Confront the Issues in Sexual Abuse Cases from Infants to Seniors
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CONFRONT THE ISSUES IN SEXUAL ABUSE CASES FROM INFANTS TO SENIORS

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CONFRONT THE ISSUES IN SEXUAL ABUSE CASES FROM INFANTS TO SENIORS

I. INTRODUCTION

A. Relevance to Certified Legal Nurse Consultants\textsuperscript{CM}

1. Recent alleged sexual abuse may be the stated reason for the CLNC\textsuperscript{®} consultant's involvement.

2. Sexual abuse may not be obvious yet may be a contributing factor in current issues.
   a. The elderly patient or person with dementia.
   b. The child who is unable to articulate abuse.
   c. The adult who has been sexually abused in the past but with no information about the abuse in the record.

3. Knowledge and understanding of basic facts concerning sexual abuse.
   a. Evidence of sexual abuse in medical records and other documents.
   b. Adherence to or deviations from standards of care in prevention of and response to incidents of sexual abuse.
   c. Hidden information that may dramatically influence the outcome of the case.
   d. Pertinent and meaningful interrogatories and requests for production.

B. Definitions Related to Sexual Abuse (Exhibit A)

C. Basic Facts of Sexual Abuse

1. Occurs worldwide.

2. Old in practice but more recent in acknowledgement.

3. Difficult to know how frequently sexual abuse occurs across the age spectrum.

4. Occurs in heterosexual and homosexual situations.
5. Can occur while victim is unconscious or dead.


II. COMMONALITIES IN SEXUAL ABUSE CASES

A. Noncontact or Contact Sexual Abuse
   1. Noncontact – forced to watch sex acts, look at sexually explicit materials or look at sexual organs. Forced to listen to sexual talk, phone calls, audios or sexually abusive questions or comments. Forced to be nude and/or pose in suggestive poses.
   2. Contact – touched or fondled with or without clothes on, forced to touch another person's sexual areas with hand or tongue with or without clothes on, forced to have oral sex, forced to have vaginal/anal intercourse (penetration must occur – penis, finger or other object).

B. Familiar or Unfamiliar Sexual Abuse
   1. Settings
      a. Familiar (e.g. home, school, healthcare facility, work).
      b. Unfamiliar (e.g. outdoors, stranger's car or apartment).
   2. Perpetrator
      a. Known (e.g. relative, caretaker, colleague, neighbor, clergy).
      b. Unknown (e.g. stranger, someone met on the Internet).

C. Methods of Identifying Sexual Abuse
   1. Verbal disclosure.
   2. Physical and/or forensic examination.
   3. Behavioral, physical, and/or emotional changes.

D. Response Upon Learning of Sexual Assault
   1. Support of victim.
   2. Notification of appropriate authorities including the police.
4. Immediate examination by a sexual assault nurse examiner (SANE), preferably in a hospital emergency department (ED). *(Exhibit B)*

5. Referral for follow-up counseling for rape trauma.

E. **Symptoms of Recent Sexual Abuse**

1. Lacerations or bruising of the hymen or the anus – most often seen when an exam takes place soon after the assault has occurred.

2. Presence of bite marks, bruises or abrasions, ligature marks, petechiae on roof of mouth or bruises on oral palate.

3. Difficulty walking or sitting.

4. Torn, stained or bloodied undergarments.

5. Vaginal or anal bleeding.

6. Not uncommon for physical findings to be absent.

F. **Chronic Symptoms of Sexual Abuse (Age Dependent)**

1. Healed lacerations of the hymen or anal area.

2. Frequent office visits with varied complaints such as headaches or abdominal pain with no etiology, painful urination, urinary tract infection, genital rash with itching, vaginal discharge.

3. Change in eating habits, appetite, unexplained gagging or trouble swallowing – may have eating disorder in adolescence.

4. Change in bowel habits – diarrhea, constipation or encopresis (fecal incontinence).

5. Change in sleep patterns, waking up screaming, sweating, having nightmares. If a child, may want to sleep with parents.

6. Emotional or mood changes.

7. Behavioral changes.
G. Difficulties in Proving Sexual Assault
1. Inconclusive physical exam.
2. Inconsistencies in victim's story.
3. Victim unable to tell story.
4. Lack of documentation.
5. Lack of witnesses.

H. Immediate and Short-Term Costs Across the Age Span
1. Medical and healthcare costs.
2. Emotional and psychological costs.
3. Functioning costs – school, activities, employment.

I. Long-Term Costs
1. Effects of sexual abuse are not only persistent but additive – "The Body Keeps the Score."
   a. Survivors of sexual abuse seek medical care more often than the general public and incur higher medical costs.
   b. Increased occurrence of many physical conditions such as heart and liver disease.
   c. Strongly linked to a future diagnosis of gastrointestinal disorders, nonspecific chronic pain, psychogenic seizures, chronic pelvic pain and eating disorders.
   d. Increased occurrence of mental health problems such as depression, anxiety, insomnia or nightmares, prostitution, suicide, alcohol and drug abuse.
   e. Increased incidence of social problems such as unemployment and unwanted pregnancy.
   f. Increased incidence of revictimization and of becoming sexually abusive.
   g. Difficulties with trust, relationships and sexual intimacy.
   h. May have difficulty maintaining appropriate boundaries with others – overly friendly with strangers. May be increasingly inhibited or increasingly disinhibited.
3. Necessity for evaluation for immediate and long-term counseling.
J. **Factors Affecting Recovery**

1. Severity of and circumstances surrounding trauma.
2. Age and level of development.
3. Timing of disclosure.
4. Response of others.
5. Support.
6. Counseling.
7. Previous traumas.
9. Personality characteristics.

III. **SEXUAL ABUSE OF CHILDREN**

A. **Unique Characteristics**

1. Child immature and therefore legally unable to give consent.
2. Child not emotionally or psychologically able to deal with sexual situations on an equal basis with adults.
3. Other person, either adult or older child, may be in a position of power or control over the child.
4. Lost childhood.
5. Statistics.

B. **Perpetrator Gains Sexual Access to Child**

1. Pressured encounters.
2. Forced encounters.
C. Disclosure of the Abuse
   1. Immediate.
   2. Delayed.
   3. Incremental.

D. Factors Influencing Disclosure
   1. Response of caregiver to disclosure.
   2. Relationship between victim and offender.
   3. Location of abuse.
   4. Perpetrator’s control of victim.
   5. Age.
   6. Lack of other attention.
   7. Emotions.

E. Specific Issues for Adolescent Victims
   1. Female issues.

F. Factors Affecting Processing of Trauma
   1. Increased vulnerability of infants and very young children.
   2. Process depends on age and level of development.
   3. Coping mechanisms.
   4. Sequelae go beyond post-traumatic stress disorder, as in attachment disorders.

G. Recognition of Overt and Latent Family Concerns
H. Examples of Sexual Abuse of Children

1. Adult abuses infant.
   a. May occur in context of physical abuse.
   b. Male may masturbate against infant’s genital area or the area between baby's buttocks.
   c. Adult can stimulate infant for self-gratification.

2. Adult abuses child.
   b. Other adult – usually someone known to the child.
   c. Role of Internet, social media, sexting.

3. Child abuses child. (Exhibit C)
   a. State laws vary. Some states require perpetrator to be at least five years older than the victim and most require perpetrator to be older than victim.
   b. Different from age appropriate normal sexual exploration.

IV. SEXUAL ABUSE IN ADULTS

A. Characteristics

1. Many types. (Exhibit A)

2. Worldwide.
   a. Cruise ships.
   b. Military.


B. Myths and Assumptions

1. If assaulted, victim is expected to:
   a. Be in a state of high emotional upset.
   b. Be bruised and bloody from having fought the rapist.
   c. Have obvious injuries from the assault itself.
   d. Have been assaulted by a stranger.
   e. Come immediately after the attack to the ED perhaps in a disheveled condition.

2. It was her own fault. She “asked for it.”
3. Only “certain” women are raped.
4. Victim’s sexual history negates the current accusation.
5. Alleged assailant is “not that kind of person.”
6. Alleged assailant is known to victim so could not have been the perpetrator.
7. Alleged assailant is her husband so rape was not possible.
8. Nothing like that would ever happen in the military, in that prestigious company, by that public official, etc.
9. Most reports are false accusations.

C. Example of Rape Not in the Context of Intimate Partner Violence (Exhibit D)

D. Sexual Abuse Within the Context of Intimate Partner Violence
   1. Victim may be subject of other abuse in addition to sexual abuse, e.g. forced sexual activity, often involving violence.
   2. Jill’s story.
   3. Effect on children who witness abuse.

E. Rape Trauma Syndrome
   2. Relates more to the phases by which victims recover from rape than to the actual psychological harm experienced by victim.
      b. Long-term phase – reorganization.
   3. Multidimensional therapy.
   4. Legal importance of acceptance as a nursing diagnosis.

F. False Allegations of Sexual Abuse
   1. Facts.
   2. Potential consequences.
3. Reasons for false allegations.
4. Key to understanding: how this allegation helps the complainant.

V. SEXUAL ABUSE OF THE ELDERLY

A. Characteristics

1. Vulnerable population; obligation to protect.
2. Is a felony in all states.
3. Perpetrators can be family members, care providers, other residents in care facilities or strangers.
4. Difficulties in gathering data.
   a. Impaired cognition, memory, language, perception.
   b. Communication difficulties.
   c. May recant testimony.
   d. Feelings of shame, dependency, isolation, fear.
   e. Physical health problems.
   f. Refusal to be examined.
   g. Trauma found is assumed to be due to accidental bruising.
   h. Lack of documentation.
   i. Sexually transmitted diseases may not be diagnosed until months after unknown assault occurred.
5. Attitudes about sexuality in the elderly.
   a. Lack of recognition or acceptance that elders are sexually abused.
   b. Treated as consensual.
   c. Jurors may have a perception that elder sexual abuse claims are not credible.

B. Additional Symptoms in the Elderly Following Sexual Abuse

1. General deterioration in physical health.
2. Avoidant behaviors of certain personnel, other residents.
3. Increased confusion.
4. Decreased ability to concentrate and focus.
5. Obvious changes in emotional, social behaviors.
6. Changes in relationships with family, friends, clergy.
7. Development of odd, unusual mannerisms, movements.
9. Use of coded speech.

C. Two Cases of Elderly Sexual Abuse
1. Margaret’s story. (Exhibit E)
2. Albert Lea Nursing Home.

VI. SEXUAL ABUSE IN OTHER SPECIALIZED SETTINGS

A. Institutions Caring for Physically or Mentally Challenged Females of Childbearing Age
1. Risk of patients becoming pregnant.

B. Prison Assault
1. Facts.
2. Nan’s story. (Exhibit F)

C. Sexual Abuse in Facilities for Developmentally Disabled Youth (Exhibit G)
1. Developmentally disabled are exposed to abuse at a rate higher than other youth.
2. Underreporting, impaired communication and belief that either no assault took place or could not be successfully prosecuted if it did.
3. Responses and reactions may be different from those of other youth.
4. Underlying behaviors may be exacerbated by the assault.
D. Sexual Abuse in Psychiatric Facilities for Children

1. Mitchell’s story.
2. Johnny’s story.

VII. COMMON PLAINTIFF ALLEGATIONS FOR SEXUAL ABUSE

A. Within Institution or Facility

1. Failure to provide safe, protective environment for patients, residents or inmates.
   a. Inadequate oversight or supervision of patients.
   b. Insufficient staff to meet patients' needs.
   c. Failure to respond to patients in distress.

2. Failure to maintain nursing practice standards.

3. Failure to maintain standards of Joint Commission on Accreditation.

4. Failure to maintain adequate and accurate records.
   a. Failure to document and chart monthly menstrual periods or note enlarging abdomen of patient who is pregnant.
   b. Failure to observe/record deterioration in emotional status.

5. Failure to provide prenatal and perinatal care (patient was unknowingly pregnant).

6. Failure to implement physician’s orders and failure to detect that the orders had not been implemented.

7. Failure of the institution to develop a plan for the treatment of victims of sexual assault.
   a. Calling physician.
   b. Notifying police and other authorities.
   c. Taking patient to the hospital ED.
   d. Notifying family.
   e. Providing emotional and psychological support to victim.

8. Failure to follow institutional policies and procedures concerning sexual assault (i.e., implement the plan in place).

9. Failure to have a policy concerning sexual harassment.
10. Failure to provide adequate supervision of staff members.
   a. Staff assigned one to one but not carrying out this responsibility.
   b. Incomplete and/or inaccurate charting of patient's behavior, sleep patterns and eating.

11. Failure to train and educate staff concerning sexual abuse.

12. Failure of supervisors to investigate rumors of employee's sexual behavior at work.

13. Failure to recognize that if a patient is declared incompetent, then the patient is legally unable to consent to sexual activity.

14. Failure to recognize or acknowledge that even though a patient has been declared legally incompetent, the patient is capable of suffering mental anguish and can demonstrate emotional damage.

15. Failure to recognize that if an employee (inmate or guard) and patient relationship (a fiduciary relationship) exists, then sexual activity is in violation of state law, whether or not the patient (or inmate) gives consent.

B. Under Any Circumstances

1. Failure of mandated reporters to report sexual abuse.

2. Failure to protect children.

3. Failure to maintain and monitor electronic monitoring equipment, e.g. video cameras.

4. Failure to intervene when a sexual assault is taking place.

5. Failure to collect and preserve evidence of sexual assault.

VIII. COMMON DEFENSES FOR SEXUAL ABUSE CASES

A. Within Institutions or Facilities

1. The episode didn't happen.
   a. The patient (child) imagined the episode.
   b. One-to-one supervision of the patient precluded any sexual abuse from having occurred.
   c. The patient never reported having been sexually assaulted.
2. Children experiment with sexual activity but that is not abuse.

3. Patient requested sexual activity and allowed defendant to undress and position her.

4. Because the patient has been declared legally incompetent, she was legally incapable of recognizing the gravity of her plight; therefore, she had suffered no mental or emotional damage.

5. There were no deviations from applicable standards of care.

6. Appropriate policies and procedures were in place. One individual did not follow them.

7. Patient's observed physical trauma was due to repeated falls.

B. **Under Any Circumstances**

1. The sexual activity was consensual between two willing adults.

2. The SANE exam was inappropriately done and/or inappropriately interpreted.

3. Because the SANE exam showed no physical signs of sexual assault, no assault took place.

4. There is no such diagnosis as rape trauma syndrome.

5. There is little or no evidence that there are long-term effects of inappropriate sexual activity.

6. Patient's pre-existing psychiatric (or medical) diagnosis is contributing to or causing current behavior, not the sexual assault.

7. Faulty memory contributed to the allegation of sexual assault.

8. The children involved were out of sight of an adult and no other witnesses were present.

9. The job description of the employee at the lobby desk did not include security.

10. The mall is not required to provide security cameras in the garage.

11. The security provided in the medical building is appropriate and consistent with security in other buildings.
IX. THE ROLE OF THE CERTIFIED LEGAL NURSE CONSULTANT\textsuperscript{CM} IN SEXUAL ABUSE CASES

A. Review All Relevant Medical Records

1. ED records.
   a. Review notes of physical exam and history.
   b. Review assessment of victim's emotional state.
   c. Note carefully who was present with the victim and what comments each made about the victim.
   d. Assess if appropriate lab tests were ordered and review results of those tests.
   e. Review medications ordered.
   f. Review what follow-up services were recommended.

2. SANE report including results of SANE testing.
   a. Review date and time of testing.
   b. Identify qualifications of person doing testing.
   c. Review all completed forms.
   d. Note that all appropriate procedures were followed concerning use and disposition of rape kit.

3. Pre- and post-event medical records.

4. Pre- and post-event psychiatric, psychological and counseling records.

B. Review Additional Available Records

1. Records of police investigation and investigations by other entities.

2. Video of forensic interview, if it has occurred.

3. All depositions.

4. Criminal transcript, if trial has occurred.

5. Perpetrator’s medical and psychological records and criminal history.

6. Physical setting and environment in which assault took place.

8. Electronic equipment including cell phone, fax, computer and all other devices in which data concerning the activities of plaintiff and defendant(s) are recorded.

9. Social media sites.

C. **CLNC® Consultant’s Responses and Feelings**

1. Consider any personal history (or that of someone you know) of sexual abuse (or false accusation of sexual abuse) and its possible effect on objectivity.

2. Identify any personal biases and assumptions regarding either the victim or the defendant in sexual abuse cases.

3. Recognize personal feelings and responses to the issues raised and develop appropriate ways to cope with these feelings to function effectively as a CLNC® consultant.

D. **Factors to Consider**

1. Defense CLNC® consultant.
   a. Evidence of mistaken identity – defendant was not involved.
   b. Evidence that the abuse did not occur (false allegation).
   c. Evidence that the sexual activity was consensual.
   d. Evidence that there had been prior sexual abuse which is contributing to or causing current symptoms.
   e. Evaluation of the SANE exam to see if carried out and interpreted appropriately (e.g. is there evidence that sexual assault took place?).
   f. Evaluation of physical, mental and emotional status of both plaintiff and defendant looking for history of substance abuse, emotional instability.
   g. Evidence to support that there was no wrongdoing (or at least, little wrongdoing) on the part of the defendant(s) (e.g. all applicable standards of care were met).
   h. Literature or research to support defense’s claim that there is no such thing as rape trauma syndrome.
   i. Literature or research to support the claim that patients with dementia are unreliable or unable to experience psychological trauma from sexual assault.
   j. Literature or research to support the claim that children’s fantasies color their story of sexual abuse.
   k. Evidence to support that the employee observing sexual assault acted independently in not reporting the incident.
2. Plaintiff CLNC® consultant.
   a. Evidence that assault took place and under the circumstances described by the plaintiff, if plaintiff able to provide data. Look for coded speech.
   b. Evidence of physical, emotional, mental and psychological trauma. Pay attention to location, description and size of injuries.
   c. Examples of victim's "imperfections" (which might normally make her a less than adequate witness) to illustrate that those imperfections helped make her the ideal victim.
   d. Detailed understanding of the circumstances surrounding the assault, e.g. how did the rapist get control over the victim – especially important if no weapon was used.
   e. Characteristics of the setting that allowed for alleged abuse to take place without anyone else's knowledge.
   f. Clear understanding of reasons for delayed reporting (if that occurred). Specifically, what did the offender do or say that contributed to the delay?
   g. Evidence of any indication of prior sexual abuse in plaintiff's history.
   h. Evidence of lack of adherence to applicable nursing (or prison) standards.
   i. Evidence of lack of adherence to policies and procedures for appropriate action following alleged sexual assault.
   j. Evidence of defendant's history of previous "bad" behaviors (lawsuits, restraining orders, prior assaults, military and employment records, conduct during previous trials, style of behavior in previous criminal acts).
   k. Case theme that is focused on the offender not the victim.
   l. Evidence in medical records showing that on later review, sexual trauma took place when initial examination of data determined that it had not.

E. Prepare Case Reports with Information Needed by the Attorney for Criminal or Civil Trials

1. Develop detailed chronology of all relevant events.

2. Prepare timelines, tables, etc. to demonstrate pre- and post-assault changes (or lack of changes) in behavior; participation in activities; emotional status; medication use; sleeping and eating patterns; work, school and home responsibilities; physical status; interactions with others and development of coded speech.
3. Prepare timelines and chronologies to highlight staff’s response to assault.

4. Prepare appropriate life-planning documents with recommendations for needed services.

F. Identify Potential Defendants

G. Assist the Attorney in Developing Interrogatories, Requests for Production and Deposition Questions

H. Identify Potential Difficulties

1. Expect that it may be difficult to locate a therapist for the victim.
   a. Victim may not wish to have her psychiatric history divulged.
   b. Victim may have gone public with her story pretrial.
   c. Therapist may not take notes in a way that would protect the patient’s privacy.
   d. Agency may not wish to violate confidentiality agreement.

2. Expect the possibility that victim could decide at any time to refuse to continue with legal proceedings.
   a. Initial response by others to the assault can affect victim’s decision.
   b. Feelings of shame, guilt and embarrassment may be overwhelming.

I. Research Relevant Standards and Scientific Literature

J. Locate and Recommend Expert Witnesses

1. Nursing home administrator and nurse specialist in nursing standards.

2. Clinical specialist in psychiatric nursing with expertise in rape trauma.

3. Clinical specialist in pediatric psychiatric nursing.

4. Life care specialists.

5. Medical specialists as needed, e.g. gynecologist, pediatrician, gerontologist.
6. Forensics experts.
7. Experts in trauma therapy.
8. Geriatric-psychiatric nurse.
10. SANE.

K. Prepare and Support the Victim (if Working for the Plaintiff Attorney)

1. Assist in coordinating all who are involved with meeting the victim to minimize the number of times that victim needs to repeat story.
2. Support victim's angst over delay in processing rape kit.
3. Prepare for deposition and court appearances.
   a. Personal appearance – don't look too “put together.”
   b. Expect to feel intimidated by defense attorney.
   c. Assist with victim impact statement.
4. Inform victim of real or potential changes in status of perpetrator (e.g. parole, escapes, appeals, probation revocation, hearings).

L. How to Gain Clients in Sexual Abuse Cases

1. Identify, market to and meet with attorneys specializing in sexual abuse.
2. Offer to meet with and speak to forensic nurses, sexual abuse nurse examiners and other nursing organizations.
3. Offer to speak at and provide educational materials to community groups.
4. Network with other Certified Legal Nurse ConsultantsCM.

X. INTERROGATORIES AND REQUESTS FOR PRODUCTION

A. Interrogatories Directed to the Defense

1. Please identify the names, addresses and title of the person answering these interrogatories.
2. Please list the names, title and telephone numbers of any and all persons known to be witnesses concerning the facts of this case and indicate whether or not written or recorded statements have been taken from these witnesses.

3. Please identify the age, gender, height and weight of the defendant who was involved in the sexually inappropriate incident with (Plaintiff) ________ on (Date) ________.

4. Please identify any and all past occurrences or incidences documented at (Facility) ________ regarding the resident (or employee) who was sexually involved with (Plaintiff) ________ on (Date) ________.

5. Please identify any and all marketing or advertising for the defendant in the past five years. [Note: to look for claims that an institution has made concerning its state-of-the-art care, safety, security, supervision, monitoring, appropriate placement of residents, etc.]

6. Please describe the placement, purpose, function and maintenance of video cameras or other monitoring equipment in the apartment complex (or institution) from (Date) ________ to (Date) ________.

7. Please describe the policy concerning location or placement of residents at (Facility or Institution) ________ that was current from (Date) ________ to (Date) ________.

8. Please list the name, address, telephone number and any other contact information concerning the owner of (Facility or Institution) ________ where the alleged sexual assault took place.

9. Please provide the name, address and telephone numbers of the first responders who provided immediate emergency care.

10. Please identify the names, addresses and telephone numbers of all those persons notified by the institution after the alleged abuse became known.

B. Interrogatories Directed to the Plaintiff

1. Please list the full name, address and telephone number of (Plaintiff or Plaintiff’s guardian, if plaintiff is a minor) ________.

2. Please describe the acts of sexual abuse alleged by (Plaintiff) ________ to have occurred at (Facility or Location) ________ on (Date) ________.
3. Please identify the witnesses to the sexual assault to (Plaintiff) ______ on (Date) ______.

4. Please identify any areas of body piercing on (Plaintiff) ______ and state if swabs of those areas were taken during sexual assault exam.

5. Please describe the level of mental functioning of (Plaintiff) ______ at the time of the alleged incident as well as the current level of mental functioning.

6. Please list the full names, addresses and telephone numbers of physicians and other healthcare personnel who provided physical, emotional and psychological examinations and counseling following the alleged incident to the present time.

7. Please list every item, document or material that supports the position taken by (Plaintiff) ______ including any which may be submitted as evidence in the trial of this case.

8. Please list the full name and credentials of the person who made the diagnosis of post-traumatic stress disorder and the date on which it was made.

9. Please identify the protective services/child welfare agencies involved with the family prior to the alleged sexual assault.

10. Please list the date of birth, height, and weight of (Plaintiff) ______.

C. Requests for Production Directed to the Defense

1. Please provide a copy of institution's policies and procedures regarding:
   b. Supervision and training of these employees.
   c. Observation and documentation of patient's (resident's) behavior and changes in behavior.
   d. Appropriate supervision of patient's (resident's) needs.
   e. Sexual activity between patients (or residents) or between patient (or resident) and staff member (or employee).
   f. Action to take if assault was reported or suspected.
   g. Notification of family or guardian if sexual abuse is suspected.
   h. Use of incident or occurrence reports.
i. Internal communication of sexual abuse incidents.

j. Placement of residents (patients) within the institution and on a specific unit.

2. Please provide copies of any and all minimum data sets (MDS), resident assessments and administrative file documents for (Plaintiff) ________ from (Date) ________ to (Date) ________.

3. Please provide copies of all medical records including physical examinations, laboratory tests and results, X rays, treatments, medications and diagnoses of (Plaintiff) ________ following the alleged sexual assault at (Facility) ________ on (Date) ________.
   [Note: appropriate for assault within an institution.]

4. Please provide copies of the past medical history, past emotional, psychological or psychiatric history and past history of abuse or trauma of (Plaintiff) ________ alleged to have been sexually assaulted by (Defendant) ________ on (Date) ________.

5. Please provide a copy of records concerning (Plaintiff) ________'s:
   a. Background.
   b. Educational history and current educational progress.
   c. Behavior pre- and post-assault.

6. Please provide the past medical history, past history of abuse and emotional, psychological and psychiatric history of (Defendant) ________ prior to the alleged sexual assault on (Date) ________.

7. Please provide record of daily assignments of (Defendant) ________ during the time period of alleged sexual abuse from (Date) ________ to (Date) ________ and how the assignments were checked.

8. Please provide a record of nursing supervisors on duty when (Defendant) ________ was on duty during the time period of alleged sexual abuse from (Date) ________ to (Date) ________ and how this supervision was documented.

9. Please provide copies of records, files and any incident reports maintained on the resident (or employee) involved with (Plaintiff) ________ in the sexually inappropriate incident on (Date) ________.

10. Please provide copies of (Facility) ________'s committee minutes, agenda, notes and schedules for (Year) ________ to (Year) ________.

Contents
11. Please provide copies of blueprints, layout or existing floor plan at (Facility) ________ where sexually inappropriate behavior took place.

12. Please provide copies of personnel files of (Names) ________, ________ and ________ at (Facility) ________ from (Date) ________ to (Date) ________.

13. Please provide the title and job description of the person on duty at the front desk (or the staff person in charge, or the prison guard on duty) at (Time) ________ on (Date) ________ of the alleged sexual assault at (Facility) ________.

14. Please provide the policies and procedures in place at (Facility) ________ from (Date) ________ to (Date) ________ concerning sexual harassment and sexual contact with prison inmates (or patients).

15. Please provide documentation as to the type and frequency of employee or staff training and the record of date that (Defendant) ________ was last trained.

16. Please provide records of all telephone calls, email correspondence and faxes made to and from the supervisor (Name of Responsible Person) ________ after she or he was notified on (Date) ________ of the alleged sexual assault to (Plaintiff) ________.

D. Requests for Production Directed to the Plaintiff

1. Please provide copies of any statements you may have that the plaintiff may have made to anyone concerning this claim.

2. Please provide copies of statements obtained by you or anyone acting on your behalf, from any witnesses or any other individuals pertaining to the incident which is the subject of this lawsuit.

3. Please provide copies of:
   a. Medical history.
   b. Emotional, psychological and psychiatric history.
   c. History of abuse or trauma of (Plaintiff) ________ alleged to have been involved in a sexually inappropriate incident with (Defendant) ________ on (Date) ________. [Note: appropriate if plaintiff is not a resident of an institution.]
4. Please provide copies of all medical records following the alleged sexually inappropriate incident with (Defendant) _______ on (Date) _______. [Note: appropriate if plaintiff is not a resident of an institution.]
   a. Physical examinations.
   b. Laboratory tests and results.
   c. X rays and other diagnostic tests.
   d. Treatments and medications.
   e. Diagnoses of (Plaintiff) _______.

5. Please provide copies of all records of psychological and psychiatric counseling or treatment following alleged sexually inappropriate incident with (Defendant) _______ on (Date) _______.

6. Please provide the name, address, occupation and qualifications of any expert witness expected to give an opinion as well as the subject matter to which each expert is expected to testify, the basis for same, and what the expert's opinions are expected to be.

7. Please provide employment records including days absent from work pre- and post-alleged sexually inappropriate incident.

8. Please provide the name, address and qualifications of the sexual assault nurse examiner who examined the plaintiff after the alleged sexual incident.

9. Please provide the records of any special needs services given to the plaintiff before and after the alleged sexual assault on (Date) _______.

10. Please provide a copy of plaintiff's history of foster home placements.

11. Please provide school records including name of school and records of school attendance, behavior and classroom functioning pre- and post-alleged sexual incident on (Date) _______.

12. Please provide a history of plaintiff's criminal record including incarcerations.
XI. RECOMMENDED QUALIFICATIONS FOR A CLNC® SUBCONTRACTOR FOR SEXUAL ABUSE CASES

A. Experience in Psychiatric Settings

B. Experience in Sexual, Pediatric and Adult Abuse

C. Geriatric and Long Term Care Experience

XII. CASE STUDIES

A. Child Abuses Child (Exhibit C)

B. Blitz Rape (Exhibit D)

C. Elder Abuse by a Resident (Exhibit E)

D. Prison Assault (Exhibit F)

E. Sexual Assault of a Developmentally Disabled Young Man (Exhibit G)

XIII. RESOURCES

A. Associations and Organizations

1. American Academy of Child and Adolescent Psychiatry. aacap.org


3. American College Health Association. acha.org

4. American College of Emergency Physicians. acep.org
5. American Professional Society on the Abuse of Children. apsac.org
7. Emergency Nurses Association. ena.org
8. International Association for Forensic Nurses. iafn.org

B. Authoritative Textbooks

C. Journal Articles


25. Patterson, Debra and Campbell, Rebecca. “A Comparative Study of the Prosecution of Childhood Sexual Abuse Cases: the


D. Websites

1. Centers for Disease Control and Prevention.
   - [cdc.gov/nchs](http://cdc.gov/nchs)
   - [cdc.gov/violenceprevention](http://cdc.gov/violenceprevention)
   - [cdc.gov/std/treatment](http://cdc.gov/std/treatment)
   - [cdc.gov/excite/ScienceAmbassador/ambassador_pgm/lessonplans_chooserespect.htm](http://cdc.gov/excite/ScienceAmbassador/ambassador_pgm/lessonplans_chooserespect.htm)
2. Department of Justice Office on Violence Against Women. oww.usdoj.gov
4. National Center on Elder Abuse. ncea.aoa.gov
5. The National Child Traumatic Stress Network. nctsn.org
7. National Committee for the Prevention of Elder Abuse. preventelderabuse.org
9. Rape, Abuse and Incest National Network. rainn.org
10. SANE-SART (Sexual Assault Nurse Examiner-Sexual Assault Response Team). sane-sart.com
11. Stop It Now!®. stopitnow.org
Exhibit A
Definitions Related to Sexual Abuse

Arousal symptoms – symptoms of traumatic stress that include difficulty falling or staying asleep, emotional outbursts, difficulty concentrating, hypervigilance and exaggerated startle response.

Avoidance symptoms – symptoms of traumatic stress that include efforts to avoid thoughts or stimuli that are reminiscent of the event, avoiding people and places that cause distress, inability to recall important aspects of the event, restricted affect and feelings of detachment.

Boundaries – rules or limits that define each person’s personal privacy.

Child pornography – the obscene photographing, filming or depicting of children for commercial purposes or for arousal of self, subject child or viewing audience. To be legally classified as child pornography, the image must be a visual depiction of a minor that is sexually explicit. It is a form of sexual abuse.

Competency – refers to the ability to comprehend and appropriately respond to questions and issues at hand.

Cunnilingus – oral stimulation of the vulva or clitoris.

Disclosure – the victim telling about the abuse.

Encopresis – incontinence of feces not due to organic defect or illness.

Exhibitionism – indecent exposure.

Fellatio – oral stimulation of the penis.

Grooming – the process of manipulation often used by child molesters, intended to reduce a victim or potential victim’s resistance to sexual abuse. Typical grooming activities include gaining the child victim’s trust or gradually escalating boundary violations of the child's body in order to desensitize the victim to further abuse.

Incest – sexual intercourse with a descendent by blood or adoption. Some add to this definition a religious or significant person in the victim's life.

Infantilism – baby role-playing.

Necrophilia – sexual attraction to or sexual contact with dead bodies.
Paraphilia – a psychosexual disorder characterized by recurrent intense sexual urges and sexually arousing fantasies involving use of an object, the suffering or humiliation of oneself, one's partner, children or other nonconsenting partners.

Pedophile – sexual molester who prefers children, usually between the ages of five and twelve.

Rape – unlawful sexual activity, usually sexual intercourse carried out forcibly or under threat of injury against the will usually of a female or with a person who is beneath a certain age or incapable of valid consent. Some terms associated with rape:

Social acquaintance rape – rape committed by someone known to the victim; usually a form of confidence rape.

Anger retaliatory rape – rapist displaces anger, rage or hatred onto a victim.

Blitz rape – rapist commits a sudden, unexpected physical assault.

Confidence rape – rapist verbally "cons" the victim whom he knows from some time or place (e.g. school, work, social activity, community).

Date rape – a form of social acquaintance rape.

Gang rape – rape committed by three or more males acting with a pack mentality.

Opportunistic rape – unplanned rape which takes place as an afterthought in the context of another planned crime.

Power assertive rape – rapist uses rape to assert his virility and dominance over women.

Power reassurance rape – rapist uses rape to reassure his doubts about masculinity and sexual adequacy.

Sadistic rape (or anger excitation rape) – rapist finds pleasure and excitement in victim's suffering.

Rape trauma syndrome – a clustering of signs and symptoms experienced by adult victims of attempted forcible rape or forcible rape occurring in two phases: an acute, disruptive phase and a long-term reorganization phase. It is a recognized nursing diagnosis and is a “sub-group” of post-traumatic stress disorder. This syndrome is compounded when the patient has an additional factor such as dementia or developmental delay. Recognizing this syndrome assists in designing and implementing appropriate treatment for rape victims.

Sadism – sexual gratification is obtained through infliction of pain either by humiliating or hurting another.

SANE – sexual assault nurse examiner; a program whereby specially trained forensic nurses provide 24-hour coverage as first response caregivers to sexual assault victims, generally in a hospital ED.
**SART** – sexual assault response team which includes law enforcement, detectives, victim advocates and healthcare providers. Purpose is to assist sexual assault victims through the criminal justice process, increase odds of successful prosecution of perpetrator and help victims cope with and recover from the assault.

**Sexual abuse (child)** – the involvement of a child in sexual activity, including fondling, intercourse and other penetration, oral sex, making sexual comments, and any involvement with pornography of any kind, that the child doesn't comprehend, to which the child can't consent, or for which the child isn't developmentally prepared, where the child is being used for sexual stimulation of the adult or the subject child.

**Sexual abuse (elderly)** – touching, fondling, intercourse or any other activity with an older adult when the older adult is unable to understand, unwilling to consent, threatened or physically forced.

**Sexual assault** – illegal sexual contact that usually involves force upon a person without consent or is inflicted upon a person who is incapable of giving consent (because of age or physical or mental incapacity) or who places the assailant (as a family friend) in a position of trust or authority. The term "sexual assault" is used to describe sexual abuse that is immediate, short term or infrequent.

**Sexual violence** – "the use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed; an attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act; and abusive sexual contact." (CDC 2004.)

**Sodomy** – anal copulation with a member of the same or opposite sex.

**Statutory rape** – sexual intercourse with a person who is below the age of consent as defined by law.

**Trichotillomania** – compulsive pulling or twisting of the hair until it breaks off causing hair loss.

**Victimology** – the study of the victim from a social-structural way of viewing crime and the law and the criminal and the victim.
Exhibit B
Components of a Sexual Assault Examination

Initial Evaluation: The ED physician sees the patient and takes vital signs but does not treat injuries until the sexual assault nurse examiner (SANE) completes the examination. However, before the sexual assault examination takes place, the entire procedure is explained to the victim and a signed consent form is obtained from the victim. Note that procedures for prepubertal girls may differ from those for an adult.

Examination to Obtain Evidence: This exam is conducted by the SANE who protects the victim’s dignity and does nothing to cause further trauma. She ensures that the victim remains part of the decision process throughout the step-by-step procedure of collecting evidence. Some research suggests that evidence may be available beyond the time period of 96 hours post-assault. Individual states and institutions have developed their own forms on which the following is recorded or documented.
- Document assault history – information pertaining to the assault (from victim, from whoever has accompanied patient, and from written documents which victim or others have brought to the exam).
- Document the forms of violence used and where.
- Document if victim has bathed, showered or changed clothes following assault.
- Obtain victim's medical information including pregnancy status.
- Conduct physical examination for trauma beginning with nongenital areas and concluding with genital area. Record findings, including injuries on appropriate form (abrasions, areas of swelling, bites, bruises, burns, contusions, erythema, fractures, indications of tenderness, induration, lacerations, stains or foreign materials).
- Take photographs.
- Collect victim's clothing and package it according to state’s policy. If clothing has been changed following assault, then obtain clothing worn at the time of the assault.
- Collect specimens from body surfaces including skin, hair and nails (and more recently, from areas of body piercings).
- Collect body fluids and orifice specimens.
- Draw blood and obtain urine specimen for drug analysis, DNA screen and other appropriate lab tests.
- Obtain cultures as necessary and provide prophylactic treatment of STDs.

Maintaining Chain of Evidence and Integrity of Evidence: The SANE is responsible for collecting and identifying the evidence, for preserving and storing it in a designated secure area free from contaminants and for ensuring that documentation is complete.

Crisis Intervention: After conducting a mental health assessment, the SANE will refer the victim for follow-up counseling, generally provided by the rape crisis center advocate. If indicated the SANE will also provide crisis intervention and work with the victim to obtain follow-up services.
Exhibit C
Child Abuses Child

Background: Adam was a ten-and-a-half-year-old boy in the fifth grade born to a single teenage mother. Intervention services began at age two and continued through childhood for numerous psychiatric diagnoses as well as an auditory processing disorder, cognitive impairment in memory, visual, spatial and information processing speed, and impairment in executive function, attention and motor skills.

Sexual assault: In the fifth grade Adam attended a Midwest Christian school with a classroom for fourth through eighth grade children. Adam received supplemental instruction and had a teacher's assistant. Shortly after beginning school, Adam told his mother that two days previously during recess, a twelve-year-old classmate grabbed Adam's right forearm and forced him to pull his pants down, inserted his penis into Adam "half way" (showing his mother about two inches) and that it hurt. Roger threatened him not to tell anyone. Adam had been scared and felt bad inside but didn’t call for help fearing Roger would beat him. He then told her he had been successful at escaping Roger other times.

During the assault, the teacher had been leaning against the school building observing children inside as well as outside. Adam did not tell her because he felt he would not be believed. Some classmates witnessed the behavior and told their teacher the following morning. One child thought that Roger had raped Adam. In the past, Roger had touched other children inappropriately. They had informed the teacher as had a parent but apparently had received no response.

Post-sexual assault: While the teacher had notified the perpetrator's parents when the children informed her of the incident, no one had notified Adam’s mother. She took Adam to the hospital; his physical exam was normal and Adam reported no pain or discomfort. A flat affect was noted. Because of the time delay, no rape kit was initiated. Division of Youth and Family Services and police were notified.

For six months following the assault, Adam presented with increased depressed affect and dysthymic mood, increased aggression and agitation, defiance at home and school, trichotillomania and poor relationships with peers. He was discharged from outpatient therapy and admitted to a partial hospitalization program for observation, evaluation and medication adjustment. After this evaluation, Adam was placed in an out-of-district school setting that would provide him with the emotional, social and academic support he needed as well as continue psychological evaluation and treatment.

Report of criminal investigation: The following complaints were issued against Roger: aggravated sexual assault, sexual assault and endangering the welfare of a child.
Exhibit D
Blitz Rape

**Background:** Andrea is a 29-year-old college graduate and the youngest of four siblings living in a large Northeastern city. After her roommates moved away, Andrea carefully researched apartments where she could safely live alone and found what appeared to be ideal – an apartment building in a culturally diverse university and family neighborhood two blocks from public transportation and advertised to have 24/7 security coverage, security cameras in all the hallways, a well-lit lobby with controlled access and a requirement that all guests sign in, regardless of how many visits they had previously made. Her parents and fiancé agreed that it appeared safe and appropriate.

**Sexual assault:** Less than a week after moving into her apartment, Andrea walked into her apartment building while talking to her fiancé on her cell phone. She was followed into the building and grabbed as she opened the inner lobby door. Her unknown assailant wrapped his right arm around her body, placed his left hand over her mouth (and over the cell phone still at her mouth) and proceeded to drag her through the lobby, past the security desk where someone was on duty, past three apartments, and into a utility room where he orally and vaginally assaulted her repeatedly over a period of about 20 minutes. Andrea had screamed as she was dragged by the desk and by the apartments, though her assailant tried to keep her mouth fully covered; her fiancé heard the first scream and residents in the apartments reported hearing her scream as she was pulled by their doors. She escaped and ran to the security desk screaming. When the security guard did nothing, Andrea grabbed the telephone and called the police.

**Post-sexual assault:** All appropriate procedures were followed; Andrea was taken to the hospital where evidence was gathered and she was evaluated and treated by a SANE. She was interviewed by the police and was well supported by her fiancé and family. She immediately moved in with her parents and was unable to return to work or leave their home for several months. While Andrea is now living in an apartment alone, she is escorted to and from work and is not comfortable going outside alone. Her relationship with her fiancé has markedly suffered over these past four years and she remains emotionally devastated by the assault. Even the knowledge that the perpetrator was found and had been incarcerated has not provided much solace. She has intermittently been involved in therapy but has not found a therapist with whom she is comfortable or therapy that she has found beneficial.
Exhibit E
Elder Abuse by a Resident

**Background:** Margaret, an 86-year-old woman with moderate dementia, was admitted to a highly advertised facility providing specialized care for people with Alzheimer’s and other memory disorders. The facility promised excellent nursing and state-of-the-art supportive care enabling the patient to live in a safe, secure place while being treated with dignity, compassion and personalized attention.

Five days later, after becoming increasingly combative, Margaret was taken to the ED of a large university hospital where she was admitted with acute renal failure and dehydration. After a week of treatment including discontinuing two medications she was taking – one known to cause renal failure in the elderly and another which contributed to agitation in the elderly, Margaret markedly improved. She was evaluated for and accepted into hospice care and discharged back to the facility.

In the following five weeks, Margaret continued her improvement. She read, watched television, got out of bed alone, was continent and slept and ate well. Two days before she was sexually assaulted, Margaret went out shopping with her daughter-in-law who reported that her mother-in-law interacted, communicated, had fun and enjoyed her company. Plans were in place to discontinue hospice care.

**Sexual assault:** Two days later, Margaret was seen by two attendants in another resident’s room with a male resident who had pulled down her undergarment and was touching her buttocks and vagina. They did not intervene until they saw Margaret shaking and heard her crying and saying no to the male resident’s statement that he wanted her to have an orgasm. They escorted Margaret to her room and put her to bed; she refused to be checked and one attendant stayed with her until she fell asleep.

The attendant in charge notified the LPN on call who notified the manager. No calls were made to family, physician or police. No medical personnel evaluated Margaret nor was she taken to an ED. The following morning Margaret was found on the floor of her bathroom covered with feces, having fallen sometime during the night. She was taken by ambulance to the hospital for evaluation of any possible injuries but no information about the assault or any other information about the patient was sent with the EMT’s to the hospital. Consequently, no exam for sexual assault was done. Margaret had bruises, abrasions and contusions but no broken bones. She was also in acute renal failure precipitated by dehydration.

Margaret’s son was notified that she had fallen but not that she had been sexually assaulted. Her daughter-in-law stayed with Margaret in the ED and wondered why she had fallen, why she was so shaken and traumatized and why she was unable to talk. Margaret returned to the residence the same day. She responded to her name but spoke incomprehensibly and moaned with pain. Over the next fifteen days, Margaret's physical and emotional state spiraled downward until she quietly died.
Exhibit F
Prison Assault

**Background:** Nan is a 32-year-old only child of a depressed single mother who abused drugs and alcohol and put drugs into Nan's milk so that she would sleep longer. There is an extensive history of substance abuse as well as learning disabilities and depression. When Nan was six, her mother married. For the next six years Nan was sexually abused by her stepfather. She began substance use at age fifteen and attempted suicide twice as a teenager. Nan received special education services for learning disabilities until she left school in her junior year because she was pregnant.

**Adulthood:** Nan married the father of her daughter and had two additional daughters during the few years they were married. Nan and her husband were involved with substance abuse. He abused Nan physically and emotionally and sexually abused their oldest daughter. Before he faced charges for that abuse he was incarcerated for the murder of a twelve-year-old girl. Nan then married Robert with whom she had a son who died of SIDS at five weeks. After separating from Robert, she became involved with Elson, a registered violent offender on probation, began using methamphetamines and ignored her girls.

**Psychiatric and medical history:** Over the years Nan has been treated with numerous medications including antipsychotics, antidepressants, anxiolytics, sedatives and narcotics for pain for a long list of psychiatric and medical diagnoses. Nan used medical and psychiatric/mental services extensively.

**History of incarceration/sexual abuse:** Shortly after having become involved with Elson, both she and he were arrested for possession and distribution of methamphetamine. During the few weeks Nan was in jail (until the charges were dropped because of an illegal search), she met the prison guard, Dave. After her release, Nan returned to the jail to pick up her asthma inhalers. Dave told her he had them at home and instructed her to come to his home to retrieve the inhalers. She did and she said that Dave forced her to have sexual intercourse in exchange for her inhalers. She did not report the assault.

Approximately one month later Nan was incarcerated for three months for forgery and attempted forgery. During this period she was sexually abused by Dave including forced vaginal intercourse and forced attempted intercourse. After her release Nan reported to her lawyer that she had been raped and sexually assaulted.

Nan began a relationship with Don, became pregnant and delivered a boy ten months after leaving prison. During this time she was briefly incarcerated, had a few suicide attempts, used mental health services extensively and violated the terms of her probation by using methadone. After the birth of her son, Nan was sent to prison for three years. Dave received 18 months’ probation.
**Exhibit G**  
**Sexual Assault of a Developmentally Disabled Young Man**

**Background:** Jack, an African-American male, was diagnosed at age three with moderate mental retardation and pervasive developmental delay. At age 11, Jack was admitted to a residential treatment facility with disruptive behaviors (aggressive, self-injurious, noncompliant, impulsive), poor communication skills, lack of safety awareness, poor functional abilities, poor academic progress, low frustration tolerance and mood swings. Supervision included being in visual sight within five feet in the group apartment and within arm's length in the community. Bedroom checks were made every two minutes, 15-minute checks while asleep and one-to-one supervision while in school. Jack utters a few understandable syllables and communicates primarily with sounds and grunts.

**Pre-assault:** Six months prior to the sexual assault when Jack was 17, Billy, a Caucasian, was admitted to the room next to Jack. They shared a common internal hallway between the two rooms not visible from the public room. While a few months younger than Jack, Billy was street smart having been a gang participant. He had a long institutional history with multiple psychiatric diagnoses and a history of combativeness, suspicion of being sexually active with male peers, aggressiveness including attempting to bite and hit staff and peers. Bill's IQ of 43 and his functioning were higher than Jack's.

During the period between Billy's admission and his sexual assault of Jack, there were numerous physical incidents between the two. Jack's behavior deteriorated with crying and clinging at home and wanting to sleep with parents, resistance to returning to the facility, and increased head banging, self-mutilation and aggressiveness. His functioning in school and other activities was erratic and his medications were increased.

His parents noticed bruising between his thighs and requested that a video camera be installed by his door to observe those entering the room at night. This request was not granted. Administration did agree to install door chimes which ring if someone enters Jack's room.

**Sexual assault:** Jack came into the living room from his bedroom bleeding from his mouth. Staff called the nurse to come and examine Jack; while waiting they noticed a long scratch on his back and other small scratches. They found a used condom and a condom wrapper on Jack's floor. No one heard the door chimes on the door. The chimes had been disconnected and the receiver was under Jack's mattress.

Jack was taken to the hospital and seen by a SANE. Evidence revealed that he had been sexually assaulted by Billy who was imprisoned two months later for aggravated sexual assault. Following the sexual assault, Jack's head banging and self-mutilation increased. He fractured his nose which cannot be treated because of persistent trauma, had a skull fracture with subdural hematoma requiring a craniotomy, hematomas on his
ear from banging requiring surgery, and numerous bites, scratches and lacerations. He is required to wear a helmet when awake. Medications to attempt to modify Jack’s behavior and the diagnosis of post-traumatic stress disorder have been added.