

# ONTARIO NETWORK OF SEXUAL ASSAULT & DOMESTIC VIOLENCE TREATMENT CENTRES



## ***Guidelines for the COLLECTION OF FORENSIC EVIDENCE FROM THE PERSON WHO IS UNABLE TO PROVIDE CONSENT***

Written by:

Sheila Macdonald RN, MN, SANE  
Provincial Coordinator for Sexual Assault & Domestic Violence Treatment  
Centres in Ontario

Petra Norris RN, BA, SANE  
Outreach Nurse, Sexual Assault & Domestic Violence Care Centre,  
Women's College Hospital, Toronto

On behalf of the Ontario Network of Sexual Assault & Domestic Violence Treatment  
Centres

September 5, 2007

Revised June 2010

## **Ontario Network of Sexual Assault & Domestic Violence Treatment Centres (SA/DVTC)**

### **Issue for Consideration**

The determination of whether to collect forensic evidence from a person who is unable to consent following a suspected crime is contentious. For the SA/DV team, collecting evidence without consent is contrary to our own program values and philosophy in which victim/survivor autonomy is paramount. This Guideline addresses the issue specifically for persons who are suspected of being victims of sexual assault or domestic assault, are unable to provide consent, and the SA/DVTC team has been requested to attend to provide forensic care.

Victims/survivors who present to a Sexual Assault/Domestic Violence (SA/DV) Treatment Centre in Ontario, and who are mentally capable of doing so are entitled to make both their own health care decisions regarding issues such as treatment of injuries and medications to prevent sexually transmitted infection and pregnancy. They are also entitled to make non-health care decisions such as whether or not to consent to the collection of forensic evidence (Sexual Assault Evidence Kit). However there are circumstances in which persons brought to the hospital are not legally capable of making these decisions. A person may be unconscious or otherwise incapable due to a variety of permanent or temporary causes such as dementia, intellectual disability, serious mental illness or the effect of psychoactive substances. It should be noted, however, that every conscious person is entitled to be presumed capable unless a determination to the contrary has been made.

The moral and ethical dilemma is trying to determine what the person would want if she/he had the capacity to make his/her own decision. For the person who is unconscious due to head injury from an assault, would she/he want the assailant identified and prosecuted? What is the psychological harm in telling the victim that the assailant is not identifiable because no evidence was collected at the time? Would she/he feel violated if forensic evidence was collected and that was not what was wanted?

However, sexual and domestic assault are being perpetrated against persons who are vulnerable, may be unable to communicate what has happened such as in the case of an Alzheimer's patient and the need for any and all evidence becomes significant.

While the majority of sexual assault and domestic violence victims are capable of providing their own consent, there are situations where:

- A sexual or domestic assault is known or suspected
- The police are investigating
- The person is brought to the hospital emergency department and the SA/DV on-call nurse is called to collect forensic evidence

A determination is made that the person is legally incapable of deciding whether or not to consent to the collection of the evidence due to:

- Short-term incapacity resulting from alcohol/drug use or injury, or
- The incapacity appears to be either permanent or it is not reasonable to expect that the incapacity will remit in time for evidence to be collected within 72 hours of the assault. (estimated time of assault to be determined by police services)

The concern is that vulnerable people who are at risk of sexual assault will not be provided the best legal opportunity of having a suspected offender successfully prosecuted for the crime. While the forensic examination can be deferred in some cases of mental incapacity such as the over-use of alcohol or drugs when the effects will wear off in time, the dilemma is when mental capacity is unlikely to ever be restored or there is no reasonable expectation of restored capacity within the 72 hour time frame.

It is our responsibility to carefully consider an appropriate approach to forensic care for the unconscious or mentally incapable patient who has been a victim of a crime. Medical care is less of an issue as the law allows emergency department staff to provide medical care to unconscious and other mentally incapable patients in many situations.

### **Sexual Assault/Domestic Violence Treatment Centres (SA/DVTC)**

There are 35 SA/DVTC's hospital based programs located across Ontario. These are regional programs and serve catchment areas ranging from 11,000 to 1,000,000 people. The programs are established to provide a high standard of comprehensive care to persons who have experienced a recent sexual assault or violence perpetrated by an intimate partner. A recent sexual assault is defined as any form of sexual activity with another person without her/his consent occurring within the previous 72 hours. A recent domestic assault is defined as abuse perpetrated against the person by a current/past intimate partner within the previous 7 days.

Note: Time frames may vary among SA/DVTCs

Victims/survivors can present to the hospital on their own, with police or with a support person. The police do not need to be involved in a case in order for a victim/survivor to receive care.

The mandate of the program is to attend to the health, emotional, social, and legal needs of clients in a prompt, professional, and compassionate manner. The service is provided by nurse examiners/physicians who are on-call 24 hours/day and respond to the hospital when paged. Services include:

- Crisis intervention
- Emergency medical and nursing care including prophylactic medication for the prevention of pregnancy and sexually transmitted infections
- Forensic evidence collection, documentation of assault history
- Documentation and photographs of injuries
- Assessment of risk and safety planning

- Referral to community agencies for longer-term counselling, issues of safety, and court support
- Education and community consultation

In response to individual, community, and program needs, other services are established as required. Many Centres have evolved to include counselling, emergency care for children and adolescents, follow-up medical care, research and program evaluation.

The manner in which services are delivered by the SA/DVTCS is based on the following precepts:

- To provide care in a non-judgmental manner
- To help clients reclaim their autonomy
- To encourage clients to make decisions about their own care
- To deem assailants responsible for the violent behaviour
- To recognize that sexual assault and domestic violence are critical issues that must be addressed by the health care, legal, social, and political systems

### **Forensic Evidence Collection and Consent**

Care for persons who have been assaulted is individualized and ensures that:

- Special needs are met
- All options in medical, therapeutic, and legal procedures are made available and thoroughly explained
- Adequate time is given to process the information so that informed, appropriate decisions can be made
- Full, well-informed and capable consent is given
- Any delays in the acute phase of treatment are minimized

In sexual assault cases, forensic evidence is collected through utilization of the Sexual Assault Evidence Kit (SAEK), a forensic tool that is used to collect samples from a victim/survivor of sexual assault. It is produced and provided to the SA/DVTC programs by the Centre of Forensic Sciences (CFS), Ministry of the Attorney General. Samples may include head hair, oral swabs, external body swabs, vaginal swabs, rectal swabs, blood, urine, and clothing. Sample collection is dependent on the assault history as reported by the victim/survivor. The samples are analyzed at the CFS. The findings of the analysis may confirm (or not) any force used such as torn clothing, the presence of foreign DNA and the identity of the DNA.

The SAEK can be completed up to 72 hours following a sexual assault however the sooner the evidence is collected, the greater the opportunity for positive findings.

In domestic violence cases, a standardized documentation tool is used to record both the current and previous occurrences of abuse, as well as assessment of risk and safety planning. Photographs of injuries are taken. Clothing may be collected as evidence.

## **Core Principles**

In order to assist clients in dealing with the aftermath of sexual assault and to expedite the recovery process, SA/DVTC staff have a responsibility to act in the best interests of clients at all times and to respect their right to:

- Be treated in a considerate and sensitive manner
- Confidentiality and privacy
- Services, treatments, and/or procedures explained in detail
- Decline services, treatments, and/or procedures or to change their mind without explanation
- Access to information collected about them
- Decide what happens to their body
- Decide whether or not to involve the police
- Be listened to, supported, and respected
- A cultural, deaf or sign language interpreter
- Display or express whatever emotional response to the sexual assault they may be experiencing without judgment

## **Privacy and Confidentiality**

Privacy and confidentiality are to be ensured at all times. Sexually assaulted persons are asked to wait in a private area in the emergency department and are seen alone, although support persons are permitted at their discretion. When the on-call nurse examiner/nurse arrives, a client is moved to the SA/DVTC, a private set of rooms typically removed from the emergency department. All information and documentation obtained during assessment and treatment is considered extremely confidential and is not released without the client's consent. It should be noted, however, that these records could be subpoenaed for use in court. As well, if a person is under age 16 and at ongoing risk from the perpetrator, the nurse examiner/nurse has a duty to report the case to the Children's Aid Society which, at its discretion, will inform the police.

## **Consent**

Informed consent is required for treatment administered by a health practitioner. The consent must come from the client unless a determination has been made that the client is incapable of making that decision. In that case, the treatment decision must be made by the substitute decisions maker as determined by the *Health Care Consent Act*. There is no age of consent in Ontario. Consent may be revoked at any time. The law allows treatment without consent in certain emergency situations where a substitute decision-maker is not available or where the substitute decision-maker is unreasonably withholding consent.

Consent is also required in cases where a sexual assault examination kit is administered. Documents and specimens collected as part of the examination are forwarded to the police only when written consent to do so has been given.

## **Legislation**

The *Health Care Consent Act* sets out the rules regarding decisional capacity, consent and substitute decision-making with regard to health care treatment. This legislation clearly states that treatment is not to be given without informed, capable consent from a capable patient or the qualified substitute decision-maker except in certain emergency situations. According to the law, there is an emergency if the patient is apparently experiencing severe suffering or is likely to suffer serious bodily harm if the treatment is delayed. If there is an emergency, treatment without consent is permitted in the case of a capable patient who is unable to communicate but who is not demonstrating an objection to the treatment and in the case of an incapable patient if a substitute decision-maker is not reasonably available or if the substitute decision maker is refusing consent in violating of the best interest decision-making rules contained in the legislation.

There is no equivalent legislation governing the forensic/legal role of health and helping professionals caring for victims of crime in these situations.

## **The Elements of Consent**

Without the following elements, there is no valid consent to treatment:

The consent must:

1. Capable
2. Relate to the treatment
3. Be informed
4. Be voluntary
5. Not be obtained through misrepresentation or fraud

## **Capacity to Consent**

A person is capable to consent to treatment when the person is able to understand the information that is relevant to making a decision about the treatment AND able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

## **Consent to the use of the Sexual Assault Evidence Kit (SAEK)**

The SAEK is not considered treatment and therefore the Health Care Consent Act does not apply. It is also recognized that the SAEK is an invasive procedure and must never be forced on a person. What is not so clear is whether capable, informed consent is required to use the SAEK and what the parameters of these terms are (i.e. what is meant by informed?). Also unclear is whether a substitute decision maker is able to consent for the incapacitated person.

There is very little information in the literature regarding consent in these circumstances.

The British Columbia Centre of Excellence for Women's Health published a document, "In the Absence of Consent, Sexual Assault. Unconsciousness and Forensic Evidence" (2001). We reviewed their position and the underlying assumptions which led them to decide not to collect evidence on the incapacitated person suspected of being sexually assaulted.

In their document, they outline various issues that factored into their decision including:

- legal documentation from the Canadian Medical Association Code of Ethics that only procedures considered medically necessary to sustain life can be undertaken without consent
- explication of discordant philosophies of feminism, law and medicine
- lack of research and case law on unconscious patients or patients unable to consent who require forensic evidence collection
- lack of legislation that relates to forensic evidence collection on unconscious patients
- clarification and guidelines for seeking consent when providing health care
- the potential for examiners to be sued for battery or negligence
- the overall low rate of reporting and low rate of convictions in sexual assault cases, and research that questions the usefulness of evidence in obtaining convictions
- increasing use of DNA technology

Their overall conclusion is that evidence should not be collected when the patient is unable to provide consent.

An article published in the Journal of Forensic Nursing by Pierce-Weeks and Campbell (2008) describes various U.S. state policies regarding the collection of forensic evidence from a comatose patient. The article addresses some of the ethical and legal concerns of collecting evidence on the comatose patient such as patient autonomy and choice, progressive loss of evidence due over time when collection is delayed. The need for SANE programs to develop policies in a multi-disciplinary framework is encouraged. It alludes to, but does not specifically address those patients who are unable to consent due to permanent incapacitation (mental disability).

## Guideline

The position of the Ontario Network of Sexual Assault/Domestic Violence Treatment Centre is that an algorithm (Appendix A) and Algorithm Explanation Guide (Appendix B) should be utilized to guide the examiner in determining whether to collect evidence on the person unable to provide informed consent. Considerations include:

- 1) A reasonable justification for the suspicion that a sexual or domestic assault has occurred. It is not enough that a woman is brought to the emergency department in an unconscious or incapacitated condition –was an assault witnessed? Are there injuries present? Clothes in disarray? There needs to be additional evidence that would warrant evidence collection.
- 2) Police involvement and their request that evidence be collected. Evidence should not be exclusively reliant on the SAEK as frequently the findings can be negative or limited. It is assumed that the police would be gathering other evidence.
- 3) An assessment to determine whether it is reasonable to expect the patient to regain the ability to consent within 72 hours of the assault and therefore the examination can be deferred until that time. Forensic evidence can be collected up to 72 hours post sexual assault. The unconscious patient may regain consciousness, as may the person who has been drugged. Whenever possible, the examiner should consider whether the person will regain mental capacity. In situations where this is not possible such as the case of an Alzheimer's patient, this will not factor in the decision-making process. Assessment of regaining capacity to consent is part of the decision making process.
- 4) Policies and protocols for the Emergency Department Staff and Intensive Care Unit staff to implement that would preserve any evidence from the patient while a decision is being made (e.g. immediately placing a blue pad under the patient's genital area to collect any semen due to drainage, minimizing washing of patient, preserving clothing). The SA/DVTC can provide the ED/ICU with a forensic swab kit which would include sterile water and swabs, swab protectors and tamper evident DryPak evidence bags.

The decision to collect evidence from a person unable to provide consent should not be the exclusive decision of the examiner on-call. A team consisting of the examiner, lead police investigator on the case, attending physician, hospital administrator on call should be available for consultation. Family members should be consulted except in cases where they are the suspected assailants.

Additionally, if evidence is collected and the person does regain the ability to consent, that she/he ultimately is given the right to make their own decision about whether or not to proceed with a legal investigation. It would be expected that if the person regains capacity, it is the responsibility of the SA/DV program manager or designate to explain to the person why evidence was collected and what the evidence collection entailed. It is expected that the police would provide the legal options to the person and obtain consent to continue/stop an investigation.



## **Summary**

The decision to collect forensic evidence on a person unable to consent is not straightforward. Factors that need to be considered include estimated timeframe that the person may regain the ability to provide consent, police suspicion that a sexual/domestic assault has occurred, and the wishes of the family and what they believe would have been the patient's preference. All must be balanced in determining whether or not evidence should be collected.

*Acknowledgement – Information regarding consent, capacity to consent and consent in relation to forensic evidence collection was extracted from a presentation given by Michael Bay, Juris Doctor*

## **Appendix B – Explanation of the Determining Capacity to Consent: Responding to the Forensic Needs of Sexual Assault and Domestic Violence Patients Algorithm**

The Sexual Assault/Domestic Violence Care/Treatment Centre nursing orientation must be structured in a way that will support and address the needs of the nurses so they are confident and comfortable in responding effectively to all types of cases, including those that involve patients who are unable to consent to forensic evidence collection.

This patient care algorithm is available to guide the Sexual Assault/Domestic Violence Nurse in the event of a patient presenting in any area of the hospital who discloses or is suspected of being a victim of sexual assault and/or domestic violence and may or may not be incapable of making the necessary decisions regarding evidence gathering. The incapable patient may be unconscious or simply lacking the mental capacity to make the necessary decisions owing to a chronic or acute mental or physical condition or injury. There may be Sexual Assault/Domestic Violence Care/Treatment Centre specific variations in the use of these guidelines.

The goal in structuring the algorithm has been to respect the control of patients over their own bodies while ensuring, as much as we are able, that patients do not lose the right to have their assailants brought to justice.

In case where the patient is deemed incapable of giving consent, the SA/DV Nurse completing the case must have reasonable grounds for suspecting sexual/domestic assault.

It is recommended that this document be approved by the administrators, ethic boards and legal departments of the hospital, in order to limit the number of ‘incapable patient’ cases requiring consultation. If the Police Services are not already involved in the case, they should be notified in order to discuss the probability of an investigation being initiated.

### **Abbreviations:**

**ED:** Emergency Department

**ED Staff:** The physician and/or primary nurse caring for the patient

**RN or Primary Nurse:** Registered Nurse (referring to the nurse ultimately responsible for caring for the incapable patient)

**SA/DV:** Sexual Assault/Domestic Violence

**SA/DVTC:** Sexual Assault/Domestic Violence Treatment Centre

**SAEK:** Sexual Assault Evidence Kit

**SANE:** Sexual Assault Nurse Examiner

## Appendix A (Algorithm)

**SA/DV Nurse:** This refers to any nurse working at a Sexual Assault/Domestic Violence Care/Treatment Centre. This nurse may or may not be a Sexual Assault Nurse Examiner (SANE).

1. The SA/DV Nurse speaks with the ED staff. This could be either the nurse or physician in charge of the patient's care if there is a question of capacity from the start, i.e. if the patient is unconscious. Discuss with the police officer/detective in order to determine the possibility of a SA/DV case. Persons apparently significant to the patient (e.g. next of kin or caregiver) may be spoken to at this stage for the purpose of information gathering. This patient care algorithm may be initiated by the SA/DV nurse on the phone and again when she arrives at the hospital

*Example 1:* If in conversation with the ED staff, the SA/DV nurse determines that the patient is alert and oriented, the client must be reassessed by the SA/DV nurse on arrival at the hospital. For example, patients who are under the influence of drugs/alcohol may appear to be alert and oriented at one time and then upon assessment 45 minutes later may not be able to give consent. A time for further reassessment is discussed with the ED staff.

*Example 2:* In the case of a patient who is not mentally capable at the time of arrival to the ED, but is considered likely to regain capacity in the next 72 hours, the SA/DV nurse attendance to the hospital will be deferred until patient capacity is regained. During this time the ED staff will save or minimize the disturbance of evidence (Step 10).

*Example 3:* If in conversation with the ED staff, the SA/DV nurse determines that the patient is unlikely to regain consciousness within 72 hours, evidence collection is best done as soon as possible and consultation with a SANE or Coordinator is required (Step 20/21).

2. Screening questions to be used in determining the suspicion of sexual assault or domestic violence.

Suspicion of **Sexual Assault** may be based on the following criteria<sup>1</sup>:

- Do police have reasonable and probable grounds for investigating a case as a sexual assault?
- Prior to the patient losing consciousness did (s)he disclosed to police or another individual that (s)he was sexually assaulted prior to losing consciousness?
- Did someone witness the unconscious patient being assaulted?
- Are the injuries consistent with sexual assault?
- Was the patient found unconscious in a compromising/suspicious state (e.g., various stages of undress)?

---

<sup>1</sup> Sexual Assault Squad Toronto Police Services, Personal Communication. May 3, 2006

Suspicion of **Domestic Violence** may be based on the following criteria<sup>2</sup>:

- Do police have reasonable and probable grounds for investigating a case as a domestic assault?
- Prior to the patient losing consciousness did (s)he disclosed to police or another individual that (s)he was a victim of domestic violence prior to losing consciousness?
- Did someone witness the unconscious patient being assaulted by an intimate partner?
- Are the injuries inconsistent with a presented explanation of how they occurred?
- Is there suspicious bruising in hidden areas, in various stages of healing, or a patterned injury?
- Did the patient have frequent visits to the ED with a history of unexplained injuries or reoccurring injury?
- Is there a known history of Domestic Violence?

Persons apparently significant to the patient (eg next of kin or caregiver) may be consulted as part of the information gathering process. They should not, however, be involved in decision-making until and unless it has been determined that the patient is decisionally incapable and the appropriate surrogate has been identified.

3. If after telephone consultation with physician, police and others, there is no suspicion of assault then proceed to #4 in which the client is not an appropriate referral for SA/DV Care/Treatment Centre (SA/DVTC) Services. If there is suspicion of sexual and/or domestic assault then continue to Step 5.

4. Patient not referred to SA/DVTC because there is not a known or suspected assault. Primary nurse may want to consult with social worker.

5. Determine decisional capacity using the guidelines found in the *Ontario Health Care Consent Act*. That Act emphasizes that everyone is presumed decisionally capable unless incapacity is shown. It is not appropriate to assess decisional capacity unless there are reasons to suspect that capacity may be compromised. A diagnosis or clinical state short of unconsciousness is never determinative of incapacity without considering the test set out below. Decisional capacity is issue and time specific. A person may be capable at one point in time and incapable at another. The person may also be decisionally capable for one purpose and incapable for another. A determination that the patient is incapable of making treatment decisions does not necessarily resolve the question of decisional capacity for other purposes. The Act states that a person is capable if she or he has:

---

<sup>2</sup> Domestic Violence Community Program Toronto Police Services, Personal Communication. July 5, 2007

- ❖ The ability to understand the information relevant to making the necessary decisions, and
  - ❖ The ability to appreciate the consequences of a decision or lack of a decision.
6. If the patient is decisionally capable the SA/DV nurse can proceed as per regular SA/DVTC response protocols (Step 7). If client is not decisionally capable then proceed to Step 8.
  7. Nurse responds to hospital, reassesses capacity, if patient is capable of giving consent continue with SA/DVTC options as outline by your SA/DVTC.
  8. Discuss with physician in charge of the patient the time frame in which the patient is likely to regain decisional capacity.

Every patient is different, but many people will regain decisional capacity within 72 hours from the time of the assault if suffering from:

- Drug and/or alcohol overdose/intoxication
  - Seizure disorder
  - Decreased blood sugar
  - Psychotic episode
9. If it is concluded that the person is likely to regain decisional capacity within 72 hours of the time of the assault, proceed to Step 10.

As a general rule, patients suffering from the following are less likely to regain capacity within seventy-two hours of the assault or at all:

- Stroke
- Coma
- Alzheimer
- Senility
- Developmentally delayed
- Mental illness resulting in decisional incapacity

If the conclusion is that the person is not likely to regain decisional capacity within 72 hours of the time of the assault, proceed to Step 18.

10. If the patient is expected to regain consciousness within 72 hours the SA/DV Nurse will give hospital staff (Nurses and/or Physician) direction to minimize the disturbance of evidence based on the principles of forensic evidence collection and preservation, for example<sup>3</sup>:
  - Prior to catheterizing a patient, wipe external genitals with sterile gauze moistened with sterile water. When done put gauze in sterile urine container, seal, and label with content type, date/time and name of RN collecting sample. Store in tamper evident DryPac evidence bags and

---

<sup>3</sup> Sexual Assault Team Biology Section, Centre of Forensic Sciences. Personal Communication. June 12, 2007

keep in safe place until SACC RN arrival to maintain continuity of evidence or give to police

- Take blood and urine for toxicology
- Do not wash patient. Washing may wipe away evidence. Coordinate care with hospital staff.
- If the patient has wounds, bite marks, it may be in the best interest of the patient for the SACC RN to respond to the case in order to take photos and to collect debris from the wound. The evidence can be stored in the DryPac. When taking wounds swabs, swab around the wound, avoid bloody areas (you may get too much of the patient's blood if you do this)
- Do not handle patient more than necessary to ensure medical stability. Over handling may destroy evidence.
- Place blue absorbent pad under patient in order to collect any vaginal/anal drainage, alternatively. When changing pad store in DryPac, seal, label with content type, date/time and name of RN collecting sample and keep in safe place to maintain continuity of evidence until SACC RN arrival or give to police
- Store clothing in paper bags, one item per bag (if police involvement, clothing will likely be apprehended at the time of admission to the ED)
- If necessary to cut through clothing do not do so through tears, bullet holes or knife incisions.
- If there is a question of where the patient may have scratched the assailant the nurse will minimize contact with hands and/or protect hands by putting them in paper bags until SACC RN arrival in the am

11. The SA/DV Nurse or designate should periodically (suggestion: every shift) speak with the patient's primary nurse to reevaluate the patient's decisional capacity according to the test set out in Step 5, above, at any time that it appears that capacity may have returned. This step is indicated, for example, once the patient regains consciousness and is assessed to be alert and orientated as per one or more of the following criteria:

- Able to walk a straight line
- Able to maintain a meaningful state of wakefulness
- Orientated to person, place and time
- May or may not be able to recount events that led to state of unconsciousness

Based on the estimated time of assault, given by police, the SA/DV nurse communicates to the primary nurse that a reassessment of capacity must occur between six and eight hours of the end of the 72 period so that appropriate steps can be taken should it be determined that the patient has not regained decisional capacity by that point.

12. If the patient is decisionally capable then proceed to Step 16. If the patient remains incapacitated proceed to Step 13.

13. Police can estimate time of assault. The best time frame for the collection of vaginal evidence is within 72 hours; however, semen can last up to seven days in the vagina. If the patient is unconscious and therefore lying still, there is a likelihood that evidence will be preserved longer. If less than 64 hours has passed proceed to Step 11. If more than 64 hours has passed proceed to Step 18.
14. Continue to reassess the patient periodically as per Step 11. At the 64 hours mark proceed to Step 15.
15. If the patient remains incapacitated after 64 hours proceed to Step 18.
16. Hospital staff (RN or Physician) or police to assess the patient's recollection of events. If there was no sexual/domestic assault the patient is not referred to SA/DV Care/Treatment Centre. If the client is unsure or recalls a sexual/domestic assault then the hospital staff can offer SA/DV Care/Treatment Centre services.
17. The hospital staff pages the SA/DV Nurse if and when the patient agrees to be seen. The SA/DV Nurse will respond following the protocol for patients who disclose sexual and/or domestic assault, Step 7.
18. If the patient is unlikely to regain decisional capacity within 72 hours, the appropriate surrogate for the patient should be sought out. Section 21 of the *Health Care Consent Act (HCCA)* provides a hierarchy of potential substitute decision-makers (SDMs) for treatment. That Act provides that decision making authority for treatment vests in the highest ranking person on that list who is decisionally capable, available, and willing to accept the role. The HCCA SDM should be allowed to act as surrogate for your purposes unless clearly inappropriate by virtue of obvious hostility or conflict with the patient or if there are suspicions that the potential surrogate is the perpetrator. If the highest-ranking potential surrogate is disqualified, you should attempt to continue down the list until an appropriate surrogate is found. Remember, a person is not the appropriate surrogate unless available, willing and decisionally capable.
19. Once the appropriate surrogate is found proceed to Step 21. If no one assumes this role then proceed to Step 20.
20. The SA/DV Nurse consults with a SANE or the SA/DV Care/Treatment Centre Coordinator, police investigator, patient's physician, ethics person, hospital administrator on-call. A decision by consensus determines the appropriate forensic care. (proceed to step 22)
21. The SA/DV Nurse consults with a SANE or the SA/DV Care/Treatment Centre Coordinator, police investigator, patient's physician, ethics person, hospital administrator on-call and patient's family (surrogate). A decision by consensus determines the appropriate forensic care. The opinion of the surrogate deserves a great deal of respect and should have considerable influence on the ultimate recommendation. There will be occasions, however, when the recommendation is to proceed in a manner contrary to that desired by the surrogate, for example, if

significant other is a suspect in the assault and does not want any evidence collected or documentation. It should be remembered that, while attempts to respect the wishes of those close to the patient, the HCCA does not apply to evidence gathering and the wishes of the surrogate are not binding. Proceeding in a manner opposed by the surrogate should not be done unless there are good reasons for doing so and careful documentation of those reasons is done on the health record. It is wise to consult with colleagues before deciding not to abide by the wishes of the surrogate.

22. Call SA/DV Care/Treatment Centre Coordinator to arrange for another SA/DV Nurse, preferably a SANE. It is preferable that two SA/DV nurses provide care to persons who are not decisionally capable as it can be emotionally and practically (logistically) difficult for the nurse. Every effort should be made to arrange a second nurse to be available. If possible, calls during the night should be deferred to daytime hours when additional supports are available. Please see Step 10 to assist the hospital staff in minimizing the disturbance of evidence. If no SA/DV Nurse/SANE available proceed to Step 23.
23. If there is no SA/DV Nurse or SANE available then the on call SA/DV Nurse completes the case on her own with support from the nurse/physician in charge of the patient's care. Telephone back up provided by the SA/DVTC Coordinator. If there is another SA/DV Nurse or SANE available, then respond to the case together with one nurse taking the lead role.
24. Forensic evidence is collected as warranted. A polilight (if available) can be used to guide the areas that should be swabbed. Generally these areas include, but are not limited to, the mouth, ears, neck, breasts and genital areas. Photographs may be taken of non-genital injuries. Any genital injuries are documented on the body maps.
25. Using local SA/DVTC protocol for guidance, the SAEK (and photographs) are either released immediately to the police, or stored in a freezer pending the ability of the victim to provide her/his own consent for release of the SAEK to police. The SAEK can also be released to police when a search warrant is issued. SA/DVTC may want to consult with the hospital privacy officer or risk management as to the necessity of the warrant in each individual case.
26. If, subsequent to the collection of forensic evidence, the patient regains consciousness/capacity, it is their right to know what has occurred during the state of unconsciousness/incapacity. The SA/DV Treatment Centre Coordinator or delegate should explain to the patient what evidence was collected and why it was done at that time. As well, follow up care should be discussed and offered.

Considerations for determining appropriate timing and for having this conversation:

- Patient is alert and orientated to person, place, time



- Patient is asking questions about what happened
- Consultation with relevant members of the team who were involved in decision making process. i.e. significant other, physician , with respect to the client's emotional state and ability to tolerate information at this time
- Social worker or other support person to be witness to conversation in order to support client after the SA/DVTC nurse leaves
- Assess patients memory of what happened i.e. do they recall a sexual assault
- Explain what was done (evidence collection and medical treatment of STI/pregnancy) and why. If the standard of practice was not followed, what were the deviations and why.
- Explain the option to release the SAEK if kit remains frozen.
- Explain option to stop investigation, if no assault occurred or if patient wishes not to continue the process. With patient consent, inform police if this is the case.
- SA/DVTC contact number given to patient in case of further questions
- Counselling and follow-up resources to be explained
- Document interaction and clients response to having evidence collected while incapacitated