelter for Women & Children — Rupert
  https://www.cassia.gov/maps/location/Mini-CassiaShelterforWomenChildren

Western Idaho Resources (District 3)

- Ada County Indigent Services — Boise
  https://adacounty.id.gov/clerk/indigent-services/

- Ada County Victim Services Center — Boise
  adacounty.id.gov/victimservices/

- Advocates Against Family Violence — Caldwell
  https://www.aafvhope.org/

- Elmore County Domestic Violence Council — Mountain Home
  https://www.ecdvc.org/

- Family Advocate Program — Boise
  https://www.familyadvocates.org

- FACES of HOPE — Boise/Meridian
  https://facesofhopeidaho.org/

- Nampa Family Justice Center — Nampa
  https://www.cityofnampa.us/190/Nampa-Family-Justice-Center

- Rise Up 2 Thrive — Cascade
  https://riseup2thrive.org/

- Rose Advocates — Weiser
  https://www.roseadvocates.org/

- Safe Place Ministries — Boise
  https://www.safeplaceministries.com/

- Terry Reilly Trauma and Resilience Centers — Boise
  https://www.trhs.org/

- Napuha Kha Nii — Owyhee County
  https://shopaitribes.org/spstopv/

- WCA — Boise
  https://wcaboise.org/

Southern Idaho Resources (District 4)

- The Advocates — Hailey
  https://www.theadvocatesorg.org

- Voices Against Violence — Twin Falls / Rupert
  https://www.vavmv.org/

Southeastern Idaho (District 5)

- Bingham Crisis Center — Blackfoot
  https://binghamcrisiscenter.org/

- Family Services Alliance of SE Idaho — Pocatello
  https://fsalliance.org/

- Oneida Crisis Center — Malad
  https://oneidacrisiscenter.org/

- Shoshone-Bannock Tribes Victims of Crime Assistance Program — Fort Hall
  https://www.sbtribes.com/tribal-health-and-human-services/

- Shoshone County Crisis and Resource Center — Wallace
  https://sccrcenter.org/

- CAPSA
  https://www.capsa.org/about/idaho/

Eastern Idaho (District 6)

- Domestic Violence & Sexual Assault Center — Idaho Falls
  https://www.dvsacac.org/

- Family Crisis Center — Rexburg
  https://familycrisiscenter.wixsite.com/familycrisiscenter

- Family Safety Network — Driggs
  https://www.familysafetynetwork.org

- FERN
  https://www.facebook.com/fernforensiccare/

- Mahoney House / Lemhi County Crisis Intervention — Salmon
  https://mahoneyhouse.org

Professional Resources

- PREA Resource Center
  Purpose: PREA standards, implementation, and confinement response resources.

- Idaho Sheriffs' Association
  Phone: (208) 287-0001

- Idaho Department of Correction — PREA Coordinator
  Phone: (208) 605-4772

- Idaho Department of Juvenile Corrections

- Federal Bureau of Investigation (FBI) Victim Specialist
  Purpose: Victim support and federal case coordination.

Strangulation Response

A multidisciplinary approach and guideline for the identification and response to on-fatal strangulation (NFS).

Quick Reference Guide: Non-Fatal Strangulation (NFS)

No visible injury does not rule out strangulation
Always treat as a potentially fatal event

Critical Facts

- High risk for stroke, brain injury, and death
- Loss of consciousness can occur in seconds
- No visible injury in ≈ 50% of cases
- Serious complications, including stroke or airway compromise, may occur hours to days later

Red Flags – IMMEDIATE ACTION REQUIRED

Symptom	Possible Injury	Required Action
Loss of consciousness	Anoxic Brain Injury	Immediate imaging (CT, MRI)
Voice changes (hoarse, raspy, absent).	Laryngeal Injury	Airway evaluation
Difficulty breathing/swallowing	Compromised airway	Emergency evaluation
Neurological symptoms (confusion, seizures, weakness)	Stroke / brain injury	Immediate imaging and emergency evaluation
Visual changes	Cortical injury	Emergency evaluation
Petechiae (face/eyes)	Venous obstruction	Full strangulation workup
Neck swelling/bruising	Soft tissue injury	Imaging and monitoring
Incontinence	Severe hypoxia	Emergency evaluation

Medical Response (All Clinicians & EMS)

Priorities

- Assume internal injury regardless of external findings
- Strongly encourage emergency department evaluation and imaging
- Monitor for delayed deterioration

Imaging (General Guidance)

- CTA Neck = Gold standard for vascular injury
- Encourage transport (even if symptoms are mild)
    - Visible and reported symptoms

Law Enforcement Priorities

- Treat as life-threatening felony
- No injury required for charge
- Photograph:
    - Injuries
    - Scene
- Collect:
    - 911call
    - Witnesses
    - Evidence

Evidence Basics (All Disciplines)

- Use exact quotes
- Photograph using the Rule of 3's
    - Orientation
    - Close-up
    - Scaled
- Swab:
    - Neck
    - Hands
    - Fingernails

Advocacy Priorities

- Screen for strangulation
    - "Did anyone put pressure on your neck?"
    - "Did you have trouble breathing?"
- Encourage medical care
- Focus on safety planning

Discharge Criteria (General)

Return immediately if:

- Breathing/swallowing becomes difficult
- Neurological changes
- Neck swelling
- Behavioral changes

Foundations: Non-Fatal Strangulation (NFS)

Purpose: The Idaho Strangulation Addendum serves as a multidisciplinary guidance to supplement the Sexual Assault Response Guidelines for the identification, assessment, documentation, and response to NFS. It is intended for use by:

- Healthcare providers
- Emergency Medical Services (EMS)
- Law enforcement
- Advocates
- Legal professionals

Goal: Support a coordinated, trauma-informed, and evidence-based response to a high-risk and often underrecognized form of violence.

Key Definitions

Note: Definitions are standardized for multidisciplinary use and may differ slightly across medical and legal contexts.

Strangulation:
The application of external pressure to the neck that obstructs blood and/or airflow, impairing normal breathing or circulation[39]

Manual Strangulation:
Compression of the neck using hands, forearms, or other body parts

Ligature Strangulation:
Use of a cord-like object (e.g. rope, belt, clothing) applied around the neck without suspension

Strangulation by Hanging:
Use of a ligature with suspension of the body (partial or full)

Choking:
An internal obstruction of the airway (e.g., food or foreign object). *Note: Victims/Patients often use "choking" to describe strangulation*

Suffocation:
External obstruction of airflow (e.g., covering mouth/nose or compressing chest), which may occur with or without strangulation

Asphyxia:
A condition of reduced oxygen delivery to the body due to airway obstruction or impaired breathing

Hypoxia:

Low oxygen levels in body tissues.

Anoxia:
Complete absence of oxygen to tissues or the brain

Petechiae:
Small red, brown, or purple spots caused by capillary rupture due to increased venous pressure, from vascular obstruction[40]

Overview of Strangulation

Strangulation is a high-lethality form of violence that can result in rapid unconsciousness, serious internal injury, or death-even in the absence of visible external trauma or injury39.

In many cases:

- External injuries are minimal or absent[41]
- Internal injuries may be delayed and life-threatening39
- Victims or patients may minimize or misinterpret symptoms

Strangulation is most commonly associated with intimate partner violence and is frequently used as a mechanism of control and coercion.39

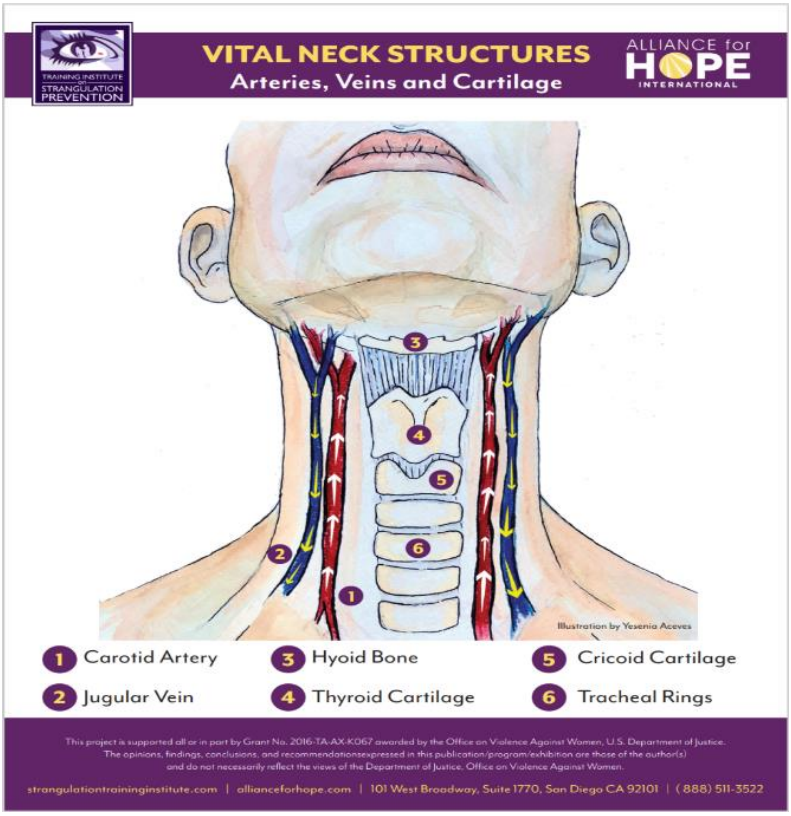
Mechanism of Injury

Strangulation causes harm through three primary physiological mechanisms:

1. **Vascular obstruction**
   Jugular vein compression prevents blood from leaving the brain resulting in increased intracranial pressure and vascular congestion39
2. **Arterial occlusion**
   Carotid artery compression restricts oxygenated blood flow to the brain and can lead to rapid loss of consciousness and brain injury39
3. **Neurological Reflex (Carotid Sinus Stimulation)**
   Pressure on the carotid sinus can trigger bradycardia (slowed heart rate) or cardiac arrest39

Neck Structures & Pressure Thresholds

Understanding the vulnerability of the neck structures highlights how minimal force can cause significant harm



Structure	Function	Approximate Pressure	Physiological Impact
Jugular Veins	Return blood from brain to heart	~4.4 lbs	Venous congestion, petechiae, ↑ intracranial pressure
Carotid Arteries	Supply oxygenated blood to brain	~11 lbs	Loss of consciousness, brain hypoxia
Trachea	Airway for breathing	~33 lbs	Airway obstruction

Even low levels of pressure can result in rapid and severe physiological compromise[40]

Time Course of Injury

Strangulation can result in immediate and delayed complications

- Seconds (0-10): Loss of consciousness can occur[39]
- Minutes: Brain injury or death is possible[39]
- Hours-Days: Stroke, airway swelling, vascular injury[39]
- Up to 1 year: Delayed complications, including stroke, airway compromise, or death have been reported.

Risk and Lethality

Non-fatal strangulation is a significant predictor of future violence and homicide.

- A history of strangulation is associated with a substantially increased risk of future lethal violence
- A single strangulation event has been associated with an approximately 7-fold (750%) increased risk of homicide[42]
- Victims/patients may not initially recognize the seriousness due to:
    - Lack of visible injury
    - Delayed symptom onset
    - Trauma-related memory impairment

Strangulation should always be treated as a medical emergency and high-risk event, regardless of presentation.

Key Clinical and Investigative Considerations

- Absence of visible injury does not rule out strangulation41
- Internal injuries may be rapidly fatal or delayed[1]
- Symptoms may be subtle or delayed[1]
- Victims/patients may:
    - Minimize the event
    - Use the term "choking"
    - Have impaired recall due to hypoxia or trauma39

Multidisciplinary Importance

Effective response to strangulation requires coordination across disciplines:

- Healthcare/EMS: Identify injury, stabilize, document
- Law Enforcement: Investigate, document evidence, build cases
- Advocacy: Provide safety planning and support
- Legal Professionals: Utilize evidence-based prosecution

A shared understanding of strangulation improves:

- Patient outcomes
- Victim safety
- Evidence quality
- Case prosecution

Medical/Clinical Response

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*While this manual uses the term "victim" to describe someone who has experienced strangulation, healthcare providers primarily treat "patients". Consequently, when referring to medical care, the individual will be referred to as a **patient**.*

Purpose: This section provides guidance for clinical assessment, stabilization, imaging, and disposition of patients presenting after suspected or confirmed NFS

The priorities are:

- Identify life-threatening injuries
- Recognize subtle or delayed symptoms
- Ensure appropriate imaging and monitoring
- Support accurate documentation for medical and legal purposes

Guiding Principles

- Assume internal injury regardless of external findings[39]
- Absence of visible injury does not exclude strangulation[39]
- Symptoms may be delayed, subtle, or rapidly progressive[39]
- Strangulation is a time-sensitive, high-risk condition[39]
- Maintain a trauma-informed, patient-centered approach

Initial Assessment and Stabilization

Immediate Priorities:

- Ensure airway, breathing, circulation
- Assess for life-threatening conditions
- Initiate rapid escalation when indicated

High-Risk Indicators (Require Immediate Evaluation)

Category	Findings
Neurological	Loss of consciousness, confusion, amnesia, seizures, stroke-like symptoms
Airway/Respiratory	Dyspnea, dysphonia (hoarse), aphonia, stridor, difficulty swallowing
Physical	Neck swelling, bruising, ligature marks, petechiae (face/eyes), subcutaneous edema
Other	Incontinence, visual changes, severe headache

Presence of any high-risk indicator should prompt urgent imaging and specialist evaluation[39]

Focused Clinical Assessment

Use open-ended questions and avoid reliance on precise timelines, as trauma and hypoxia may impair recall[39]

Key elements:

- Mechanism: Hands, body part, ligature, object
- Duration/Force: Perceived intensity
- Symptoms during event:
    - Loss of consciousness
    - Inability to breathe or speak
    - Visual changes (“spots”, “tunnel vision”)[39]
- Post event symptoms:
    - Voice changes
    - Headache, dizziness
    - Swallowing difficulty
- Safety considerations:
    - Pregnancy status
    - Prior strangulation history

Physical Examination

General:

- Perform head-to-toe assessment
- Recognize that injuries may be minimal or absent[39]

Neck & Head Findings:

- Bruising, redness, abrasions
- Ligature marks
- Swelling or tenderness
- Petechiae:
    - Eyelids
    - Conjunctiva
    - Face/scalp
    - Oral cavity (under tongue)

Additional Findings

- Torn frenulum
- Behind ears (mastoid) bruising
- Chest/shoulder injuries
- Signs of defensive injury (hands/arms)

Neurological & Functional Assessment

- Mental status (orientation, memory)
- Cranial nerve function
- Motor strength (bilateral)
- Sensory deficits
- Gait and coordination
- Pupillary response (PERRLA)

Airway & Voice Assessment

- Hoarseness or voice loss
- Pain with speaking or swallowing
- Frequent throat clearing
- Coughing
- Sign of airway compromise

Imaging and Diagnostic Evaluation

Indications for imaging: Imaging is recommended when[43]:

History (ANY of the following; current OR assault related and now resolved)	**Physical Exam (ANY abnormality)**
Loss of consciousness	Functional assessment of breathing, swallowing, and voice
Visual Changes: "spots," "flashing lights"	Thorough examination of neck, eyes, TMs, oral mucosa, nose, airway, upper torso for: tenderness, swelling, bruising, abrasions, crepitance, bruit
History of altered mental status: "dizzy," "confused," "lightheaded," "loss of memory," "loss of awareness"	Venous congestion/petechial hemorrhages/scleral hemorrhages
Incontinence (bladder or bowel)	Ligature mark = HIGH RISK
Neurological symptoms: seizure-like activity, stroke-like symptoms, headache, tinnitus	Tenderness of airway structures/carotid arteries = HIGH RISK
Ligature marks or neck contusion	Mental status/complete neurological exam
Neck tenderness or pain/sore throat/pain with swallowing	Clinical concern persists despite minimal findings
Change in voice; unable to speak, hoarse or raspy voice	

Imaging Modalities & Clinical Decision Guidance

Study	**Primary Use**
CT Angiogram (CTA)	Gold standard for vascular injury
MRI Neck	Soft tissue and vascular evaluation

MRI Brain	Anoxic brain injury, stroke
CT Neck (contrast)	Bone/cartilage injury
Carotid Doppler	Not recommended due to low sensitivity

Clinical Decision Guidance

Vascular Concerns → CTA Neck[44]
Neurological Symptoms → MRI Brain
Airway/soft tissue concern → MRI Neck

*Consider administration of one 325 mg aspirin if there is any delay in obtaining a radiographic study, unless contraindicated and consistent with provider judgment/protocol.*44

*When in doubt, err on the side of imaging, and injuries may be occult*39

Medical Forensic Considerations

Clinical care takes priority. Forensic elements should be integrated after stabilization and with informed consent39

Key Components

- Document patient statements verbatim (using quotation marks)
- Perform thorough injury documentation
- Coordinate with forensic examiners (SANE, SAFE).

Evidence Considerations

- Avoid unnecessary cleaning of injuries prior to documentation
- Identify areas for potential DNA collection (neck, hands, fingernails)
- Maintain chain of custody when applicable

Documentation Standards

Accurate documentation is critical for both clinical and legal proceedings.

- Patient's exact words describing the event
- Observed injuries (even if subtle or absent)
- Reported symptoms (during event, post event, and current)
- Behavioral observations (confusion, distress, affect)
- Clinical findings and interventions

Use:

- Body maps
- Narrative notes
- Clear, objective, and non-judgmental or blaming language

Disposition and Discharge

Criteria for Discharge

Patients may be considered for discharge when:

- Imaging (if performed) is negative
- No progression of symptoms
- Airway is stable
- A reliable observer (*not the perpetrator*) is available for at least 48 hours[39]

Discharge Instructions

Patients should return immediately if they experience:

- Difficulty breathing or swallowing
- Voice changes or worsening neck swelling
- Headache, dizziness, or confusion
- Vision changes
- Weakness or numbness
- Seizure activity
- Behavioral or mental status changes

Special Considerations

Pregnancy

Strangulation during pregnancy poses increased risk to both patient and fetus and requires urgent medical evaluation[39]

Delayed Complications

Patients are at risk for:

- Stroke (hours to days later)[39]
- Airway compromise (delayed swelling)[39]
- Neurological decline
- Death (reported up to 1-year post-event)[39]

Patient Refusal of Care

If a patient declines further evaluation:

- Document informed refusal
- Educate on serious risks and delayed complications
- Provide written discharge instructions
- Encourage follow-up care

Multidisciplinary Coordination

Healthcare providers should:

- Notify or coordinate with law enforcement when appropriate

- Offer referral to victim advocate
- Provide information on available resources (e.g., Crime Victims Compensation)

**Key Reminder: Patients may appear stable while harboring life-threatening injuries. Maintain a low threshold for imaging, observation, and escalation*[45]

Forensic/Evidence Response

Purpose: This section provides guidance for the recognition, documentation, and preservation of forensic evidence in cases of suspected or confirmed NFS

Goals:

- Preserve time-sensitive and fragile evidence
- Ensure accurate, objective documentation
- Support evidence-based investigation and prosecution
- Maintain a trauma-informed patient-centered approach

Guiding Principles

- Patient care takes priority over evidence collection[46]
- Obtain informed consent prior to forensic procedures46
- Evidence may be present without visible injury46
- Documentation should be objective, specific, and defensible
- Avoid actions that may compromise or contaminate evidence
- Maintain clear role boundaries across disciplines

Forensic Readiness: When to Consider Evidence Collection

Forensic considerations should be initiated when:

- There is reported or suspected strangulation
- The patient describes assault involving the neck, face, or airway
- There are visible or reported symptoms, even if subtle46
- Law enforcement involvement is present or anticipated

*Absence of visible injury does NOT eliminate forensic value*46

Documentation Standards

Accurate documentation is one of the most powerful forms of evidence

- Patient Statements:
    - Use verbatim quotes
    - Avoid paraphrasing
    - Example: Patient states “He put both hands around my neck and I couldn’t breathe”

Verbatim documentation improves evidentiary value and admissibility[47]

Descriptive Injury Documentation

Document:

- Location (using anatomical terms)
- Size (measure if cm)
- Color
- Shape/pattern (linear, oval, clustered)

- Number of injuries
- Patient-reported pain (even without visible injury)46

Behavioral Observations

Include:

- Affect (e.g., tearful, flat)
- Speech (hoarse, raspy, slow)
- Cognition (confusion, memory gaps)46

Required Tools

- Body map diagrams
- Narrative clinical notes
- Time/date stamps for all documentation

Forensic Photography

Photography provides objective visual evidence and should follow standardized technique

Rule of 3's:

- Orientation photo (location on body)
- Close up photo
- Scaled Photo (with measurement tool)

*Standardized forensic photography improves reliability and courtroom utility*47

Photography Best Practices

- Use consistent lighting
- Photograph at 90-degree angle
- Capture:
    - All visible injuries
    - Areas of reported pain (even if no visible injury)46
- Avoid:
    - Filters or editing
    - Obstruct injuries with measurement tools

Follow-up Photography

- Recommended at 24, 48, and 72 hours46
- Bruising and petechiae may develop or worsen over time46

Biological Evidence Collection

In cases of NFS, where sexual assault did not occur, a sexual assault collection kit should not be used for biological evidence collection

Indications

Collect DNA evidence when:

- There was direct contact (hands, ligature, body)

- The patient reports resistance (scratching, grabbing)
- There are contact areas or visible injuries[6]

Common Collection Sites

- Neck
- Under fingernails
- Palms/hands
- Face or other contact areas

Collection Principles

- Collect as soon as possible
- Use separate swabs for each site
- Label clearly (site, date, time, collector)

Evidence Handling

- Allow swabs to air dry for a minimum of 60 minutes
- Package in appropriate containers
- Maintain chain of custody[7]

Evidence Preservation Considerations

Do NOT:

- Clean wounds unless medically necessary46
- Apply dressing before documentation (if it is safe to delay)
- Allow unnecessary handling of evidence

Encourage patients (when appropriate)

- Avoid washing neck/hands prior to exam
- Avoid changing clothes
- Preserve items worn during the incident46

Multidisciplinary Roles

Clear role delineation prevents evidence compromise

Healthcare Providers/SANE/SAFE

- Conduct medical forensic exam (when trained)
- Document injuries and patient statements
- Collect biological evidence

EMS

- Prioritize life-saving care
- Document:
    - Patient statements

    - Voice changes
    - Mental status
- Preserve evidence when possible[46]

Law Enforcement

- Secure scene
- Collect physical evidence (objects and clothing)
- Photograph the scene and injuries (if indicated)
- Maintain chain of custody

Advocates

- Provide support
- Reinforce understanding of options
- Do not participate in evidence collection

Chain of Custody:

All collected evidence must be:

- Properly labeled
- Securely stored
- Transferred with documented tracking

Include:

- Collector
- Date/time
- Transfer documentation

Proper chain of custody is essential for admissibility in court[47]

Common Pitfalls to Avoid

- Failure to document due to lack of visible injury[46]
- Paraphrasing instead of quoting statements
- Vague descriptions (“red mark”)
- Delayed or missing photography
- Mixing evidence from multiple sites
- Breaks in chain of custody

Integration with Clinical Care

- Forensic processes should not delay urgent medical care[46]
- Coordinate:
    - Imaging
    - Evidence collection
    - Law enforcement involvement

Forensic steps should be integrated into clinical workflow whenever possible[46]

Advocacy Response

Purpose: this section provides guidance for advocates supporting individuals who have experienced NFS

Goals:

- Enhance immediate and long-term safety
- Provide trauma-informed support
- Improve victim understanding of risk
- Connect individuals to medical, legal, and community resources

Guiding Principles:

- Prioritize victim autonomy and choice
- Use a trauma-informed and non-judgmental approach
- Recognize strangulation as a high-lethality indicator
- Provide clear, accurate education about risks
- Support without directing or pressuring decisions

Role of the Advocate

Advocates play a critical role in:

- Early engagement and rapport building
- Safety planning and risk assessment
- Education on the seriousness of strangulation
- Facilitating access to services

Advocates do not:

- Conduct medical assessments
- Perform forensic evidence collection
- Investigate or determine legal outcomes

Initial Contact and Engagement

The first interaction is a critical window for establishing trust and addressing immediate needs.

Priorities:

- Ensure immediate safety
- Assess urgency of medical needs
- Provide emotional support and validation
- Introduce available resources and options

Trauma-Informed Approach

- Use open-ended, non-leading questions
- Avoid pressuring for details
- Validate experiences:
    - “What you went through is serious”
- Allow the individuals to control the pace and depth of disclosure

Screening for Strangulation

Screening for strangulation is critical to identifying individuals at elevated risk of serious harm or future violence.[48]

Victims may not identify their experience as strangulation and may use terms like “choking.”

Key screening questions:

- “Has anyone put pressure on your neck?”
- “Did you have trouble breathing during the incident?”
- “Has anyone covered your mouth or nose so you couldn’t breathe?”
- “Did you feel like you might pass out or lose consciousness?”

These questions help identify high-risk situations that require immediate attention

Education and Risk Awareness

Strangulation is a high-lethality form of violence and a significant predictor of future homicide39

Advocates play a key role in helping individuals understand the severity and potential consequences of strangulation

Key points to communicate:

- Strangulation can cause serious internal injury without visible marks
- Symptoms may be delayed or worsen over time
- It is a strong predictor of future violence

Language Guidance

Use clear, accurate terminology:

- Replace “choking” with “strangulation” when appropriate
- Explain the difference in a supportive and non-corrective way

Example: “When someone puts pressure on the neck, that’s called strangulation. It can be very dangerous, even if it didn’t leave marks.”

Safety Planning

Safety planning should be individualized, practical, and ongoing

Key Components:

- Assess current level of danger
- Identify safe places and exit strategies
- Develop a plan for emergency situations
- Discuss children’s safety (if applicable)
- Consider access to weapons

High risk indicators to address

- Prior strangulation incidents
- Escalating violence

- Threats to kill
- Pregnancy
- Access to firearms

Medical Advocacy

Advocates should strongly encourage medical evaluation, even if symptoms appear mild.
Serious internal injuries may occur without visible external signs, and symptoms can be delayed.39

When to emphasize urgency:

- Any breathing or swallowing difficulty
- Voice changes
- Neurological symptoms (confusion, dizziness)
- Pregnancy

Support Strategies:

- Explain why medical care is important
- Offer to help
    - Arrange transportation
    - Stay with the victim during care (if appropriate)
- Reinforce that lack of visible injury doesn't mean safety

Symptom Monitoring and Follow-Up

Symptoms may not appear immediately and can develop over time.

Internal Complications, including stroke or delayed fatal outcomes, have been documented following non-fatal strangulation.39

Encourage individuals to:

- Monitor for new or worsening symptoms
- Keep a log of symptoms (date/time)
- Seek immediate care if symptoms develop

Common delayed symptoms:

- Headache, dizziness
- Difficulty swallowing
- Voice changes
- Vision changes
- Behavioral or cognitive changes

Resource Connection

Advocates should connect individuals with relevant services, including:

- Medical providers
- Law enforcement (if victim chooses)

- Legal assistance
- Domestic violence services
- Idaho Crime Victims Compensation Program (CVCP)

Key support areas:

- Emergency shelter
- Protective orders
- Counseling services
- Financial assistance (e.g., CVCP)

Documentation (Advocate Role)

Advocates may document for internal or service purposes

Best practices:

- Record objective observations
- Document services provided
- Maintain confidentiality per agency policy

Avoid:

- Detailed forensic or investigation documentation
- Speculation or conclusions

Special Considerations

Victim Minimization

- Victims may downplay the severity
- Use education, not correction, to increase awareness

Trauma and Memory

- Memory gaps or inconsistencies are common
- Avoid interpreting this as lack of credibility

Cultural and Language Needs

- Use professional interpreters when needed
- Respect cultural context and barriers to seeking help

Multidisciplinary Collaboration

Advocates are a key part of a coordinated response

Collaboration includes:

- Healthcare providers (for medical needs)
- Law enforcement (when involved)
- Legal professionals
- Community organizations

Advocate Role in Collaboration

- Supporting the victim's informed decision making
- Help navigate systems
- Maintain a victim-centered perspective

Law Enforcement[49]

Investigation of Strangulation Cases

This section focuses on the challenges of investigating a strangulation case, discusses the core components for improving a strangulation investigation, reviews new tools, and provides practical tips for handling a strangulation case for dispatchers, first responders, detectives, and investigators working with prosecutors. Law enforcement officers need to be aware that by the time officers respond, victims may already be recanting, minimizing, or simply unaware of the seriousness of their assault, especially when strangulation is involved, as the victim may be suffering from anoxic brain injury. Victims may be traumatized by the incident, embarrassed, and/or afraid of the abuser or the police.

Law enforcement (indeed, all who interact with these victims) need to realize that a victim of prior strangulation is 750% more likely to be a victim of homicide at the hands of the same partner[50], although death may not be accomplished by strangulation.

While most strangulation victims (including fatal) will have no external evidence of injury, life-threatening internal injuries may be present.[51] The level of injuries and symptoms depends on many different factors including the method of strangulation, the age and health of the victim, whether the victim struggled to break free, whether the victim was under the influence of alcohol and/or drugs, the size and weight of the suspect, and the amount of force used.

The mindset of all domestic violence responders should mirror the philosophy of the prosecutor: How can this case be proved without the participation of the victim? Successful prosecution of strangulation cases is based on the responder's collection of evidence. If the entire case focuses on proving the offender's conduct, the investigation will move beyond the victim's testimony and lead to a stronger case supported by independent corroboration.

Strangulation may be commonly viewed as a non-consequential "disturbance" between a couple or a simple assault, but **strangulation should always be considered a life-threatening event**. Strangulation is a felony crime. If an investigation does not support the elements of strangulation, aggravated assault should be considered. Refer to the Prosecutor's section for other possible charges.

Idaho Code does not require injuries to prove attempted strangulation. The code, 18-923(1) reads, "Any person who willfully and unlawfully chokes or attempts to strangle a household member, or a person with whom he or she has or had a dating relationship, is guilty of a felony…"

- Household member is the same definition as set in 18-918(1)**, 18-918(3)**
- Dating relationship is defined as a social relationship of a romantic nature.
- While the prosecution is not required to show the defendant intended to kill or injure, the prosecution must show the intent to "choke" or attempt to strangle as defined. Intent can be proven through the investigation process.

If there is evidence to suggest the victim was strangled and their life was threatened, the case should be considered and investigated as if it were an attempted homicide.

Dispatch

When a caller reports a strangulation incident, communications personnel should follow standard agency protocols. In addition, communications personnel may consider the following actions:

- Dispatch a minimum of two officers whenever possible
- Assign a priority response whether the suspect is known to be on the premises
- Document the call and action taken for the call, including those that involve or appear to involve a law enforcement officer
- Attempt to elicit all information from the caller that may help the responding and investigating officer(s) assess the situation, including the following:
    - The immediate safety of the caller and those at the scene
    - Send medics to stage when any strangulation is reported
    - Other persons involved or witnesses at the scene, including children
        - Relationship between parties
        - Whether law enforcement has been called previously because of this suspect and the number of times.
        - Previous history of domestic violence
        - Presence of firearms or other weapons
        - Use of drugs or alcohol by either party
        - If dispatch locates any warrants for any parties involved
        - Determine whether there is a valid protection order or no contact order for any parties involved
- Whenever possible and when it will not jeopardize the individual's safety, keep the caller on the line to relay ongoing information to the responding officer(s). An alternative may be to ask the caller to place the phone down but leave the line open if possible and safe to do so.
- If a caller requests that law enforcement response be cancelled, advise the responding officer(s) of the second call. Officers should continue to respond, investigate, and assess the situation to ensure that all parties are safe.

The recording of the 911 call often contains "excited utterances" from the victim. Excited utterances generally refer to the spontaneous statements a victim makes just seconds and minutes after the assault. Courts view spontaneous statements or excited utterances under Idaho Rules of Evidence as admissible as an exception to the hearsay rule.

Initial Law Enforcement Officer Response – Special Considerations

When responding to a report of strangulation, officers should follow standard incident response procedures. Jurisdiction sizes and available resources vary across the state. Initial Law Enforcement Response, Crime Scene, and Follow-up Investigations might be handled by the same officer.

Officers should assume that any evidence not collected at the initial response may be lost forever if the victim becomes uncooperative.

After contacting the victim, the officers should ask the victim if they have talked with anyone since the strangulation and, if so, determine who they talked to.

- The importance of this question cannot be overstated, as asking the question during the initial response helps ensure it has been asked before the victim becomes uncooperative.

Follow the same steps for a thorough strangulation investigation.

In addition, officers shall do the following:

- Avoid parking law enforcement vehicles in front of the residence or other site of the disturbance when possible.
- Request entry in the event the incident is at a private residence. A warrantless entry is permissible if there is an objectively reasonable basis to believe that the safety of an occupant may be in jeopardy.
- Contact all individuals present, including potential witnesses, victims, or suspect(s); separate all parties, keeping all individuals out of sight and hearing range of one another as safety permits.
- Restrain and remove the suspect if necessary.
- Assess and document all injuries to all parties.
- Ask strangulation questions to victim to corroborate strangulation and determine external/internal injuries
- Administer first aid if needed
- Ask about sexual violence
- Ensure EMS are en route
    - Law enforcement should ask for EMS (if not already dispatched and en route) and should not ask the victim if he/she wants medical evaluation
    - Airway compromise can occur up to 96 hours after strangulation[52]
    - See Crime Victims Compensation Program (CVCP) Section for details on cost, reimbursement, payment, etc.
- Inquire about weapons in the area or access to weapons; identify and take temporary custody of firearms or weapons in plain sight.
- Determine whether there are any potential language barriers and request an interpreter when necessary. Do not use family to interpret, instead use language line.

If you are present during EMS exams and evaluations, do not interrupt or interject. Stand by for safety and protection.

Warning of Dangerousness of Strangulation

Officers should develop messaging that educates the victim of the extreme dangerousness of strangulation, this conversation may initially be helpful when informing them that EMS has been activated. Such messaging could resemble:

> "I want to caution you on the dangerousness of strangulation. Strangulation can cause internal injuries, brain damage, and/or delayed health consequences such as strokes, thyroid injuries, miscarriage and/or death. Research shows if you are strangled even one time, you are 750%

more likely to be killed by your partner.[53] We strongly encourage you to seek immediate medical attention at an emergency department and ask for support from an advocate."[54]

EMS should respond to all strangulations reported within 72-96 hours.

Look for other signs of injury such as subtle injuries around the eyes, under the eyelids, nose, ears, mouth, neck, shoulders, and upper chest area; where injuries are present, look for redness, scratches, red marks, swelling, bruising, or tiny red spots (petechiae) that arise from area of obstruction up from increased venous pressure.

Remember: There are often no signs of physical injury

If available, a medical forensic examination by a trained healthcare provider (SANE, SAFE, or Forensic Nurse) is strongly encouraged. In addition to a complete medical assessment of injury and trauma, the forensic nurse is highly trained in evidence collection, including swabbing of injuries for DNA and forensic photography.

If no signs are present that mandate immediate medical transport and transport for a medical forensic examination has been declined, complete the interview to capture pertinent information using the Idaho Strangulation Supplement Form.

On-scene Investigation

The investigating officer(s) should do the following:

- Inform the victim in advance of actions to be taken.
- Offer to contact a local victim witness coordinator or advocate to provide support to the victim as available and provide a list of current contact information for local domestic violence victim advocacy organizations.
- The officer should ask open-ended questions and allow victim to give a narrative.
- After the initial medical assessment, if the victim is not transported, conduct victim interviews in a location away from others at the scene. Interviews should be conducted in a way that recognize the impact of trauma on the victim. There is no right or wrong way to respond to a traumatic incident. The interview is a chance for a victim to share more information about what they can recall. This should not include a request for providing a chronological narrative. Officers should also avoid victim blaming statements. The interviewing officer should use active listening to show the victim their intent to understand what the victim is saying about their experience. Active listening allows the victim to provide an uninterrupted narrative prior to asking follow-up or clarifying questions. Officers should use open-ended questions instead of questions requiring a "yes" or "no" answer.

Examples of open-ended questions are:

- What are you able to tell me about your experience?
- Where would you like to start?
- What are you able to tell me about what happened prior to my arrival?

Interviews should include questions about:

- Follow up related to the Idaho Strangulation Supplement (*See* Addendum) to document signs and symptoms of external and internal injury.
- Acts of intimidation are intended to prevent the victim from calling law enforcement or seeking other assistance.
- Unwanted contact by the suspect that made the victim feel frightened or threatened.
- Ask the victim who they have talked to (if anyone) since the strangulation.
    - Commonly, there may be an important witness not present at the scene.
- Take photographs of injuries to all parties, including any healing or old injuries.
    - Ideally photographs should be taken 24, 48, and 72 hours later in the event the injuries become more visible and pronounced. If additional injuries are present, the injuries should be documented to show progression past the 72 hours.
    - Descriptive and specific documentation of the injuries should accompany the photos.
    - Officers should be sensitive to the victim's need for privacy, which may include the use of an officer of the same sex as the victim to photograph injuries.
- Take photographs of the scene to document any signs of disturbance and assist the prosecutor present a clearer picture of the incident to the jury at time of trial.
    - Photographs of the scene should be taken regardless of "signs of violence"
- Collect evidence to establish the facts of the crime.
- Check for the existence of a protection or no contact order through county records. Verify validity and any exceptions.
- Obtain a comprehensive account of the events from all parties. Whenever reasonable and practical, interviews shall be recorded.
- Cursory Interview children at the scene in a manner appropriate to their age. Document any signs of trauma and any apparent wounds or healing of wounds on the children and take appropriate action, in accordance with law, to prevent imminent harm to the children, such as notifying the appropriate child protective agency.
- Assess for and document all actual and suspected incidents of violence, including physical and sexual abuse, elder or child abuse, property damage, and animal cruelty.

Officer(s) shall not do the following:

- Make any statement that would discourage a victim from reporting an act of strangulation.
- Threaten, suggest, or otherwise indicate the possible arrest of all parties to discourage future requests for intervention by law enforcement personnel.
- Avoid acting because the victim stated prosecution was not desired.

Role of the Supervisor

Supervisors should do the following:

- Respond to assist officers investigating incidents of domestic violence when requested by an officer or whenever the incident appears to involve a law enforcement officer, prominent community member, or public official.

- Supervise the on-scene investigation, if not already completed, to ensure that appropriate action is taken.
- Review all reports for accuracy and consistency and conduct after-action reviews to ensure officers and investigators are conducting comprehensive, victim-centered, suspect-focused investigations.
- Assess for co-occurring and interconnected crimes when responding to domestic violence, to include (but not be limited to) stalking, sexual violence, strangulation, firearms prohibitions, protection order violations, intimidation and threats, and abuse of children, elders, and animals.

In the event a supervisor is not on duty at the time of an incident, offers shall:

- Contact the supervisor to inform them of the situation.
- When possible/practical, request a supervisor to investigate incidents that involve another officer, prominent member of the community, public official, etc.

Other Considerations

It may be appropriate to conflict these matters with an outside agency and should be considered.

Identification of the Predominant Aggressor

It can be difficult to determine if and who the predominant aggressor is.

In non-fatal strangulation cases, it is more likely that victims will use self-defense to stay alive. Because victims fear for their lives, they may protect themselves by pushing, biting, scratching, or pulling the suspect's hair. Depending on the method of strangulation being used, the suspect may be the only individual with visible injuries.

To identify the predominant aggressor officers should consider the following factors:

- Height/weight of the parties.
- Who is fearful of whom.
- Details of statement and corroboration.
- History of domestic violence, assaults, or criminal history.
- Use of alcohol or drugs.
- Whether either party is subject to a court order or on domestic violence probation.
- Pattern evidence.
- Injuries consistent with all reported statements.
    - Location and nature of injuries.
- Who poses the most danger.
- Who is seeking to stop the violence.
- Who is trying to avoid punishment.
- Use of weapons.
- Signs of offensive/defensive injuries.

In those cases where the officer does not affect an arrest but has probable cause, the law enforcement agency shall forward the offense report to the appropriate prosecutor within 10 days of making such report, unless the case is under active investigation pursuant to I.C. 39-6316(4).

The Arrest Decision

- Never ask the victim if they want the suspect to be arrested.
- Make a warrantless arrest in accordance with applicable law, as part of the preferred arrest response, if probable cause exists to believe that a person has committed a crime involving strangulation as defined by law or has violated a protection order.
- Follow the agency's policy on identifying and responding effectively to a child, present or not present, whose parent is arrested.
- When making arrest decisions, consider which individual appears to be the predominant aggressor. (Refer to previous section on identification of a predominant aggressor.)
- If an arrest is not made, the officer must provide an explanation in the report as to the reason why.
- When an arrest cannot be made due to lack of probable cause, the officer should
    - explain to the victim the reasons that an arrest is not being made, and
    - facilitate contact with a local domestic violence service provider for information regarding counseling and other services.
    - Allow victim to leave location for safety

Dual arrests are discouraged. If an officer has probable cause to believe that two or more persons committed a crime and probable cause exists to arrest both parties, the arresting officer may consider contacting their supervisor before proceeding with the arrests. In the event of a dual arrest, a report should be written and filed and include a detailed explanation indicating the probable cause for each arrest.

Evidence Gathering

- Ask the victim who they have talked with since the strangulation.
- 911 call
- Photographs of all injuries and the scene(s).
- Sketch of scene to include location of people on scene, distances, and areas of significance. (For example, the small space between the bed and wall where the assault occurred)
- Injuries elsewhere on a victim's body from strangulation and falling, being dragged, or thrown
- If Object used to strangle victim (photograph and collect). Ask the victim where the object came from (this may go toward intent) and where it currently is.
- Blood (on victim, suspect, walls, or area of assault [i.e. stairs])
- Clothing (photograph and collect)
    - Possibly stained with urine or feces as a result of strangulation.
    - Torn or ripped during the incident (may support pulling, dragging, and/or a struggle).
    - Property damaged during incident (photograph and collect)
- Collect list of "household rules" created by suspect.

- Victim diary or journal if prior incidents have been documented (copy or photograph). Avoid collecting entire documentation that might give suspect access to the victims fears and feelings.
    - If the victim has a diary or written journal of past similar events (including any electronic equipment, such as computer diary, notes, cell phone notes, etc.) the officer may ask if specific details from it can be copied/photographed. It is not recommended to collect the entire documentation as it may give the suspect (through defense) access to the victim's fears and feelings, exacerbating the control the suspect has over the victim.
    - Discuss safe methods to capture details of possible future events, such as having separate documents - one for feelings/fears and another to document specific details of threats and assaults. Assisting the victim in this manner demonstrates belief in their report of violence and may foster a stronger rapport with law enforcement, possibly leading to improved victim cooperation.
- Medical/Dental records release form
- EMS/Fire responders' names and reports
- Photographs of victim, suspect, and children (see photograph section below for more detail)

Photographs

SANE/SAFE (Sexual Assault Nurse Examiner/Sexual Assault Forensic Examiner) examiners are trained in evidence collection, including forensic photography. If an agency has access to a SANE/SAFE to perform a medical examination, forensic photographs can be taken by them. If that is not possible, consider having a female officer take photos of the female victim, especially if there are injuries to the sensitive areas. The victim may need to change or remove clothing to accurately document injuries. Expose only the portion of the anatomy with the injury to protect the victim's modesty. Victims will likely be embarrassed and there could be cultural considerations. Law Enforcement should be aware and mindful of the use of BWC (Body Worn Cameras) during collection of these specific areas.

Photographs are an important piece of evidence in the investigation. Keep an open mind about what you should or should not take photos of, which may include:

- Distance photograph
    - One full-body photograph of the victim from a distance will help identify the victim and the location of injury(ies)
- Close-up photograph
    - multiple close-up photographs of the face/neck area, and any other area of injury *or potential injury*
        - Any area the victim reports may have been injured, even if no injury is visible, should be photographed.
        - Ask about any areas of pain and photograph those, even if no injury is visible.
            - Bruising may develop over time and the initial photograph can corroborate that there was not a pre-existing condition.
- The photograph needs to accurately reflect what you saw.
    - Do NOT edit any photograph in any way.

- Take photographs at 90-degree angle to prevent distortion (injury appearing either larger or smaller than it actually is).
- Use a scale for each injury.
- Consider lighting, taking as many photographs as needed to accurately capture the injury.
    - Use an off-camera flash at an oblique angle to avoid lighting with harsh shadows.

- Identification and conditions should be considered when taking photographs.
    - Consider your background.
        - It should be uncluttered (if possible).
        - The background should be neutral and should not be prejudicial to the subject being photographed.
    - To document identification of a person a minimum of five photographs should be taken:
        - front of person (head to toe)
        - left side of person (head to toe)
        - right side of person (head to toe)
        - close-up of face
        - If the person is wearing any accessories (sunglasses, hat, etc.) the person should first be photographed wearing those, and then photographed with the accessories removed.
    - If the condition of a person's clothing or body is important to document, relationship and identification photos should be taken.
        - Defects in clothing should be taken with and without a scale
    - When relevant, identifying characteristics (e.g. tattoos, piercings, unique skin markings/scars/conditions) should be photographed for relationship and identification.
    - The Rule of 3's should be used for injuries:
        - An orientation photo: photo of injury with 2-3 anatomical markings to demonstrate location of injury
            - for example, if the injury is located on a cheek, take a photo of the injury that includes the nose and ear, so it is clear which side of the face the injury is on.
        - A close-up of the injury – fill the camera frame with just the injury, if possible.
        - Scale photo - pull back a bit and place an ABFO ruler (or other L-shaped ruler) next to the injury, without covering any part of the injury and photograph again to demonstrate size of the injury.

For strangulation cases, especially where there is florid petechiae (diffuse red spots that may look like a rash covering most of the face and neck), officers also take photos of the victim when the injuries have cleared. Florid petechiae is evidence of the obstruction of blood flow.[55]

Follow-up photographs can document the progression of injury and can be taken by a SANE/SAFE (if available) or officer.

Photographs of home are often powerful, and can give an indication of living conditions, which may involve children and possibly pets. The decision to photograph a child, or children, is a delicate one which must be considered on a case-by-case basis with weight being given to how such photographs may negatively impact the rapport and cooperation law enforcement has worked hard to foster with the victim. The decision must be a balance between maintaining trust and rapport with the victim against the possible value of the photographs as evidence demonstrating the presence of violence in the home.

The officer needs to ensure the children have not sustained injury during the event; if a child is injured, photo documentation of those injures is appropriate.

Strangulation by (or of) Law Enforcement

In cases where one (or more) party of a reported strangulation incident is a law enforcement officer, responding officers shall follow standard domestic violence procedures as outlined in this policy, regardless of jurisdiction. In addition, the following procedures shall be followed.

Notifications

- When communications personnel receive a call that involves or appears to involve a law enforcement officer, they shall immediately:
    - Notify and dispatch a supervisor, regardless of the involved individual's jurisdiction, and notify responding officers that the call involves a law enforcement officer.
    - If previously unaware that the call for service involves a law enforcement officer, responding officer(s) shall immediately notify communications personnel and request that a supervisor of higher rank than the involved officer report to the scene, regardless of the involved officer's jurisdiction.
- The on-scene supervisor shall notify the chief executive or their designee and the accused individual's immediate supervisor as soon as possible.
- If the officer is from another jurisdiction, the supervisor shall ensure that the chief executive or their designee in the accused officer's jurisdiction is notified.
- If the reported incident involves the chief executive of a law enforcement agency, the appropriate prosecutors and the individual with direct oversight of the accused individual shall be notified.
- All notifications and attempts to notify shall be fully documented.

Victim Safety and Protection

Officers shall do the following:

- Remain at the scene of the incident until the situation is under control.
- Provide victims with information about:
    - obtaining an order of protection, if legally permissible.
    - local domestic violence service providers.

    - victim compensation
    - Victim Information and Notification Everyday (VINE – see Addendum); and
    - crime report number and officer contact information.
- Advise the victim what to do if the suspect or others harasses or intimidate the victim, witnesses, or others.
- Assist the victim in establishing a safety plan, whether they plan to remain with the suspect.
- Law enforcement should complete an Idaho Risk Assessment of Dangerousness (IRAD) on each domestic violence call for service including domestic battery, sexual assault, stalking, and strangulation. See Addendum for example of IRAD.

Idaho Risk Assessment of Dangerousness (IRAD)

The Idaho Coalition joined with Boise State University (BSU) to help research and develop a risk and lethality assessment tool for Idaho. BSU utilized national and state specific case law, fatality reviews, and research to design a tool. The goals, purpose, and usefulness of the tool were identified. The research helped highlight the most prominent antecedents, which were incorporated into seven risk factors on the IRAD. The categories include history of domestic violence, threats to kill, threats of suicide, separation, coercive/controlling behavior, prior police contact, and alcohol or drug abuse. The IRAD is a tool that can be used by multiple disciplines who interact with either a survivor or offender of domestic violence.

Incident Documentation

- Complete a thorough, detailed report following response to or investigation of a report of strangulation to include the Idaho Strangulation Supplement, whether an arrest is made.
- In addition to routine documentation regarding the incident, the officer should ensure that elements as they relate to the domestic violence relationship are captured, including the following:
    - Observations upon approach, including the demeanor of the victim, suspect, and witnesses
    - Relationship of parties involved
    - History of relationship
    - Current or past protection orders
    - Prior calls to the location involving the suspect
    - Probation or parole status of the suspect
- Information on co-occurring crimes to include stalking; sexual violence; strangulation; firearms prohibitions; protection order violations; intimidation and threats; and abuse of children, elders, and animals
    - Details of any children present
    - All threats and intimidation tactics used by the suspect
    - Presence or use of firearms or weapons
- Consider use of a report checklist similar to below:

(*See* attachments for the *Idaho Strangulation Form* and *Strangulation To-Do's Checklist* for investigation.)

Follow-Up Investigations

Follow-up is a crucial step in strangulation cases. Because of potential witness intimation or fear, victims are often reluctant to move forward. The more information that can be gathered will be beneficial in helping the prosecutor's office with the focus on how to prove the case even without the participation of the victim.

1. A detective, or the investigating officer shall be designated to make follow-up contact with victims of strangulation and inquire whether additional violence or intimidation has occurred. Subsequent incident(s) shall be treated as separate events, assigned a new case number, and investigated in accordance with the agency's policy.
2. Following an arrest, the detective, or investigating officer shall notify victims of any conditions of bail and advise the victim of their right to request revocation of bail from the state, county, or city attorney's office if the conditions are violated.
3. A trained member of the agency should be assigned to assess the level of danger posed to the victim to inform suspect release decisions.
4. Follow-up investigation should verify the above investigative steps were taken from dispatch call until the follow-up investigation.
5. Take follow-up photographs 2 to 3 days following the original incident. They can provide far more powerful evidence of the true extent of injury(ies) than initial on-scene photographs. Since most bruises are not visible for days after a violent assault, follow-up photographs must be central to every investigation.
6. Conduct a detailed follow-up interview. A follow-up interview with the victim is just as important as taking follow-up photographs; officers need to consider that the impact of trauma may still impact memory for 24-48 (and possibly up to 96) hours after the event. Victims may often give more detailed statements after they have had a chance to recover from the trauma response. Refer to the Neurobiology of Trauma chapter for additional information.
    a. Obtain the name, address, and phone number of two close friends or relatives of the victim who will likely know their whereabouts in the future
    b. Obtain statements of family members, including any children in visual or auditory presence of the assault for corroboration of the assault and/or history of the relationship.
    c. Request records check for documented domestic violence history.
    d. An interview with the victim regarding all prior domestic violence incidents including dates, locations, witnesses, injury, and corroborating evidence.
    e. Obtain a statement by the victim regarding prior admissions and apologies from the defendant, especially those documented in any texts, e-mail, social media, letters, notes, or cards.
    f. Attempt an interview with the suspect if he was not interviewed by responding officers.
    g. Consider the defendant's phone records to show his contact with the victim, including copies of the recordings of calls from jail.

h. Consider notes, cards, emails, faxes, and letters (including those sent from jail).
i. Any statement by the victim regarding any "house rules" for the victim to follow that the abuser may have written and displayed in the house; and
j. A log of history of abuse by the defendant.
k. Post arrest follow-up considerations

After the defendant is arrested, there will be new evidence to collect. Defendants will call, message, or video visit victims from the jail. They will apologize, harass, threaten, intimidate, and violate protection orders in order to get their victims to drop charges. Therefore, it is important to obtain copies of jail communication made from suspects who are in jail, and review the content of the calls, text messages, and video visits. By collecting this valuable evidence, investigators can assist prosecutors in building their case.

Monitor for:

- violation(s) of no contact orders and/or court orders
    - send a copy of the no contact order to the victim
- bond
- stalking
- intimidation
- re-offenses

Remember, victims may experience voice changes in non-fatal strangulation cases. ***Record (via audio or video) your follow-up investigation to document voice changes*** for later evaluation by medical experts and to corroborate the victim's allegations. Many digital cameras today also have a video feature; use this feature to capture a raspy voice, difficulty swallowing, coughing, pain exhibited by the victim, and drooling.

Collaboration and Training

- Agencies should establish or maintain ongoing partnerships with local community stakeholders and victim advocacy organizations to develop a holistic approach to responding to victims of domestic violence and ensure they are notified of all available resources.
- Agencies should consider comprehensive mandatory instruction on their policy on an annual basis.

Lack of training among law enforcement, first responders, and healthcare providers may reduce recognition and documentation quality for strangulation cases.[56]

Law enforcement should anticipate the possible recantation of the victim when investigating a strangulation associated with domestic violence; recantation does not indicate the need to end an investigation, but to build a case that can be prosecuted without the cooperation of the victim (*See* "Recantation" and the Addendum section for the Recantation Process Wheel).[57]

Prosecution

"Anytime we are able to file a felony charge and convict on one, we are enhancing victim safety."

WATCH Report, 2007

Purpose: This section provides guidance for the prosecution of non-fatal strangulation cases, emphasizing evidence-based case development, multidisciplinary collaboration, and victim-informed practices.

Goals:

- Build cases that are not dependent on victim testimony
- Strengthen outcomes through corroborating evidence
- Improve victim safety through successful prosecution

Overview

In some respects, prosecuting strangulation cases is similar to prosecuting other types of domestic violence. These cases rely on two key elements for successful prosecution: (1) make the case more dependent on the evidence than it is upon the testimony of the victim, and (2) develop as much corroborating evidence as possible. Strangulation prosecution requires the additional need to explain and emphasize the seriousness of the act. Accomplishing this requires using expert testimony. Vertical prosecution (in which one prosecutor handles the case from start to finish) by specially trained prosecutors can greatly improve the probability for a successful prosecution

Initial Investigation

The initial investigation of strangulation cases falls outside the prosecutor's direct control, but that does not prohibit prosecutors from influencing the way law enforcement conducts the initial case investigation. Prosecutors possess both the ability and responsibility to collaborate with law enforcement in developing an effective response.

Depending upon the resources available in a particular jurisdiction, protocols may need to be modified to include:

- Recorded statements by the victim
    - Getting LE specialized training on trauma-informed interviewing
- Asking the victim who they have spoken to since the strangulation, which may identify undiscovered witnesses
- Interviews of all witnesses
- Defendant's statement

- Photographs of the crime scene and documentation of injuries/lack of visible injuries
    - Progression photos
- Collection of any evidence left by law enforcement
- 911 or other calls to law enforcement
- Medical records- implement a practice of having patrol get a medical release signed
- Evidence of prior acts
- Police reports
- Restraining orders or other family law paperwork

Pre-filing Contact with the Victim

Victims can recant, minimize, and avoid coming to court. Early victim contact can limit this behavior. Still, prosecutors should not assume the victim will be available and willing to cooperate with the prosecution of the case. In situations with living victims, prosecutors should approach the case as if they are prosecuting a homicide, because homicide cases are always prosecuted without a victim.

One critical component of early contact is to provide victims with an opportunity to be heard and ask questions. While it is important to inform victims about their rights and the court process, the initial contact should focus on the victim doing most of the talking. Victims often enter the initial contact influenced by their abuser regarding what to expect, and so victims can be guarded or nervous. So, let them speak first. Let them ask questions. This can really help bring the walls down, so to speak. Even if the victim is ultimately uncooperative, there is value in maintaining open communication. Build that comfort level and rapport first. Then focus on victims' rights and court process details. Have the initial contact be in-person as much as possible.

If you can prove your case independent of the victim coming to court to testify about what occurred, then you have a very solid case. However, this emphasis on evidence-based prosecution should not limit your desire to obtain information from the victim.

Follow-up investigation

Because the initial investigation may fail to uncover clear, visible evidence of injury, successful strangulation prosecution demands follow-up investigation with the victim. In some jurisdictions, this investigation can be conducted by law enforcement, but in many jurisdictions the existence of any follow-up investigation will fall upon the prosecutor's office[58]. If your jurisdiction cannot allow for pre-filing interviews, the investigation conducted by law enforcement becomes even more critical in the filing determination.

While Idaho law does not specifically entitle a victim to an advocate or support person, this is a best practice and consistent with the spirit of the rights of crime victims found in Article 1, Section 22 of the Idaho Constitution[59] and Idaho Code 19-5306. Early contact informs victims about their rights and the

court process.[60] The interview creates an excellent opportunity to provide victims with information regarding their case and to dispel misinformation.

The follow-up interview also provides an opportunity for providing and collecting information as well photographing bruises or other injuries as they progress, develop, or heal. The follow-up interview provides law enforcement with the chance to collect evidence that might have been missed during the initial investigation, and it can provide a glimpse into the power and control involved in the relationship. If possible, have law enforcement present at the interview to further document injuries and additional information provided by the victim.

The interview may help to better document prior instances of domestic violence. It can alert the prosecutor to issues involving the victim's ability to cooperate with prosecution efforts. Even where law enforcement conducts a thorough investigation, evidence that initially seemed irrelevant gains meaning. If the victim has not adequately described the incident, this is a good time to get that description.

Prosecutors and law enforcement are cautioned against demonstrating the strangulation on the victim. To avoid re-traumatization, use a mannequin or wig head, doll, or stuffed animal. As demonstrations can be quite compelling consider video recording them as they may be admissible at trial. At the very least, if a follow-up interview is not able to be conducted, invite the victim to take progression photos and email them to the investigating officer or prosecuting attorney's office investigator.

Medical Examinations

One of the best methods of collecting evidence for the prosecution is through a medical examination of the victim. If the victim was not examined by medical personnel following the crime strongly encourage the victim to schedule an examination.

Properly trained medical personnel can provide not only emergency medical treatment, but careful diagnosis of the victim and documentation of physical signs and symptoms. Alternate light sources, laryngoscopy, CAT scans, MRIs, and other medical tools not only document evidence of the strangulation but also provide life-saving diagnostics. Prosecutors should work closely with their medical providers to develop effective protocols to document and treat strangulation victims.[61]

The medical examination may yield some potentially exculpatory evidence. Part of the treatment and documentation process may reveal the victim has used intoxicants. It may also indicate the victim inflicted some of her own injuries in an effort to stop the abuser. **The importance of the victim receiving proper treatment and documentation of injuries outweighs any concern of obtaining potentially exculpatory evidence.**[62] Whether an item of evidence is favorable to the prosecution or to the defense turns on the argument of the lawyers and not the evidence itself.

Mandatory Reporting

Treatment of Victims of a Crime or Injury Inflicted by Firearm.

Idaho Statute 39-1390 requires "[A]ny person operating a hospital or other medical treatment facility, or any physician, resident on a hospital staff, intern, physician assistant, nurse or emergency medical technician, shall notify the local law enforcement agency of that jurisdiction upon the treatment of or

request for treatment of a person when the reporting person has reason to believe that the person treated or requesting treatment has received:

(a) Any injury inflicted by means of a firearm; or

(b) Any injury indicating that the person may be a victim of a criminal offense.

(I.C. § 39-1390(1)). The report to law enforcement must be made "[a]s soon as treatment permits" and (except when obtaining anonymous sexual assault evidence kits) "shall include the name and address of the injured person, the character and extent of the person's injuries, and the medical basis for making the report." (*Id.* at § 39-1390(2)).

Significantly, § 39-1390 requires the report regardless of whether the patient desires or consents to the report….

Under this statute the strangulation must be reported regardless of the victim's preference; it must also be noted that if strangulation occurs during a sexual assault the sexual assault does not need to be reported; healthcare providers can, at the preference of the victim, report just the strangulation.

Photo-documentation and Voice Recordings

Because the injuries caused during a strangulation attack may prove difficult to recognize, a good practice is to take follow-up photographs over a period of time. This can help differentiate petechiae from other red spots on the face, and it can also show changes in skin hue and document swelling and reduction of swelling.

Voice recording of the victim may also demonstrate changes in voice and speech patterns. It may be helpful to obtain a copy of any voice message left by the victim prior to the strangulation for comparison to the post-strangulation voice.

Victim Advocacy

Advocacy is an important part of the victim follow-up process. This is the opportunity to inform the victim about safety options and to assess the danger to the victim. Victim advocacy is discussed in detail in the Advocacy section of this manual.

Identification of Other Witnesses

After the initial chaos of the crime has subsided, the victim may be in a better position to recount what occurred and may have already done so with a neighbor, a close friend, or a relative, or may have reported the incident as a justification for missing employment. The initial statement may not completely reflect the incident.

The victim may still be experiencing trauma from the assault or experience stroke-like symptoms that inhibit speech function called dysexecutive syndrome. Reviewing the report of the incident with the victim may be helpful. Document persons the victim has seen since the incident. Follow-up interviews with those individuals may provide evidence that the victim was acting or speaking differently after the incident than s/he normally behaves.

If a victim has sought a civil domestic violence protective order, the statements made by the victim in the petition as well as those on the record at the hearing(s) are often useful.[63] Copies of these records should be obtained and provided to the prosecutor and disclosed to the defense attorney.

If emergency personnel evaluated the victim and/or transported the victim to a medical facility, obtain the records of paramedics and interview the involved personnel. The victim may make statements in the course of the emergency that are later admissible at trial even over the defendant's right of confrontation.[64]

The Filing Decision

The Idaho Constitution guarantees victims the right to a timely disposition of the case. Speed can protect the victim and help break the abuser's control over the victim. The evidence in strangulation cases can be lost quickly. Because of their lethality and the evanescent nature of the evidence, strangulation cases should have priority review.

Protocols/Policies

A case should not be filed unless there is probable cause to support the charge…[65] (Or ABA standard 3-4.3 A prosecutor should seek or file criminal charges only if the prosecutor reasonably believes that the charges are supported by probable cause, that admissible evidence will be sufficient to support conviction beyond a reasonable doubt, and that the decision to charge is in the interests of justice.) Nothing in this section should override that guideline. Prosecutors also need to be aware of any filing protocols within their own office. There are a number of factors to consider in making the determination whether to file a charge.

Recognize that the lack of injuries may cause prosecutors to minimize the severity of the incident. Also recognize that the existence of injury does not necessarily identify the abuser or victim. Identifying the dominant aggressor is an important aspect of strangulation-case evaluation. The batterer may have numerous cuts, scratches, bite marks, or other injuries that were inflicted by the victim as a direct response to being strangled by the abuser. This creates a misperception that the party with the visible injury must be the victim. This oversimplification can lead to the filing of charges against actual victims, leaving them unprotected against their abuser.

Victim Cooperation

Can you prove the case without the victim? Utilize the theme of "treat the case like a homicide so it doesn't become a homicide." If the defendant was successful in efforts to strangle the victim to death, there would be no victim in court. Assume you do not have a victim. Assume the victim will be pressured by the defendant and others to not testify. The victim may go into hiding, become uncooperative, or come to court and be held in contempt for refusing to testify. If any of these things occur, consider how you will establish the case.

A solid investigation may allow you to proceed without the victim. Examine the physical evidence and any statements made by the batterer. Look for pieces of non-testimonial hearsay evidence that might be admissible as a spontaneous statement or otherwise admissible hearsay. Remember that the

confrontation right is a trial right that can be overcome if the statement is non-testimonial and otherwise admissible.[66] It can also be overcome if there is evidence of witness intimidation or wrongdoing by the defendant in which case the defendant forfeits his right to cross-examine the victim. Idaho Evidence Rule 804(b)(5)

The Victim's Attitude Towards the Prosecution

As long as the case can be proven without the testimony of the victim, the victim's attitude toward the prosecution of the case has no bearing on the charging decision. If the case cannot be established without the victim's testimony, what is the victim's attitude towards the prosecution of the case and, more importantly, why is the attitude the way it is? Perhaps victim advocacy can address the reasons for the victim's refusal to cooperate.

If the victim is being coerced into not cooperating, this may give rise to a claim of forfeiture by wrongdoing.[67] Under Idaho Rule of Evidence 804(5) prosecutors may argue forfeiture by wrongdoing or pursue witness intimidation charges against the defendant.[68]If the victim is being coerced into not cooperating, this may give rise to other charges as well.

Choice of Charges/Multiple Charges

Multiple charges may be considered and brought for each distinct criminal act which occurs during the assault episode. For example, should the offender first use their hands to apply pressure to the victim's throat and impede breathing or circulation, followed later by using an object to cover the victim's mouth to interfere with breathing, two counts should be charged.

The list could continue almost indefinitely. The point is that strangulation is often one component of a series of domestic violence and other criminal offenses.

However, the Idaho Court of Appeals has held "that when a person commits multiple acts against the same victim during a single criminal episode and each act could independently support a conviction for the same offense, for purposes of double jeopardy the "offense" is typically the episode, not each individual act." State v. Moffat, 154 Idaho 529 (Ct.App.2013) (Double jeopardy prevented the Defendant from conviction for both attempted strangulation and domestic battery where there were multiple acts against the same victim during a single criminal episode.)

If you have information that the defendant also committed a different crime investigate that as well; do not drop your investigation of that crime, look for the low-hanging fruit.

Consider whether the facts of the case support the following (non-exhaustive) list of potential charges:

- I.C. 18-4004, I.C. 18-204 – Attempted Murder
- I.C. 18-923 – Attempted Strangulation
- I.C. 18-907 – Aggravated Battery
- I.C. 18-905 – Aggravated Assault
- I.C. 18-903 – Battery

- I.C. 18-6501 – Robbery
- I.C. 18-2604 – Intimidation of a Witness
- I.C. 18-1505 – Abuse, Exploitation, or Neglect of a Vulnerable Adult
- I.C. 18-1401 – Burglary
- I.C. 18-7905, I.C. 18-7906 – Stalking
- I.C. 18-7008 – Misdemeanor Trespassing
- I.C. 18-2407 – Grand Theft
- I.C. 25-304 – Cruelty to Animals
- I.C. 18-918 – Domestic Battery
- I.C. 18-6409 – Disturbing the Peace
- I.C. 18-1501 – Injury to a Child
- I.C. 18-7001 – Malicious Injury to Property
- I.C. 18-920 – Violation of a No Contact Order
- I.C. 18-6710 – Use of Telephone to annoy, terrify, threaten, intimidate, harass, or offend
- I.C. 18-6810 – Intentional destruction of a telecommunication line or telecommunication instrument
- I.C. 18-2603 – Evidence Destruction
- I.C. 19-2520B – Enhancement for infliction of great bodily injury
- I.C. 19-2520 – Enhancement for use of a firearm or deadly weapon
- Various Sexual Offenses

Child Victims

The following offenses or enhancements may be considered in addition to the charges described above when children are victims of violence.

- Idaho Code 18-918(4) – doubles the penalty for domestic battery or domestic violence done in the presence of a child under 16.
- Idaho Code 18-923(8) – doubles the penalty for attempted strangulation in the presence of a child under 16.
- “in the presence of a child” means in the physical presence of a child or knowing that a child is present and may see or hear an act of domestic assault or battery. I.C. 18-923(8)

When the victim is a child, consider asking the jury to find aggravating factors so the court may impose a harsher sentence beyond the typical range of the pertinent sentencing statute. See below for a discussion of possible aggravating factors.

Felony or Misdemeanor Charges

Strangulation, when it can be proved, should always be filed as a felony. In a continuum of violence, strangulation falls just short of homicide. The seriousness of the offense cannot be overemphasized.

Setting Bail and Other Safety Measures

Bail provides several opportunities for the prosecution to impact the batterer. First, setting bail may help keep the abuser from exerting power and control over the victim. Second, establishing a bail that keeps the victim safe from the abuser empowers the victim to seek a resolution of the relationship. In setting bail, remember that the safety of the public and the victim is paramount. For crimes of domestic battery, they shall be on a no bond hold until initial arraignment. When an offender is charged with a domestic violence offense the court should not permit the offender to return to the victim's home or place of employment for as long as the Court sees fit[69]. The bail hearing provides an excellent opportunity to educate the bench regarding the lethality of this type of violence. Consider calling a strangulation expert at this stage of the proceedings. If your office is in the process of developing experts in strangulation, the bail hearing can serve as a testing ground for assessing the strength of your expert.

Preliminary Hearing & Grand Jury

Preliminary hearings provide another opportunity to break the power and control of the abuser. However, they are adversarial, as the defendant is present with counsel, and the defendant's friends or family may attend the hearing, thus applying more pressure to a victim. A prosecutor may elect to present the case to a Grand Jury instead. However, one should consider that the testimony (transcript) cannot be presented to a jury if the victim fails to appear at trial, while the preliminary hearing transcript can be used.

As Grand Jury presentation can occur relatively quickly after the offense (since you don't have to consider defense counsel's availability and preparation), when the victim and associated family member witnesses are more likely to still be cooperative and talkative. While a common practice is to take a minimalist approach - present the evidence and witnesses to the grand jury as quickly and as expeditiously as possible - another practice should be considered in domestic violence cases.

Careful and detailed questioning of the victim and witnesses before the Grand Jury is an excellent way to preserve evidence which, in the event the victim or witness recants or "forgets" at trial can be subsequently played for the trial jury.[70] Often subtle examination at Grand Jury can lay a foundation to counter the trial defense. Children - even young children - who were present at the scene are often excellent Grand Jury witnesses.

While some find it distasteful to call children to testify, doing so sends a clear message to the offender and their attorney that the prosecution is prepared and willing to do so. This encourages pleas. While it is not necessary, it is good practice to present evidence regarding strangulation to educate the Grand Jury and the public about the seriousness and effects of strangulation. This could be from a forensic nurse or other medical care provider, or in some cases, a law enforcement officer with training and experience in the field. Presenting these expert witnesses to the Grand Jury also gives them some experience as witnesses.

Case Preparation

Electronic evidence is prevalent today. Investigators can gain valuable evidence through the collection of cell phone data, text messages, social media, and other forms of electronic data. If the defendant is in custody, jail calls and jail mail should be monitored and obtained. This process becomes especially critical as trial approaches and the batterer's need to dissuade the victim increases.

Specifically ask the victim if there is a Bluetooth device (such as Alexa, etc.) in the home. Every time you meet with the victim ask if they have pictures on their phone or other device and double-check what the prosecution has against what the victim has.

Eliminating Defenses

Strangulation cases have a series of potential defenses (or excuses) that typically arise. Adequate case preparation involves being able to address these defenses:

The victim self-inflicted her injuries. If the victim has readily apparent visible injuries, the defense can claim the victim self-inflicted the injuries. The defense will play this off as a victim who is vindictive for some reason. The victim inflicts her own injuries and then contacts law enforcement in an effort to make the defendant suffer.

Two areas of preparation are required to counter this defense. First, research and then eliminate potential reasons for the victim to fabricate the claim. Second, utilize the strangulation expert to explain how the victim's injuries are the result of the defendant inflicting them or the victim defending against the defendant's attack.

The victim likes to be strangled. Another claim that may arise is that the victim and defendant engage in strangulation as a consensual activity, likely intertwined with some type of sexual behavior. Again, pre-trial investigation can eliminate this defense. The location of the occurrence and the absence of any sex toys, bondage tools, erotica, or other related instruments can be useful in defeating this defense. If this was consensual activity, the victim would not be reporting it.

The injury was an accident. This defense involves the defendant claiming the strangulation occurred through some mistaken action. The defendant was trying to calm the victim and his hands—that were meant to be placed on her shoulders—accidentally slipped to the neck, the defendant/victim fell into the grasp of the hands, or some other form of seemingly innocent explanation.

The defense can be defeated with a detailed account during either the initial or follow-up investigation. Is the conduct described by the defendant consistent with the injuries received by the victim? When there is an accident, there is usually an apology after the accident. Was there any indication of this?

The defendant acted in self-defense/mutual combat/dominant aggressor. This defense may be combined in some form with the other defenses. Under this theory, the defendant was using force to combat or defend against attack by the victim. Prosecutors sometimes mistakenly believe that the only way to introduce this type of defense is through the defendant's testimony. This is incorrect. The victim may recant and give this as an explanation for what occurred, i.e., "Everything I told the officer was correct, except it all occurred after I attacked the defendant." Countering this defense requires a detailed investigation by law enforcement.

Getting the Victim to Court

A key piece of preparation will likely involve either getting the victim to court or showing due diligence in trying to get her to court. This problem is eliminated if the case can be prosecuted without the victim's courtroom testimony. If this is not the case, early efforts to subpoena the victim should be exerted. The court may also order the victim back.[10] A material witness bond may be sought in order to obtain the victim's attendance.[11]

Prosecutors should strongly consider the implications of proceeding in this manner. You are incarcerating a victim of a crime in order to make that victim available for courtroom testimony. There are issues of re-victimization and issues of affecting the cooperation of the victim, as well. This is not a preferred method of proceeding and should be discussed at a high level before undertaking this process.

In certain circumstances, a victim may be incarcerated for refusing to testify under contempt proceedings.

Try to determine what the barriers are to victim cooperation. Enlist the shelter advocates for assistance in overcoming those barriers and securing victim cooperation.

A victim may be incarcerated for both refusing to testify and failing to respond to a valid subpoena.[15]

One additional consideration for material witness warrants or otherwise compelling a victim to appear is that it is important for defendants and defense attorneys to know that the state will take that step. If the defendant(s) or defense bar knows (or believes) that the state will <u>not</u> take that step, witness tampering and intimidation will escalate.

Pre-Trial Motions

The prosecution should prepare for the admission of expert testimony by providing notice of the expert, the expert's curriculum vitae, and a written summary or report of any testimony that the state intends to introduce at trial.[71] In jurisdictions where several expert witnesses may share duties of testifying on strangulation, it is prudent to provide this information from all the experts. That way, if one expert becomes unavailable on the date of trial, another expert may still be called without the defense claiming a lack of notice or discovery. Prosecutors should also prepare for a pre-trial hearing with the expert witness. Sample motion attached in the appendix.

Should the investigation or interview of the victim reveal the defendant has prior instances of domestic violence against the present or another victim, that evidence may be admissible at trial. The prosecution should disclose this information to defense counsel and file an Evidence Rule 404(b) motion. A 404 motion must be filed reasonably in advance of trial and with reasonable notice of the general nature of any such evidence that the prosecutor intends to offer at trial. However, the court may excuse pretrial notice if the court finds good cause. Idaho Evidence Rule 404(b)(2).

Voir Dire –

Voir dire is the preliminary examination of a juror by judge or counsel. Jury selection in a strangulation case involves many of the same issues as in other forms of domestic violence. You need to reflect on how potential jurors will react to issues in the case. Verbalize jury bias and attitude that may exist about domestic violence. These may include things such as:

- General domestic or family violence dynamics.
    - Ask potential jurors if they, or anyone close to them (such as a close friend or family member), has been involved in domestic violence situations as a victim, witness, or accused.
        - For jury members who respond "yes" asking a series of follow-up questions can effectively educate a jury and help identify problem jurors.
- Absence of the victim means there is no case.
- Absence of victim cooperation with prosecution means the crime did not occur.
- If the victim minimizes or recants, the crime did not occur.
- Two different versions from the victim means there is reasonable doubt.
- Victims who stay in a relationship deserve what they get.
- Same sex victims are not entitled to protection of "domestic violence" laws.
- A want or need for there to be injuries (visible) or medical treatment in order to convict

When educating in voir dire, remember that it "should be an education that the jury give themselves…and that your evidence then becomes consistent with."[72] Some questions to ask include:

- What are common dynamics of domestic violence?
- What should make an assault more serious (i.e. bodily injury, weapon, strangulation)?
- What are the ways strangulation is more serious than just bodily injury?
- How is strangulation used by the abuser?
- What in the anatomy of the neck makes strangulation dangerous?[73]

In addition to the more traditional topics of domestic violence jury selection, jurors in strangulation cases may have other misperceptions. These may include:

- Strangulation and choking are the same thing.
- Strangulation for a short period is not serious.
- Strangulation is only serious if the victim loses consciousness.
- Strangulation does not occur if the victim can still breathe.
    - There will be ligature marks if there is any type of strangulation.
    - Strangulation does not have any real long-term effects.

Also ask about any experiences being strangled: "Has anyone ever been "choked out" or strangled in a mixed martial arts, military, or law enforcement setting?" Ask any volunteer jurors to explain:

- Did you sustain any visible injury? If so, what?
- Describe how you felt, sensations, aftereffects, etc.[74]
- Did you require medical treatment?

Prosecutors can also use voir dire as an opportunity to shift the focus of the case towards the batterer and away from victim. Another goal of voir dire is to lower the jury's expectations regarding the level of violence required to violate the law. *See* sample Voir Dire Questions developed by the Maricopa County Prosecuting Attorney's Office.[75]

Juror Acceptance of Experts

The necessity of expert testimony requires jurors who will accept such testimony. This issue becomes more critical if your expert lacks the traditional earmarks of expertise, such as a Ph.D. or M.D. However, an expert is anyone with special knowledge, skill, experience, training, and education.[76] There is no requirement that a witness possess a particular license or academic degree in order to qualify as an expert; the criterion in determining whether a person qualifies as an expert witness is whether the fact finder can receive appreciable help from that person.[77] Jurors must be willing to accept that your nurse practitioner or law enforcement officer may have sufficient knowledge, skill, experience, training, or education to testify as a competent expert, even without a degree in "strangulation." This can be satisfied through foundational questions of the expert.

Idaho Case Law surrounding the admissibility of expert testimony:

- State v. Sanchez, 2011 WL 11038952 – With proper foundation, the Court permitted an expert to testify to the "dynamics of domestic violence and how an individual may use and control to instill fear in a victim and convince the victim to submit to severe abuse, while never telling anyone."
- State v. Ibarra 2014 WL 4345833 - The Court found "that expert testimony on the general dynamics, effects, and characteristics of domestic violence (including why victims recant) was helpful to the jury and addressed a topic that was not within common knowledge of the average juror."

- State v. Ullom 2023 WL 4634841 - Court ruled that testimony regarding why an individual might stay in a relationship, despite physical violence, as well as the dynamics of a domestic violence relationship.
- State v. Varie, 135 Idaho 848, 854 (Idaho 2001) - Defendant's argument was that she killed her husband because she suffered from battered spouse syndrome. The Court prevented the Defendant's expert from testifying to the specific diagnosis, but permitted the expert testimony regarding "domestic violence, why victims stay in abusive relationships, how victims perceive themselves and their abuser, how victims of abuse might perceive cues of their abuser, and how victims feel and react during abusive situations." The testimony was relevant to the self-defense argument on how a reasonable and prudent person acts under the same or similar circumstances.

Juror Typography

Much discussion occurs about who is a good juror and who is a bad juror in a domestic violence case. While those viewpoints are not discussed here, there are a few issues specific to strangulation cases that may prove thought provoking. For example, jurors with backgrounds that frequently expose them to minor injuries (for example laborers or athletes who engage in physically violent sports) may tend to regard scratches and redness as "non-injuries." Spend extra time with these potential jurors to determine if they can be good jurors on your strangulation case. If they cannot, the discussions with them might serve as good examples for other potential jurors about the seriousness of the offense.

Trial Strategies

Evidence-based prosecution strategies work. Prosecutors can minimize the impact of the abuser's power and control over the victim by presenting a case that proves guilt independent of the victim's testimony. A typical case might consist of the introduction of the 911 call, followed by the observations of a law enforcement officer, followed by an expert witness in strangulation, and concluding with the introduction of admissions from the defendant.

Ensure that when any "blind" expert (an expert witness that prepares an opinion without knowing the identity of the party who hired them – this may be done by using an intermediary organization to select the blind witness) is being used that the expert testify prior to any substantive evidence being introduced; this helps ensure the jury is better informed before facts of the case are introduced.

Opening Statement

The batterer who strangles his victim holds the life of the victim in his bare hands.

It takes a particularly narcissistic and callous individual to commit this type of offense

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The opening statement should be as long as necessary to explain the case and preemptively counter any perceived weakness in the case. Storytelling as a method of conveying the facts of the offense proves a highly successful approach. In telling the story, avoid overstating the case. At the same time, do not be so brief as to fail to highlight the strengths of the case. Your goal is to provide a compelling story that moves the jury to convict. The opening statement allows you to train the jurors about strangulation by telling them, in summary fashion, what your expert will testify about regarding the seriousness of the crime.

Do not be afraid to address jury bias and attitudes that may exist about strangulation or to touch upon the weaknesses of the case. Do this in a manner that makes the weakness irrelevant.

The Concept of Putting the Truth First

It can be disturbing for a jury to listen to the opening statement of the prosecutor and a description of the facts of the case and have that followed up by the prosecution's first witness denying that these facts occurred or giving a different version of the events. For that reason, unless the prosecutor has absolute confidence the victim's testimony concurs with the initial statement to law enforcement, another piece of evidence should be introduced.

This could be the 911 call, introduced through the dispatcher/custodian of records, the neighbor who heard the spontaneous statements of the victim, the officer who observed the victim with visible injuries—something that corresponds to the prosecutor's opening statement. This has the impact of assuring the jury of the prosecutor's credibility. If later during the trial, the victim does testify and recant, the jury will have already heard evidence that validates the prosecutor's opening statement. This tactic enhances the credibility of the prosecution's case.

After presenting the truthful portion of the case, the prosecutor should follow up with additional evidence in an organized fashion. Depending on the facts of the case, this may be in chronological order, or in some other fashion. Expert witness testimony needs to follow all evidence that would establish foundation for the expert opinion.

Additional Expert Testimony

While providing an expert to explain strangulation signs and symptoms, it may be prudent to include other expert witnesses. There may be a need to call an expert witness related to certain types of electronic data (cell phone towers, text messaging, and so forth) or an expert witness on intimate partner battering.

Victim Testimony

If the victim is going to testify, be prepared for that testimony to change. The nature of these cases is that the victim might not feel safe to tell the truth. Resist the natural instinct to launch into an attack of a victim who testifies inconsistently with previous statements.

The statements can almost always be confronted in a manner that is more reserved and professional and demonstrates that the victim's recanting is a natural part of the process of being abused. Try to remain

aware of your tone and body language. The testimony of the recanting victim will serve to set the stage for testimony by an expert in intimate partner battering and its effects.[78]

Cross-Examination of the Defendant

The defendant's testimony will come after hearing from the prosecution witnesses, including your strangulation expert. Anticipate that the defendant's testimony will attempt to incorporate some aspects of your expert's testimony into his version of what occurred. If your expert mentions that some persons engage in strangulation as part of their sexual practices, for example, the defendant may adopt that as a part of his testimony.

Defendants who claim self-defense should be examined with regard to the fact that they were not in fear of imminent harm, that any danger that might have existed had ceased, and the absence of any statements regarding self-defense being made to law enforcement.[79] Defendants who claim that they placed their hands on the victim to "calm them down" should be questioned in detail regarding how this action turned into strangulation.

Closing Argument

The closing argument provides the final opportunity to address with the jury the violent and potentially fatal nature of this type of attack. Prosecutors should utilize all the evidence and all logical inferences of the evidence in formulating their closing argument. Utilizing the exhibits and other forms of demonstrative evidence can illustrate the near-fatal nature of this attack.

Since the prosecutor gets to go first and last with closing arguments reserving certain arguments for rebuttal may be an effective strategy.

The batterer who strangles his victim holds the life of the victim in his bare hands. It takes a particularly narcissistic and callous individual to commit this type of offense.

Protections after conviction

If the defendant pleads guilty or is otherwise convicted at trial without the use of expert testimony, consider calling an expert at sentencing. Use the strangulation expert to emphasize the dangerousness of the offense. Because cross-examination by the defense is usually limited at such hearings, this may provide another opportunity to test and train your experts.

Post-conviction protections for the victim can include no-contact orders. The court may impose no contact with the victim as a condition of probation, AND by entering a No Contact Order that can last as long as the court deems fit, so long as the NCO has an expiration date on it.[80] The parole board may impose a no contact provision as well. When a defendant is being considered for parole, victims have the right to attend parole board meetings or may submit written comment.[8182]

Recantation

Bonomi et al (2011) published a study revealing that up to 80% of domestic violence victims will recant after time, which may paint them as a liar, a less credible victim and as wasting the resources of the

criminal justice system; professionals need to resist this categorization for despite strangulation being the number one predictor of future murder, a history of strangulation is highly correlated with victim recantation.

There are a variety of reasons that a victim may recant, including:

- Fear of escalation of violence ~ They have already suffered extreme abuse and fear future violence.
- Financial dependence on the abuser ~ Even professional women who work may not have access to their own money and be totally dependent on the abuser for financial support of themselves and their children.
- Distrust of the criminal justice system ~ Perhaps from previous experience, and the abuser may advise them that the system cannot be trusted.
- Fear of deportation ~ If they are not a U.S. citizen, they may fear deportation and the abuser is usually very willing to exploit that fear.
- Promise of change ~ The abuser often verbalizes remorse while swearing his love; the victim fell in love with this man and she wants that love back, she just wants the abuse to stop, so these promises are powerful.
- Complex care-taking needs with the abuser ~. When the abuser swears their love and need for the victim it encourages the victim to preserve the relationship, hopeful that the abuse will stop.
- Threats/fear of breaking up the family
- Threats/fear of losing custody of the children

The Five-Stage Model was developed by Dr. Amy Bonomi and David Martin, J.D. after a study in which they listened to jail calls between abusers and their partners. The model demonstrates five stages couples go through after a domestic violence event; they seldom move through the stages in a linear fashion and often move through the stages multiple times, even in very short time periods (such as during one phone call).

Coercion and manipulation are the main drivers behind recantation; those behaviors are clearly seen in the five stages of the model:

1. Gaslighting of the victim by the abuser ~ As they discuss the event the abuser pushes the narrative that the victim's memory of the abuse is incorrect and offers a different scenario in which ***the abuser*** is actually the victim. Initially the survivor resists the 're-telling' of the event but as time goes on their self-confidence is worn down. Blame, anger, and regret may be verbalized by both partners.
2. Minimization of the abuse ~ As the abuser details the many ways they are the victim, using appeals to the victim's sympathy, the victim often responds with empathy and attempts to soothe and pacify the abuser.
3. The couple then bonds over shared memories of their past, especially their early relationship and they dream about plans for their future together. An "us-against-the-world" outlook may be fostered.

4. The abuser may then ask the victim to recant. Often, this is done ***without threats or obvious coercion,*** appealing to the victim's need to care for and protect. As the victim complies it must be remembered that this is not true compliance as it has been crafted through manipulation and coercion, although the victim may not be aware of that.
5. Reconstruction of the event ~ Once it has been decided that the victim is going to recant, the couple reconstructs the event. At times the abuser gives a specific script for recantation, but at other times the victim is so strongly vested in the new relationship they may offer suggestions in changing the telling of the event.

Although couples may move through the stages of the model during one phone call it is often done over a series of phone calls, and the abuser may enlist friends and family to pressure the victim to ensure they complies with the demand for recantation. The abuser may encourage the friend/family to use violence to accomplish the goal ~ which re-emphasizes the danger of not complying.

Abusers may also manipulate children as a method of pressuring the victim; telling a child/children to "ask mommy why she hates daddy so much … why does she keep putting me in jail". Although the children may witness the abuse and are fearful, they often are still bonded to their father and accuse their mother of what their father has suggested. Similar manipulation can be seen with female abusers and male victims.

Supporting a victim through the criminal justice system may decrease the likelihood of recantation. An advocate, a law enforcement officer, or a prosecutor may show the victim the Five-Stage Model and describe the tactics an abuser has used and can be expected to use in the future. Often, the victim is amazed that this is so common, as they frequently feel alone, not realizing others have gone, and are going, through the same thing they are.

Both community-based and systems-based advocates are vital in this process, working together to provide community support (alternate housing, mental health counseling, etc.) and guidance through the criminal justice system, explaining the process and accompanying the victim to all judicial proceedings. In communities without both types of advocates there is usually a way the advocates who are present can provide this assistance.

Cases should not be dropped due to recantation. Supporting the victim can greatly reduce the possibility of recantation and keep them involved in the criminal justice process. Some support measures may include:

- Encouraging the victim to block the abuser's phone number and not to answer unknown numbers, and to not pick up a call from a friend or family member who has threatened or "reasoned" with them or attempted to convince the victim to recant.
- Encourage the victim to talk and engage with an advocate! Those who have the support an advocate can provide are much more likely to remain engaged in the criminal justice process. Being accompanied to court, for example, is a powerful method of support as the victim can be informed of expected tactics and processes and can be prepared for how to handle those

expectations. Knowing someone is "there for them" can generate strength to resist temptations to exit the criminal justice process.

- Encourage the victim to report all violations of no-contact orders and all threats against them for testifying. These may be additional crimes (witness tampering, for example), which should be considered for additional charges.
- Encourage the victim to get help from a trauma therapist who can assist in the development of coping skills and help them to successfully navigate the many challenges they face. Professionals who interact with victims should have a list of trauma therapists in their area.
- Encourage the victim to carefully reconsider any decision to "give (the abuser) a second chance" and return to the relationship. The manipulation and promise of a new, abuse-less, future together is a powerful pull, and the victim may feel safe, believing promises, feeling that time in jail/prison, anger management classes and/or completion of a batterer's program will be successful. Professionals in each discipline should emphasize that only accountability and monitoring is likely to change an abuser's behavior.

Finally, law enforcement and prosecution should consider a "victimless" approach for cases in case the victim does recant … and be aware that the victim is still in danger and in need of ongoing support if they reach out in the future.

Attachment A – Idaho Attempted Strangulation Statute

Idaho Code § 18-923 was enacted in 2005. Because statutory language may be amended during future legislative sessions, users should refer to the current published version of Idaho Code for the most current statutory language.

Current statute:
Idaho Code § 18-923 – Attempted Strangulation

Attachment B – Discharge Instructions

After Strangulation: When to Seek Help

You have been evaluated for possible strangulation. Even if you feel okay, symptoms can develop later.

Return immediately if you have:

- Difficulty breathing
- Difficulty swallowing
- Voice changes (hoarseness or unable to speak)
- Neck swelling
- Severe headache
- Dizziness or fainting
- Confusion or memory problems
- Vision changes
- Weakness or numbness
- Seizures

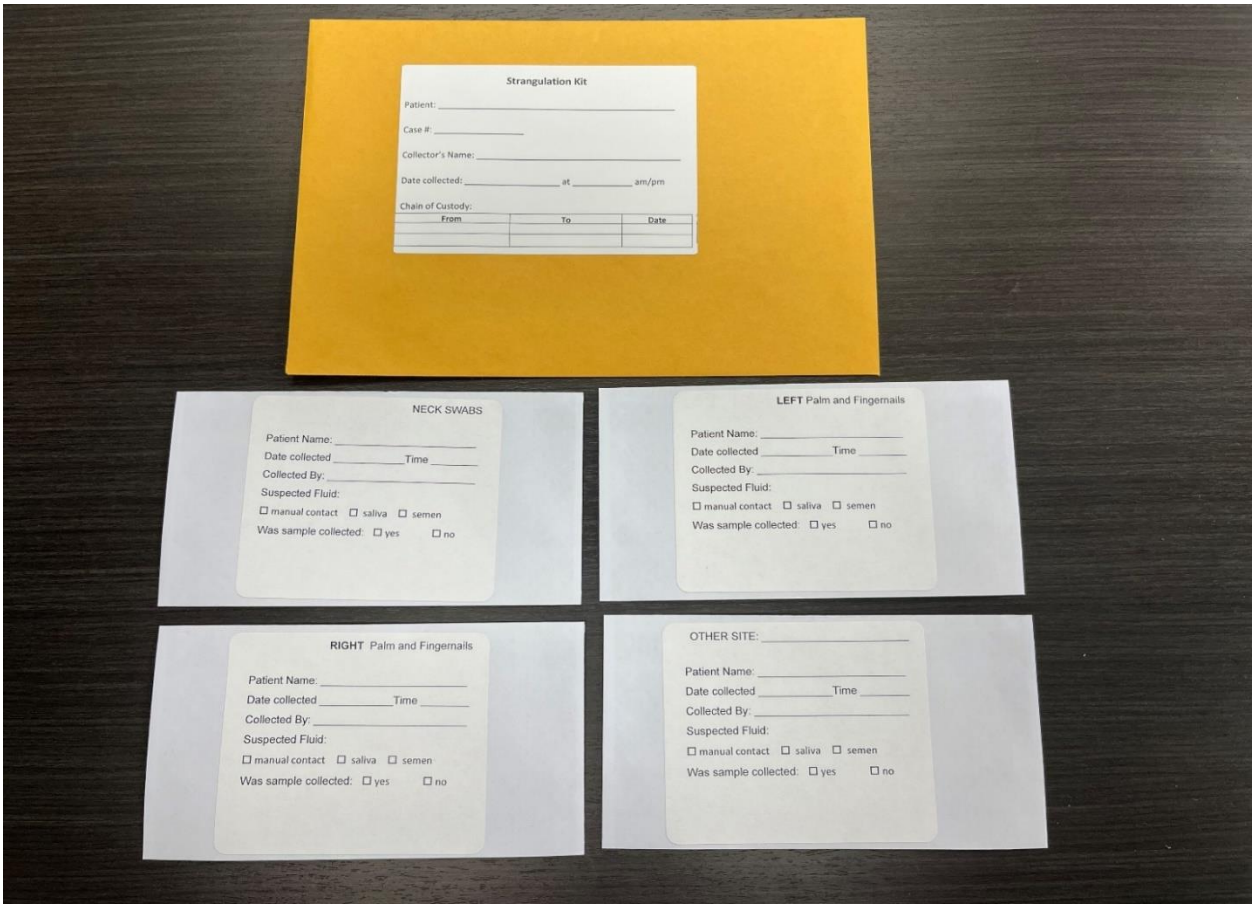
Important Information

- Serious complications can occur hours or days later
- You should not be alone for the next 24-48 hours
- Seek medical care immediately if symptoms develop

Follow-Up Care

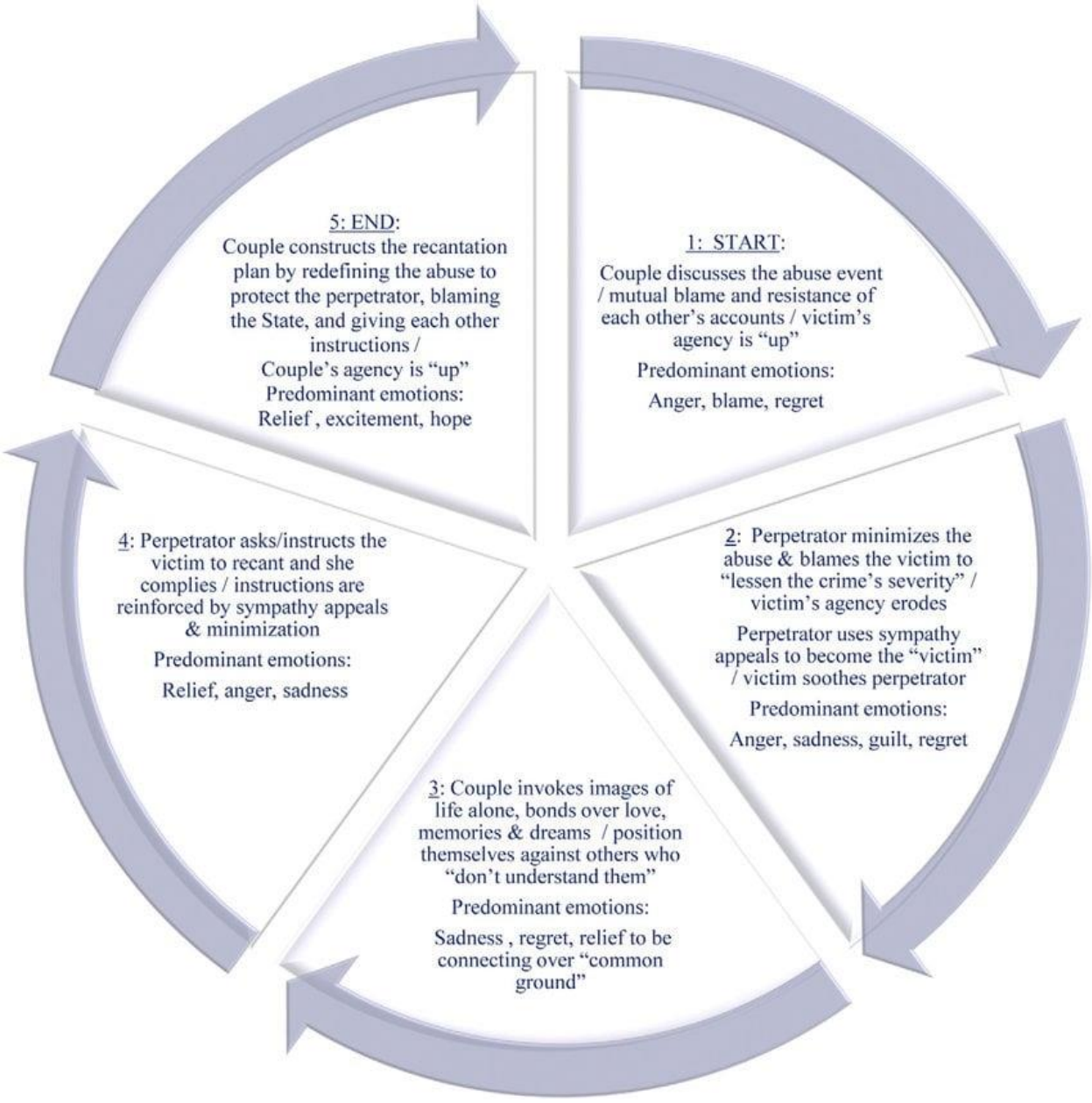
- Follow up with your healthcare provider
- Return to the emergency department if symptoms worsen

Attachment C – Evidence Collection Kit[83]



1*a: This is a sample strangulation collection kit. This is not provided by ISPFS crime lab*

Attachment D: Recantation Wheel[84]



Attachment E: Strangulation “To Do’s”

Strangulation “To Do’s”

The importance of the responding officer’s initial efforts at the scene are some of the most important details of the case and may provide the evidence needed for prosecution, regardless of additional follow-up items being done, evidence, or the cooperation of the victim.

Initial Call/Investigation	
Victim interview	See Idaho Strangulation Supplement ~ victim may become uncooperative after initial call, so a proper interview initially is imperative
	Build trust/rapport with victim
	Document symptoms of injuries, tone of voice, appearance, upset/mad, etc.
	Address (potential) history of abuse
	Family dynamics: number of people in home, potential witnesses
Suspect Interview	Should occur in almost all cases ~ Be aware of Miranda rights
Injuries	Visible injuries (50% of victims do not have visible injuries initially)
	Consider injuries covered by clothing
	Consider possible location of other injuries that may occur after the fact
	Be aware of injuries common to strangulation, including victim behaviors
	Photograph identified areas (including tenderness) regardless of visible marks/injury
Involve EMS ~ resource dependent	Inform victim of support services (advocacy, shelter, CVC, etc.)
	Have EMS respond to the scene
	Monitor the conversations between EMS and victim (body worn camera): law enforcement must not interject, interrupt, or do anything but stand by ‘rolling tape’.
Initial Medical Tasks	Getting victim to higher care facility is of utmost importance
	Obtain proper means for medical records (HIPPA release or equivalent – see Addendum)
Be sure, at minimum, to record audio of your time on scene	If body camera is utilized ensure it remains functional (low battery)

Physical Evidence	Identify physical items pertinent to the case and collect according to respective agency policy
Address the safety of the victim	Suspect arrested? Suspect at large?
	All parties level of cooperation

Strangulation To-Do, P2

Post Call for Service/Investigators	
Follow-up victim contact	Photograph those identified injury areas 24-48 hours after incident
	Obtain medical records
	Review initial officer's efforts and address anything outstanding
Possible witness or involved person interviews and/or statements	Conduct interview(s) if not completed. Obtain all contact information for any witness/involved person.
Address any area of concern with the case	Make sure PA's office has all information possible
Confirm involved persons personal information is valid	Name, address, phone number, etc.
Case Evidence	
Photographs	
Audio/body camera recordings	
Medical release	Emergency department records, forensic exam records, if pertinent, QRU/EMS/Paramedic/Fire Responder records, Any provider records
Can Do – encouraged to do	
Possible jail phone call records	Or any communication (letters and video visits)

Establishing a predominant aggressor more in-depth	Incident history, physical characteristics of both parties, who is fearful of whom, etc.
Speak to family and friends	
Sketch of the scene	
Video of the scene	
911 call recording	
Physical Evidence	

Attachment F: Idaho Strangulation Form

Idaho Strangulation Supplement

RD: DR #:

How Strangled?

Manual ☐ One ☐ Two ☐ Part of body used: Ligature ☐ What used:

Neurological

During	After		During	After	
☐	☐	Loss of memory	☐	☐	Urination
☐	☐	Dizziness Defecation	☐	☐	
☐	☐	Behavioral Vomiting	☐	☐	
☐	☐	Headaches Difficulty	☐	☐	speaking
☐	☐	Loss of sensation	☐	☐	Extremity weakness
☐	☐	Fainting Loss of	☐	☐	consciousness

Pain / Pressure

Pain

0 1 2 3 4 5 6 7 8 9 10

Pressure

0 1 2 3 4 5 6 7 8 9 10

Eyes/Eyelids

During	After	
☐	☐	Petechiae (Eyeball)
☐	☐	Petechiae (Eyelid)
☐	☐	Bloody red eyeball
☐	☐	Droopy eyelid
☐	☐	Vision changes:

_____

Face

During	After	
☐	☐	Scratch marks
☐	☐	Petechiae
☐	☐	Facial drooping
☐	☐	Swelling
☐	☐	Skin red / flushed
☐	☐	Bruising

Voice & Throat Changes

During	After		During	After	
☐	☐	Raspy/hoarse voice	☐	☐	Sore throat
☐	☐	Unable to speak Nausea	☐	☐	
☐	☐	Trouble swallowing	☐	☐	Drooling
☐	☐	Pain swallowing	☐	☐	Coughing
☐	☐	Clearing throat Stridor	☐	☐	(high pitched
☐	☐	Lump in throat			noise)

Breathing Changes

During	After		During	After	
☐	☐	Difficulty breathing	☐	☐	(Felt) Unable to breathe

Ears

Scalp

Further Incident Details

- How did the suspect attack the victim? Front? Back?
- How many times was the victim strangled during this incident?
- Has the victim ever been strangled before at any point in their life?
- What did the suspect look like?
- What did the suspect say before, during, and after?
- Threats to harm, kill, etc?
- Did the victim say anything to the suspect?
- What was the victim thinking during the strangulation?
- What did the victim see/feel/hear during the strangulation?
- What caused the suspect to stop?
- Was the victim able fight back? Any injuries to suspect?
- Was the victim shaken, thrown, or held down during the strangulatio
- Were either the suspect or the victim wearing jewelry that could leav
- mark? If delayed, did the victim take any photos or receive medical
- attention?
- Did the victim talk to anyone after the strangulation? Witnesses?

Sexual History

During	After		During	After	
☐	☐	Ringing	☐	☐	Bumps/lumps to head
☐	☐	Bruising (Behind)	☐	☐	Hair pulled
☐	☐	Bleeding in ear	☐	☐	Bald spots
☐	☐	Petechiae	☐	☐	Petechiae

Neck

During	After		During	After	
☐	☐	Redness Bruising	☐	☐	
☐	☐	Scratch marks Swelling	☐	☐	
☐	☐	Finger nail impressions	☐	☐	Ligature marks

Mouth

During	After	
☐	☐	Bruising
☐	☐	Swollen tongue
☐	☐	Swollen lip
☐	☐	Cuts/Abrasions
☐	☐	Petechiae

Chest

During	After	
☐	☐	Bruising
☐	☐	Scratches
☐	☐	Redness
☐	☐	Abrasions
☐	☐	Pain

- Was the victim forced to have sex with the suspect?
- Has the victim engaged in consensual strangulation during sex with the suspect?
- How was this strangulation different?
- Has the victim told the suspect not to choke them during sex?

Victim Health

- Is the victim sore, tender, or have any visible injuries anywhere on body?
- Is the victim pregnant? Do they have any pre existing medical conditions?
- Was the victim drinking/using drugs? Amount before? What is “normal” amount?
- Has the victim recently had a cold?

Does the victim have allergies?

Notes:

Medical:

Within 72 hours (EMS response) ☐ Medical Release

Outside 72 hours, receive medical attention? ☐ Yes ☐ No

If yes, where?

Notified by:

☐ 911 Call ☐ Non-Emergency Dispatch

☐ Officer ☐ Other

Initiated Victim Witness

Coordinator: ☐ Responded ☐ Declined ☐ Request for later contact

Attachment F: Sample Medical Exam Checklist

Example Medical Exam Checklist

Sexual Assault Forensic Exam Summary		
Patient name:		Arrival Date: Arrival Time:
Examiner:	Initials:	Arrival Date: Arrival Time:
Requesting Agency:		
Detective Assigned:		Case #
Victim Witness Coordinator:		
Advocate:		
Medical Clearance:		

Exam Process

☐Consents for exam/treatment signed

☐ Urine for pregnancy test ☐Bedside ☐Lab

☐ Urine for toxicology (in State of Idaho Biological Specimens Kit per police request)

☐ Blood

☐ History completed

Kit Number_____

☐ New, sealed kit obtained ☐Seal Intact Expiration Date: _____

Clothing

☐ No clothing collected

☐ Clothing removed

- ☐ Each item in separate bag
- ☐ Bag sealed with evidence tape

Bag labeled with:

- ☐ Item of clothing
- ☐ Patient name

☐ Date
☐ Examiner initials

Foreign Matter Collection

☐Foreign matter **not** seen

☐Foreign matter (i.e., grass, fiber, blood) seen:
_____

☐ Bindle folded and placed in brown bag, sealed and labeled

Head-To-Toe Assessment

☐ Full body inspection and identification of injuries

☐ Swabbed sites as indicated by history

☐ Photo documentation of injuries

☐Written documentation of injuries

☐Pubic hair combing ☐ N/A (pubic hair absent)

☐ Photo documentation of genital injuries

☐ Digital Camera

☐ CortexFlo

☐ Other_____

☐ Toluidine blue process used

☐ Procedure with additional documentation

☐ Vaginal exam

☐ Speculum exam

☐ Anal exam

☐ External anal

☐ Internal anal

Swab Samples (Collection Guided by Patient History)

	# of swabs expected	# of swabs collected	Time collected	Reason Not Collected if Indicated by Patient History
Oral	**4**			
Peri-Oral (mouth)	**2**			
Neck	**2**			

Bilateral Breasts	**2**			
Abdomen	**2**			
External Genitalia	**2**			
Vaginal	**4**			
Anal-External	**2**			
Anal-Internal	**4**			

Swabs

☐ Air dried for a minimum of 60 minutes

Time kit repacking started: _____

Known Blood Card Collected? ☐ Yes ☐ No
Reason Not Collected: _____
Notify Law Enforcement of the need to collect buccal swab for patient reference in 72 hours if applicable.

Additional Documentation

☐ Patient information history form (in kit) completed

Evidence & Chain of Custody

☐ All specimens placed in kit

☐ Kit closed and sealed

☐ Chain of custody maintained with all evidence in examiner's possession until:

☐ Signed over to law enforcement. Agency:
_____

☐ Placed in evidence locker. Facility:
_____

☐ Chain of evidence documentation (on top of kit) completed

Treatment/Resources/Discharge

☐ Prophylactic treatments provided:

☐ Offered HIV/STD resources/referrals

☐ Offered counseling and/or other follow-up services

☐ Give patient feedback forms and discharge instructions

☐ Dryer, room, equipment cleaned (with bleach) after procedure completed

☐ Victim notification form given

Released to: _____

Disposition:

☐ Home ☐ Transferred to ED ☐ Admitted

☐ Copy of sexual assault forensic exam summary given to law enforcement

Examiner signature: _____

Date: _____

Attachment G: Sample Adult Consent Form

IDAHO FORENSIC MEDICAL EXAMINATION CONSENT FORM
(Compliant with Idaho Statutes & Sexual Assault Response Guidelines)

---

1. PATIENT INFORMATION

Name: _____

DOB: _____

If minor or dependent:
Use pediatric specific consent

---

2. EXPLANATION OF EXAMINATION

I understand that this examination may include:

- Medical evaluation and treatment
- Documentation of injuries
- Collection of forensic evidence
- Photography and/or imaging

I have had the opportunity to ask questions and receive answers.

Initials: _____

---

3. CONSENT FOR MEDICAL CARE

I consent to medical evaluation and treatment, including:

- Injury care
- STI/pregnancy prophylaxis (if applicable)
- Toxicology testing (if indicated)

I understand I may refuse any part of care.

☐ YES ☐ NO
Initials: _____

---

4. CONSENT FOR FORENSIC EVIDENCE COLLECTION

I consent to the collection of forensic evidence, which may include:

- Swabs and biological samples
- Clothing or personal items
- Documentation of findings

I understand:

- I may decline any portion of evidence collection
- My medical care will not be affected by refusal

☐ YES ☐ NO
Initials: _____

---

5. CONSENT FOR PHOTOGRAPHY

I consent to photographs for medical and forensic documentation.
I understand:

- Photos may become part of the medical record
- **Their release is controlled separately**

☐ YES ☐ NO

Initials: _____

---

6. RELEASE OF INFORMATION / EVIDENCE

I authorize the release of information and/or evidence (including photographs) to:

☐ Law Enforcement
☐ Prosecutor's Office
☐ Other (specify): _____

I understand:

- This authorization is voluntary and may be withdrawn (where legally allowed)
- If I decline, evidence may still be stored per Idaho law

☐ YES ☐ NO
Initials: _____

---

7. COST AND PAYMENT DISCLOSURE

I understand:

- This exam will be provided regardless of my ability to pay
- Billing will follow Idaho Crime Victims Compensation Program rules

Initials: _____

---

8. RIGHT TO WITHDRAW CONSENT

I understand:

- I may stop the exam at any time
- I may withdraw consent for any portion at any time
- Consent is ongoing and may be changed

Initials: _____

---

9. SIGNATURES

Patient/Guardian: _____ Date: _____

Examiner: _____ Date: _____

Witness (if applicable): _____ Date: _____

This form is intended to comply with Idaho Code, IDAPA 16.05.01, and Idaho Sexual Assault Response Guidelines. Facilities should review with legal counsel for local policy alignment.

Attachment H: Sample Anonymous/Jane Doe Consent Form

IDAHO ANONYMOUS FORENSIC EVIDENCE COLLECTION CONSENT ("JANE DOE KIT")

---

1. PATIENT IDENTIFIER

Anonymous Code / Kit Number: _____

(No name required unless patient chooses to provide)

---

2. EXPLANATION

I understand that:

- I may have evidence collected without making a police report
- My identity will not be released to law enforcement at this time

Initials: _____

---

3. CONSENT FOR MEDICAL CARE

☐ YES ☐ NO

Initials: _____

---

4. CONSENT FOR FORENSIC EVIDENCE COLLECTION

☐ YES ☐ NO

Initials: _____

---

5. RELEASE OF INFORMATION

☐ I **DO NOT** consent to release my identity or information to law enforcement at this time
☐ I consent to release (optional – specify): _____

Initials: _____

6. EVIDENCE STORAGE

I understand:

- My evidence will be stored according to Idaho law and agency policy
- It may be held for a limited period (agency-specific)
- I may choose to report later and have the evidence tested

Initials: _____

7. HOW TO INITIATE REPORT LATER

I understand I can initiate a report by contacting:

Agency: _____

Phone: _____

And providing my kit number.

Initials: _____

8. COST DISCLOSURE

I understand this exam is provided regardless of my ability to pay.

Initials: _____

9. RIGHT TO WITHDRAW

I understand I may stop the exam at any time.

Initials: _____

10. RELEASE OF INFORMATION

I understand I may withdraw consent at any time, unless limited by law or court order.

Initials: _____

---

11. SIGNATURES

Patient (or mark): _____ Date: _____

Examiner: _____ Date: _____

Note: This form reflects Idaho Sexual Assault Response practices allowing anonymous evidence collection. Storage timelines and procedures must be filled in per local law enforcement agency policy.

Attachment I: Sample Pediatric Consent Form

IDAHO PEDIATRIC FORENSIC MEDICAL EXAMINATION CONSENT FORM

---

1. CHILD INFORMATION

Name: _____
DOB: _____

---

2. CONSENTING ADULT / AUTHORITY

☐ Parent
☐ Legal Guardian
☐ Law Enforcement / Child Protection (specify authority): _____
☐ Other (court order, etc.): _____

Name: _____
Relationship/Authority: _____

---

3. CHILD ASSENT (when appropriate)

The procedure has been explained to the child in an age-appropriate way.

☐ Child agrees to participate
☐ Child declines / unable to assent

Notes: _____

---

4. EXPLANATION OF EXAM

I understand this exam may include:

- Medical evaluation and treatment
- Injury documentation
- Forensic evidence collection
- Photography

Initials: _____

---

5. CONSENT FOR MEDICAL CARE

☐ YES ☐ NO

Includes treatment, medications, and follow-up referrals.
Initials: _____

---

6. CONSENT FOR FORENSIC EVIDENCE COLLECTION

☐ YES ☐ NO

I understand I may decline any portion and that care will still be provided.
Initials: _____

---

7. CONSENT FOR PHOTOGRAPHY

☐ YES ☐ NO

Initials: _____

---

8. MANDATORY REPORTING DISCLOSURE

I understand that healthcare providers are required by Idaho law to report suspected child abuse or neglect to authorities.

Initials: _____

---

9. RELEASE OF INFORMATION

☐ Release to Law Enforcement
☐ Release to Child Protection Services
☐ Other: _____
☐ Do NOT release beyond mandatory reporting

Initials: _____

---

10. RIGHT TO WITHDRAW

I understand I may withdraw consent at any time, unless limited by law or court order.

Initials: _____

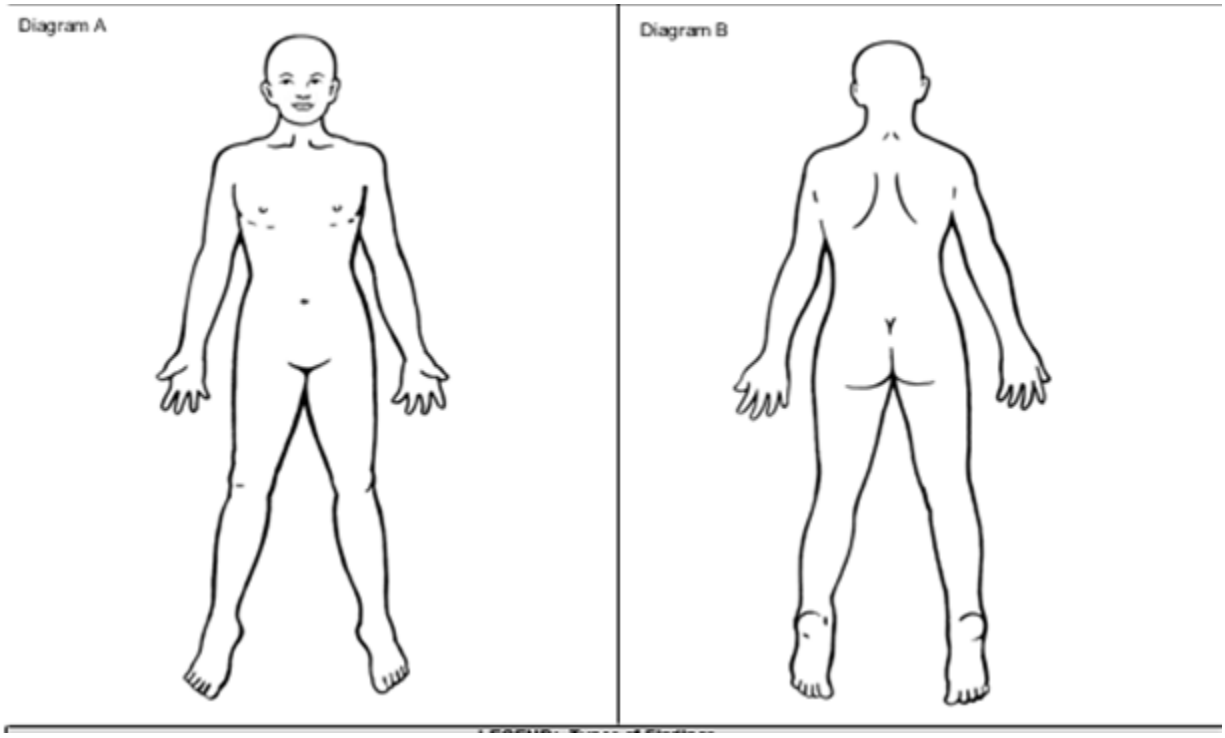
---

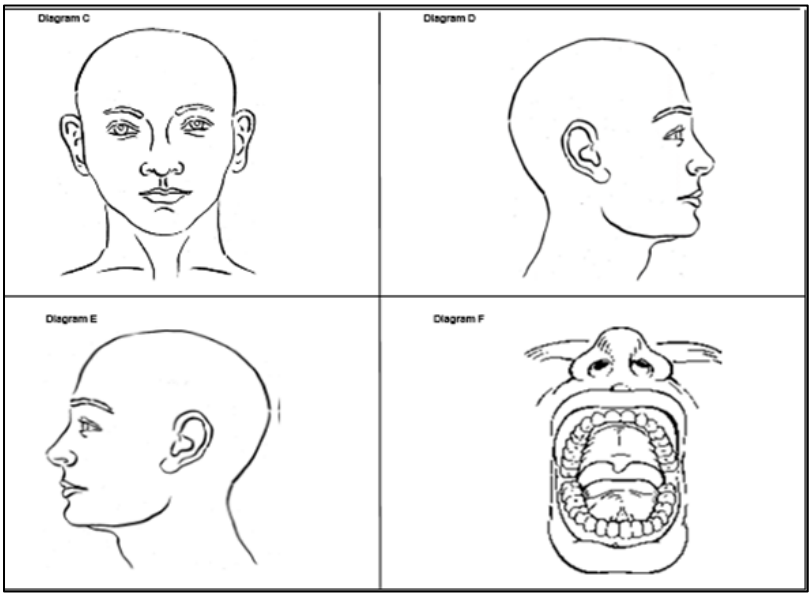
11. SIGNATURES

Consenting Adult: _____ Date: _____
Examiner: _____ Date: _____
Witness: _____ Date: _____

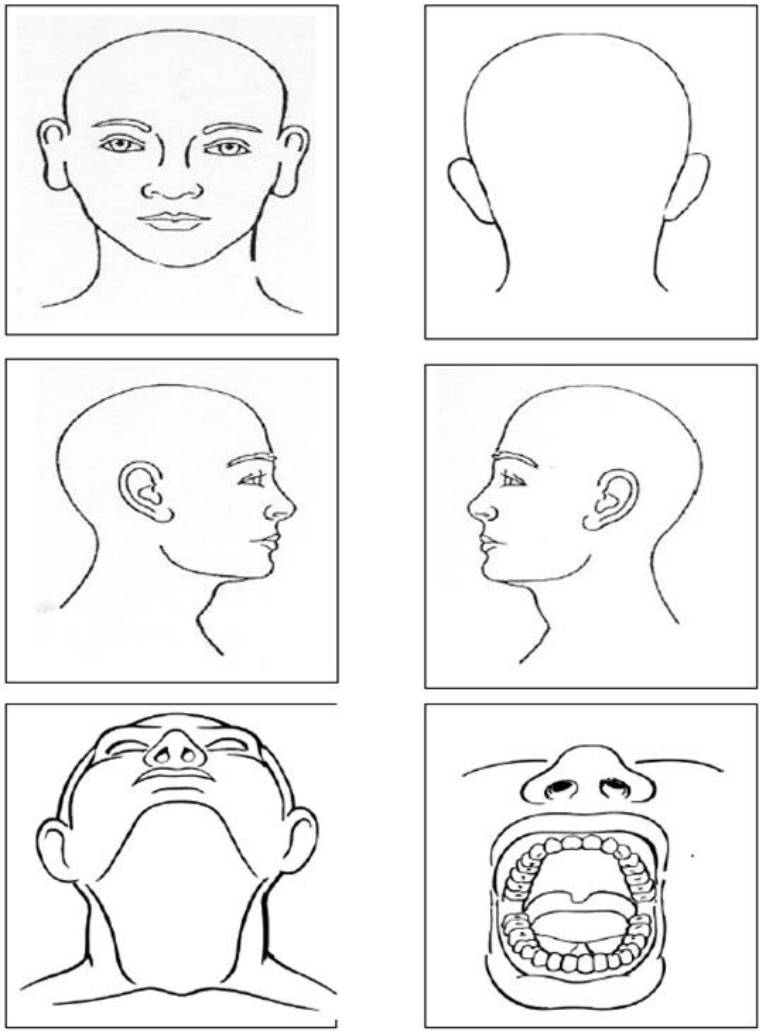
Note: This form reflects Idaho mandatory reporting laws and minor consent considerations. Final authority may depend on custody status, abuse allegations, and court orders.

Attachment J: Example Body Map





Attachment K: Example Strangulation Body Map



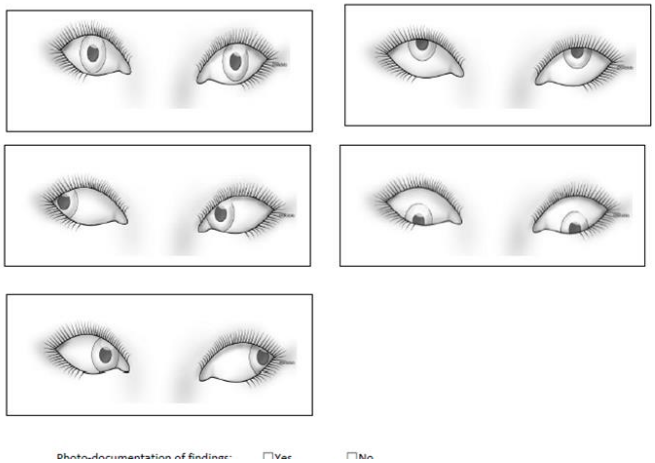
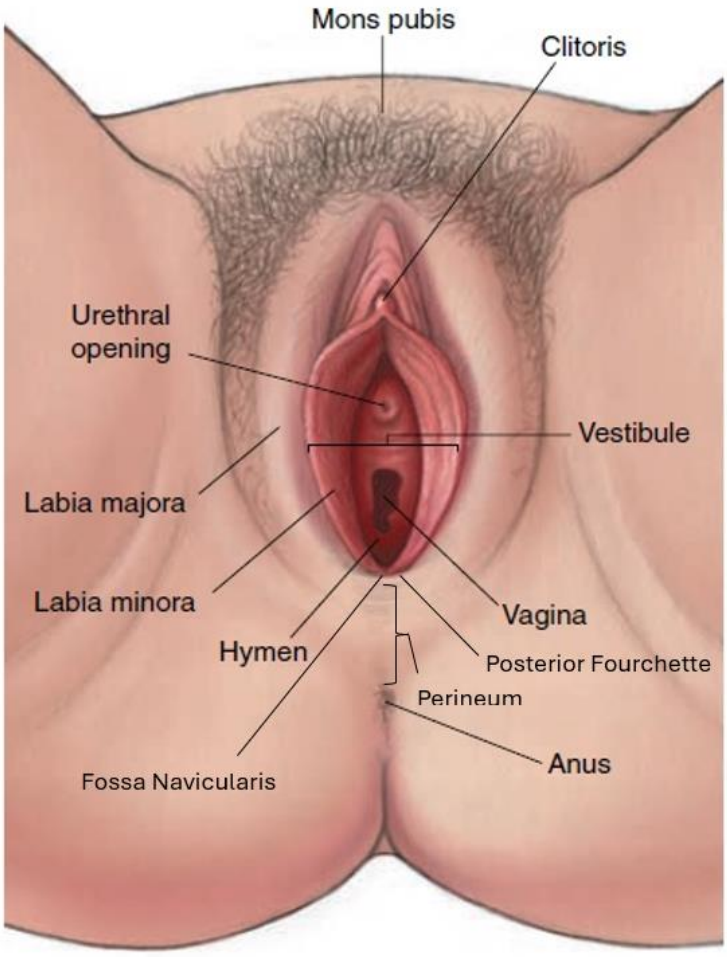
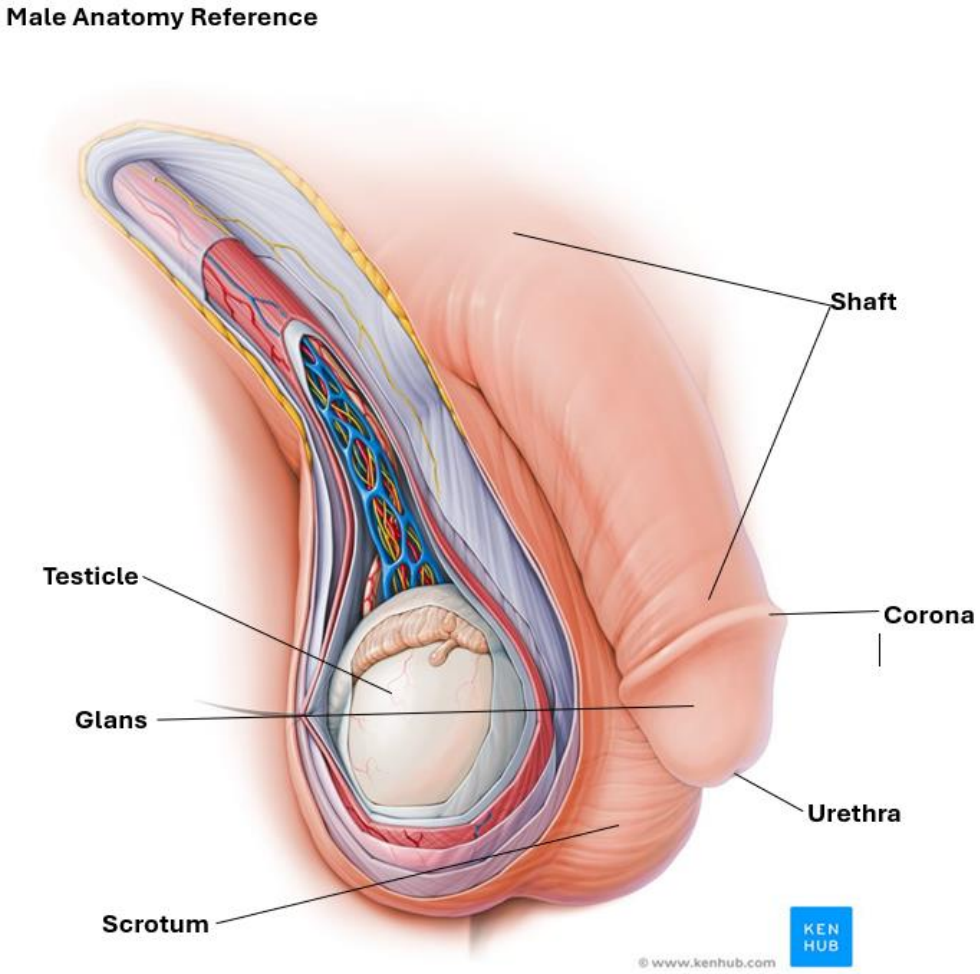


Photo-documentation of findings: ☐Yes ☐No

Attachment L: Female Ano-Genital Anatomy Reference



Attachment M: Male Genital Anatomy Reference



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[18] Federal Bureau of Investigation (FBI) Combined DNA Index System (CODIS) policies and forensic DNA interpretation guidance.
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[34] Idaho Criminal Rule 16; Brady v. Maryland; Giglio v. United States; applicable Idaho Rules of Evidence governing privileged communications.
[35] Rebecca Campbell. Trauma responses following sexual assault; U.S. Department of Justice, Office for Victims of Crime. Victim-centered response guidance.
[36] Idaho Constitution Article I, Section 22; Idaho Code §19-5306; U.S. Department of Justice, Office for Victims of Crime.
Referenced throughout this manual for constitutional and statutory crime victim rights, victim safety, dignity, privacy, participation, notification, restitution, access to information, multidisciplinary response, and victim-centered prosecution.
[37] Idaho Constitution art. I, § 22; Idaho Code § 19-5306; U.S. Department of Justice, Office for Victims of Crime. Victim safety and multidisciplinary response guidance.
[38] U.S. Department of Justice, Office for Victims of Crime. Victim-centered prosecution guidance; End Violence Against Women International. Trauma-informed prosecution and trial preparation resources.
[39] Adapted from Training Institute on Strangulation Prevention, *Physiological Consequences of Strangulation: Seconds to Minute Timeline* (2024).

[40] Adapted from Khokhlov (2001) regarding neck pressure thresholds and physiological effects of external neck compression.

[41] Adapted from Training Institute on Strangulation Prevention educational materials regarding clinical findings and the absence of visible injury in strangulation cases.

[42] See Glass et al. (2008) regarding the association between non-fatal strangulation and increased risk of future lethal violence.

[43] Adapted from Alliance for HOPE International, Training Institute on Strangulation Prevention guidance regarding medical and radiographic evaluation of acute non-fatal strangulation and modified for Idaho multidisciplinary implementation.

[44] See Training Institute on Strangulation Prevention guidance regarding clinical assessment, imaging indications, and medical evaluation following non-fatal strangulation.

[45] Adapted from Training Institute on Strangulation Prevention guidance regarding imaging modality selection and diagnostic evaluation following suspected non-fatal strangulation.

[46] See Training Institute on Strangulation Prevention guidance supporting a low threshold for imaging, observation, and escalation when strangulation-related injury is suspected.

[47] Adapted from Training Institute on Strangulation Prevention guidance regarding clinical and forensic documentation practices in suspected strangulation cases.

[48] See National Domestic Violence Hotline guidance regarding safety planning and victim support following interpersonal violence.

[49] Portions of this section were developed through multidisciplinary review and operational input from experienced law enforcement subject matter experts and adapted for statewide implementation.

[50] See Glass et al. (2008) regarding the association between non-fatal strangulation and increased risk of future lethal violence.

[51] See Training Institute on Strangulation Prevention guidance regarding clinical findings and recognition of non-fatal strangulation injuries.

[52] See Training Institute on Strangulation Prevention guidance regarding delayed complications and evolving airway compromise following non-fatal strangulation.

[53] See Glass et al. (2008) regarding the association between non-fatal strangulation and increased risk of future lethal violence.

[54] Example messaging was informed by multidisciplinary review and subject matter expert input, including review by experienced law enforcement personnel, and adapted for statewide implementation.

[55] Adapted from Alliance for HOPE International, Training Institute on Strangulation Prevention guidance regarding prosecution and court considerations in strangulation cases.

[56] Concepts in this section were informed by literature regarding training gaps and multidisciplinary response considerations in strangulation and domestic violence investigations.

[57] Adapted from Bonomi et al. (2011), Figure 1, and modified for educational and multidisciplinary training purposes.

[58] While not prohibited, the general Idaho practice is for officers from the investigating agency to conduct any follow-up interview. Should an interview of a victim or witness be conducted by the prosecutor, a law enforcement officer, or a staff member from the prosecutor's office should be present to record and document the interview. The documentation can then be discovered through the usual discovery process, thus preventing any allegations of a discovery violation and avoids the potential situation where the prosecutor becoming a witness.

[59] "Each victim of a criminal… offense shall be: . . . treated with fairness, respect dignity, and privacy throughout the criminal justice process" I.C. 19-5306(1)(a)

[60.] Idaho Code 19-5306(2) directs the prosecuting attorney, upon the filing of charges of domestic violence offenses to provide notice to the victim of their rights as provided in 19-5306. See also: https://www.ag.idaho.gov/content/uploads/2018/04/VictimsRights.pdf.

[61.] Many emergency rooms in Idaho use a strangulation specific set of forms to assess strangulation reports.)

[62] *Brady v. Maryland, 373 U.S. 83 (1963)*.

[63] Additionally, the filings in the civil domestic violence protection hearings or recordings of protection hearing may contain either inculpatory or exculpatory statements by the offender.

[64] Pursuant to Rule 803(4) (the medical records exception) of the Idaho Rules of Evidence. Be aware of the requirement to lay a proper foundation by having the medical care provider explain or testify that the examination of the victim was necessary for medical purposes. Officers, advocates and medical care providers should be certain to leave the impression with the victim that the strangulation examination is necessary to ensure the victim is medically safe.

[65.] Idaho Rule of Professional Conduct 3.8(a).

[66]See *Crawford v. Washington, 541 U.S. 36 (2004); Davis v. Washington, 547 U.S. 813 (2006)*.

[67] Idaho Rule of Evidence 804(5).

[68] Idaho Code § 18-2604.

[69] See *State v. Elizarraraz*, 166 Idaho 642, 462 P.3d 620 (Ct. App. 2020)

[70] Admissible pursuant to Idaho Rule of Evidence 801(d)(1)(A) as a prior inconsistent statement.

[71] Idaho Criminal Rule 16(b)(7).

[72] McKay, K. (2014, August 4). *Advanced Strangulation Prevention Course* [Presentation]. Training Institute on Strangulation Prevention.

[73] McKay, K. (2014, August 4). *Advanced Strangulation Prevention Course* [Presentation]. Training Institute on Strangulation Prevention.

[74] McKay, K. (2014, August 4). *Advanced Strangulation Prevention Course* [Presentation]. Training Institute on Strangulation Prevention.

[75] See Training Institute on Strangulation Prevention Resource Library for training and reference materials.

[76] Idaho Rule of Evidence 702.

[77.] State v. Hester,

[78] This type of examination assumes that the defendant did speak to law enforcement and does not take into account a discussion of *Miranda* rights.

[79] *State v. Elizarraraz*, 166 Idaho 642, 462 P.3d 620 (Ct. App. 2020).

[80.] Idaho Constitution, Article I, § 22 (Rights of Crime Victims).

[81] When a defendant is being considered for parole, victims have the right to attend parole board hearings and may submit written comments.

[83] Attachment C is provided as an educational reference example developed by an Idaho State Police Forensic Services SANE/SART Coordinator. Contents are illustrative only and are not intended to represent an official evidence collection kit configuration, manufacturer specification, agency policy, or required practice standard. Facilities and agencies should follow current local policy and kit guidance.
[84] Adapted from Bonomi et al., 2011.