

A PROSECUTOR'S REFERENCE:

**Medical Evidence and the Role of Sexual Assault
Nurse Examiners in Cases Involving Adult Victims**



ÆQUITAS

THE PROSECUTORS' RESOURCE
ON VIOLENCE AGAINST WOMEN



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Medical Evidence and the Role of Sexual Assault Nurse Examiners in Cases Involving Adult Victims

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INTRODUCTION

Sexual Assault Nurse Examiner/Sexual Assault Forensic Examiner (SANE/SAFE) Programs emerged in the 1970s and now number more than 500 programs throughout the United States. Examiners in these programs provide extensive psychological, medical, and forensic services for patients who present following sexual assault. Although SANEs strive to effectively collaborate with law enforcement, prosecution, and advocacy partners, the role of the SANE is by definition an independent and objective one, with priorities defined by the needs of the individual patient, rather than the investigation of the reported sexual assault. According to the *Forensic Nursing Scope and Standards of Practice*, the SANE is neither an arm of law enforcement, nor a victim advocate, but a healthcare specialist with distinct knowledge and training to respond to a very specific healthcare issue:

[T]he SANE will have education and certification that reflects specialized knowledge about legal systems, evidence and ethical parameters, pathophysiology and injury and potential for injury, reproductive health, epidemiology, and technology and psychology associated with sexual assault, along with specialized training about the unique victim or offender population served.

The SANE role comes together most clearly in the medical assessment and treatment of the patient. While this is identical in terms of general nursing care (e.g. assessment, planning, intervention and evaluation), the SANE will also be responsible for representing the forensic nurse's encounter to the courts and society. This may include not only the evaluation and treatment of the patient's health status and bio-psycho-social-spiritual responses, but the health and forensic assessment, including history taking, evidence collection, and evidentiary outcomes. It will also include the systems response to the sexual assault in the courts and the community at large.

This concept of the SANE as healthcare provider is a critical one. Only a small percentage of sexual assault patients will ever see their cases move forward through the criminal justice system; however, every patient will have the potential to develop healthcare sequelae from the sexual violence she or he has experienced. To focus less on the health and well-being of the patient and more (or in some cases, solely) on the evidence collection, ultimately defines the SANE encounter as investigation-centered, rather than patient-centered. The patient-centered approach is outlined and emphasized in the *National Protocol for Sexual Assault Medical Forensic Examinations* and supported by the *Forensic Nursing: Scope and Standards of Practice*.

When the SANE exam takes on a more investigation-centered approach, it is often because of the belief that such a practice philosophy will result in more effective investigation and prosecution of sexual assault cases. This is not a finding supported by recent research. Dr. Rebecca Campbell and colleagues found that SANE practice can positively impact criminal justice outcomes through increased engagement of sexual assault patients in the investigative and prosecution process. In their study, patients who had SANE exams were more likely to understand and have confidence in the criminal justice system, and therefore, more likely to participate in the process. By focusing on patient care and appropriate support services and referrals, rather than a specific investigative agenda SANEs indirectly impacted victim engagement. While this study also found that SANEs provided higher quality medical-forensic examination documentation and evidence collection, leading to more positive criminal justice outcomes, these findings were identified in SANE programs firmly rooted in a nursing-focused philosophy. As these findings demonstrate, a strong emphasis on nursing care actually improves criminal justice outcomes.

Prosecutors must also consider the potential testimony that can be provided by SANEs and other medical experts. SANEs who adhere to a healthcare-guided approach increase the likelihood that a patient's statements will be admissible into evidence under the Federal Rule of Evidence 803(4), commonly referred to as the medical hearsay exception. This evidentiary rule allows for a patient's statements, which would otherwise be considered hearsay, to be admissible evidence only if the statements were made for the purposes of medical diagnosis and treatment. SANEs and medical experts who are unable to define their approach and their priorities in healthcare terms will have difficulty making the argument that information was gathered for medical diagnosis and treatment. Effectively testifying to a patient encounter and the findings therein without the ability to also testify to patient statements can significantly limit the quality of testimony.

UNDERSTANDING THE MEDICAL EVIDENCE

In order to effectively use SANEs as experts in sexual assault prosecutions, it is important to understand the medical-forensic examination and the information contained therein. To start, consider what one can learn from the medical-forensic examination:

SOMETIMES NO INJURY IS NOTED

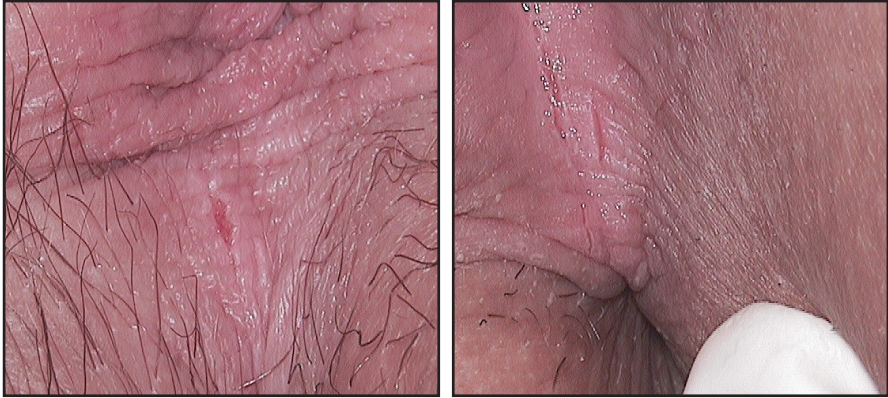
A lack of identified injury does not disprove sexual assault. Its absence following sexual assault is a common finding. It may also need to be qualified, since it is also possible that a lack of injury simply means that specialty tools and techniques, such as magnification with a colposcope or digital camera, toluidine blue dye, and foley catheters were not used, and that the assessment is limited by what could be assessed with the naked eye. Although prosecutors may be inclined to not call SANEs as witnesses in these circumstances, SANEs should be used to help judges and juries understand an exam without injury findings. Without an expert medical explanation, judges and juries are likely to assume that the lack of injury means that the patient was not sexually assaulted.

LIMITATIONS TO THE SIGNIFICANCE OF GENITAL INJURY

Many sexual assault medical-forensic examinations will have genital injury findings, but injuries alone do not prove force. The vast majority of injuries assessed during a medical-forensic examination are non-specific, meaning that they could be from non-consensual sexual contact, either with or without force, as well as consensual sexual contact. For prosecutors, this means painting a more expansive clinical picture in trial than just the genital findings, including evidence such as: external body injury, patient statements, and patient appearance and demeanor, as appropriate. It also means moving away from using outmoded explanations, such as Human

Sexual Response, as an explanation for the presence of genital injury following sexual assault, since it is clear that even consensual sexual contact can result in injury. For an example, see Figure 1.

Figure 1



The above photos show lacerations to the perineum of two separate patients. The one on the left presented to the clinic following a sexual assault 24 hours prior; the one on the right presented for her follow-up examination four weeks after her sexual assault medical-forensic examination. Upon examination, she reported that she had had consensual sex with her partner 11 hours earlier. Both patients reported only vaginal penetration with a penis. (Photos courtesy of the DOVE Program, Summa Health System)

MOST (BUT NOT ALL) GENITAL INJURY IS EXTERNAL

The vast majority of genital injury noted following sexual assault is external. In cases with digital or foreign object penetration, however, internal injury may be more likely. Therefore, patients should be offered speculum examinations as a routine part of any sexual assault medical-forensic examination in order to fully visualize the vaginal vault and cervix. Patients may also delay reporting, in which case evidence collected from

the cervix may yield the best DNA evidence. Furthermore, visualizing the cervix can be useful in identifying pathology, as well as trauma. Frequency of external versus internal genital injury, and the importance of a thorough medical assessment are other areas where SANEs can help judges and juries understand the trends in sexual assault findings, as well as the benefits of conducting a comprehensive, healthcare-focused examination. Research notwithstanding, most experienced SANEs should be able to articulate the relative frequency of external versus internal genital injury based on their clinical experience. Prosecutors can also point to the internal genital examination as one example of why SANEs are healthcare providers and not simply evidence technicians, since vaginal swabs can easily be obtained without visualizing the vaginal vault.

Although the medical-forensic examination can be revealing, there are limitations. The exam cannot “prove” a sexual assault occurred, nor can the SANE testify to the veracity of the patient’s sexual assault report (only to the consistency of findings with the history provided). In patients who have limited or no memory of events due to drugs or alcohol (voluntarily or involuntarily ingested), the exam cannot provide a road map of assault events. Furthermore, in instances where the defense is “rough sex”, more often than not the SANE’s testimony will not be able to refute this claim in its entirety, since much of the injury noted in the medical-forensic examination is non-specific, as noted previously.

WORKING WITH THE SANE BEFORE TRIAL

Prior to trial, prosecutors should consult with SANEs to understand the specifics of the medical-forensic record and the context of the findings (see Appendix A for a review of common terms found in the medical forensic record). It is also helpful to meet with the SANE for trial preparation. This will serve several purposes: (1) it will allow the SANE to understand the prosecutor's case and the specific points he or she hopes to make by calling the SANE; (2) it will provide the prosecutor with a better understanding of the SANE's clinical background, allowing for more effective use of the SANE's expertise; and (3) it will allow both the prosecutor and the SANE the opportunity to discuss the examination findings and ensure that there are no areas of disagreement or misunderstanding. Good trial preparation will also make the SANE a more confident witness. Significantly, many SANEs have limited or no experience providing testimony. Because of this, it's critical that prosecutors work with SANEs to explore the SANE's comfort level with providing expert opinions in the case at hand and, where appropriate, limiting less experienced SANEs to fact testimony.

WORKING WITH THE SANE IN TRIAL

Although there are many questions asked during the direct examination of a SANE that are fairly standardized, it's important for prosecutors to consider what specific points they hope to make when calling SANEs as witnesses. For instance, is the SANE being called as a fact witness, a teaching witness, to offer an opinion, or some combination? It's also important to consider that currently, there is no standardization of SANE curricula around the country. What is taught in one educational program may be unrelated, or worse, antithetical to what is taught in another. Therefore, prosecutors should not have the expectation that all SANEs have had the same educational background or that each SANE practices in a fashion identical to others. As with education, there may be a divergence in practice philosophies and patient care approaches. Ideally, prosecutors should explore this during trial preparation, but it is also useful to craft direct questions in light of the potential variation. See Appendix B for examples of basic direct questions.

Depending on their expertise, SANEs may also be helpful in educating judges and juries about issues beyond the medical-forensic examination findings. Consider using SANEs to explain:

- Common patient behaviors deemed “counterintuitive” by some, such as delaying presentation/reporting, reluctance or refusal to talk with law enforcement
- Issues related to alcohol and drugs: effects of alcohol on memory; medication side effects; alcohol and drug interactions
- In intimate partner sexual assault cases, victim behavior related to battering or abuse; assessing dangerousness
- Existing physical and mental health issues in individual patients and their impact on the examination process, findings, and discharge planning

Understanding the language of the medical-forensic record is essential in preparing to present medical evidence at trial. What follows are two resources to better assist prosecutors with this task. Appendix A sets forth definitions of terms commonly found in medical-forensic documentation. This includes common anatomy terms and diagnoses. Appendix B contains a sample direct examination of a SANE that can be adapted or simply used as a template for crafting a general approach to other types of medical experts, such as emergency physicians and medical residents.

APPENDIX A: TERMS FOUND IN THE MEDICAL FORENSIC EXAMINATION RECORD

GENERAL TERMS:

Abrasion: superficial damage or “scraping” of the surface of the skin or mucous membrane.

Abuse Assessment: (also: dangerousness assessment; lethality assessment) a screening tool specifically aimed at detecting domestic and/or sexual abuse.

Acid Phosphatase: an acid found in bodily fluids and particularly active in semen that can be used forensically to show evidence of semen.

Acquired Immune Deficiency Syndrome (AIDS): the final stage of HIV, a disease which causes severe damage to the immune system, which is transmitted through bodily fluids.

Acroposthitis: inflammation of the prepuce.

Adnexa: the fallopian tubes, ligaments, and ovaries in the female reproductive system.

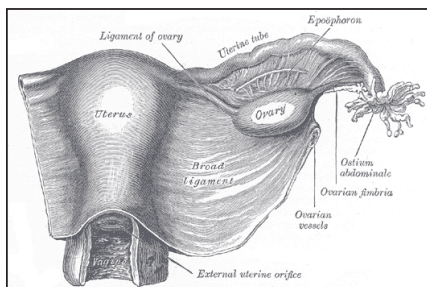


Image: Gray's Anatomy

Adolescence: period of life from the beginning of puberty until sexual maturity.

Adult: a sexually mature individual and/or someone over 18 years of age.

Affect: the mood, outward appearance, or emotional state displayed by a person.

Amenorrhea: absence of menstruation, may be due to pregnancy or other causes.

Anal Canal: last part of the large intestine from the rectum to the anus.

Anal Dilatation: opening of the external and internal anal sphincters with traction on the buttocks.

Anal Fissure: a break or split in the skin around the anus.

Anal Fold Flattening: absence of the anal folds which occurs when the internal and external sphincters are relaxed.

Anal Laxity: dilation of the anus resulting from a decrease in the muscle tone of the anal sphincter.

Anal Skin Tag: protrusion of tissue into the perianal skin folds.

Anal Venous Congestion: purple discoloration in the perianal tissues that results from pooling of blood.

Anus: opening of the rectum.

Areola: dark, raised area surrounding the nipple.

Asphyxia: a condition of deficient oxygen supply to the body.

Atraumatic: not causing an injury.

Autonomy: capacity of an individual to make an uncoerced and voluntary decision.

Avulsion: removal of layers of skin from abrasion, tearing away of skin or limbs.

Bacterial Vaginosis: infection of the vagina resulting from an imbalance of the normal bacteria of the vagina.

Balanitis: inflammation of the glans penis.

Balloon Technique: use of a Foley (balloon) catheter during a sexual assault medical-forensic exam. The balloon is placed in the vagina and inflated, causing the expansion of the hymen. This allows for better visualization of potential injury.

Battles Sign: bruising just below the ear that may indicate skull fracture or brain injury.

Bindle: sheet of paper folded to contain evidence in a secure manner.

Biological Evidence: blood, urine, semen skin cells, saliva, tears, mucous other types of biological evidence.

Blunt trauma: type of non-penetrating physical injury sustained from blunt force from an object.

Bruise (contusion): discoloration of the surface of the skin due to hemorrhage of the tissues **caused by force** without breaking the skin itself; not to be confused with *ecchymosis*.

Buccal: referring to the inner aspect of the cheek, often used as a swab site for DNA.

Buttock: fleshy areas formed by the gluteal muscles on the posterior of the body.

Candidiasis: fungal (yeast) infection of an area of the body. Common vaginal infection.

Cervical os: the opening of the uterus inside the vagina. This os is particularly gaping; most will be more closed, and if the woman has had a vaginal delivery, slit-like in appearance.

Cervicitis: inflammation of the cervix, often from a sexually transmitted infection (STI).

Cervix: neck of the uterus that extends into the vagina and provides an entryway to the uterus.

Chancre: painless lesion that is the primary lesion of syphilis.

Chlamydia: very common sexually transmitted infection, often does not cause any symptoms in men or women.

Chromosome: biological information found in each cell, “DNA.”

Clitoris: erectile tissue of the female reproductive system.

Coitus: sexual intercourse involving insertion of the penis into the vagina.

Colposcope: magnifying instrument used to detect and photograph injuries in the genital area.



Photo: Cooper Surgical

Condylomata Acuminate: genital warts caused by Human Papilloma Virus (HPV).

Condylomata Lata: papules (small, solid, round bumps) characteristic of secondary syphilis.

Conjunctiva: membrane that lines the eyelid and covers the eyeball.

Contusion: a bruise.

Copulation: sexual intercourse.

Cunnilingus: sexual activity in which the mouth and tongue are used to stimulate the female genitalia.

Cut (incision): sharp object dividing the skin; not to be confused with *laceration*.

Cyst: fluid filled sac or area of the body.

Disinhibition: a loss of inhibition due to brain injury, drugs, or other factors.

Dyspareunia: painful coitus.

Dyspermia: emission of the sperm that is painful or difficult.

Echymosis: hemorrhagic area of the skin ranging from blue-black to brown or yellow; not to be confused with *contusion* or *bruise*.

Ectropian: exposed cells of the cervical canal, a reddened area around the cervical os.

Emergency Contraception: contraceptive used following unprotected intercourse to prevent pregnancy. May be given following sexual assault to prevent unwanted pregnancy. Visit <http://www.planbonestep.com/> for manufacturer's information and other resources.

Epidemiology: study of the factors affecting health and illness of a population.

Epididymis: tube that carries sperm from the testes to the vas deferens.

Epididymitis: inflammation of the epididymis, and a frequent symptom of sexually transmitted infections in men.

Erosion (cervical): change in a portion of the cervix as a result of irritation.

Erythema: redness of the skin caused by injury, illness, infection, or inflammation.

Fellatio: oral stimulation of the penis.

Forensic Nursing: the practice of nursing globally when health and legal systems intersect.

Fornix: space in the upper vagina divided by the cervix, referred to as anterior or posterior.

Fossa Navicularis: a depression between the posterior margin of the vaginal opening and the fourchette. May not be noted separately in post-menarchal patients and instead combined under the label posterior fourchette, as it becomes more difficult to distinguish between the two after estrogen is present.

Fracture: condition in which there is a break in continuity of the bone.

Friction: rubbing.

Frottage: sexual activity without penetration, various forms of rubbing, clothed or unclothed, for sexual arousal or orgasm.

Gardnerella Vaginalis: infection of the vagina, sexually transmitted. Also known as *Bacterial Vaginosis*.

Gene: section of the DNA that contains the genetic information.

Genital warts: growths on the genitals cause by the Human Papiloma Virus (HPV).

Genitalia: external sexual body parts.

Gluteal: relating to the buttocks.

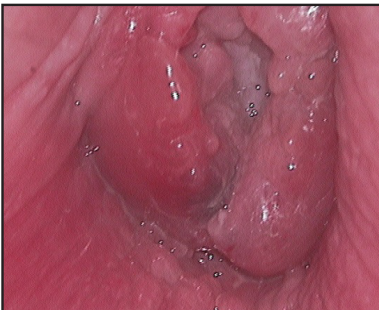
Gonorrhea: common sexually transmitted infection, often without symptoms. When symptoms are present, it's often in the male, and is characterized by a penile discharge or “drip”

Hemorrhoid: swelling of the vessels of the rectal or anal areas.

Hepatitis B: chronic liver disease transmitted through bodily fluids.

Herpes Simplex Virus (HSV): infections of the genital, oral, and anal areas, most commonly by the Herpes Type II virus.

Hymen: membranous tissue that surrounds the vaginal introitus. May be described as *annular* (forming a collar around the vaginal opening), *crescentic* (a crescent shaped hymen), *cribiform* (stretching across the vaginal opening but with several holes), *imperforate* (completely occluding the vaginal opening), *microperforate* (very small hymenal opening), *septate* (two openings separated by a narrow band of tissue), *estrogenized* (affected by female sex hormone estrogen (after puberty), *redundant* (folding back on itself or protruding), or *fimbriated* (multiple projections on the outer edge creating a ruffled appearance).



*Photo: Courtesy of
the DOVE Program,
Summa Health System*

Hyperarousal Symptoms: symptoms associated with Post Traumatic Stress Disorder, often feeling ‘jumpy’, difficulty sleeping, constantly feeling on guard, having difficulty concentrating, and experiencing sudden bursts of anger among others.

Hypervascular: having a large number of blood vessels, as seen on the face of this cervix.

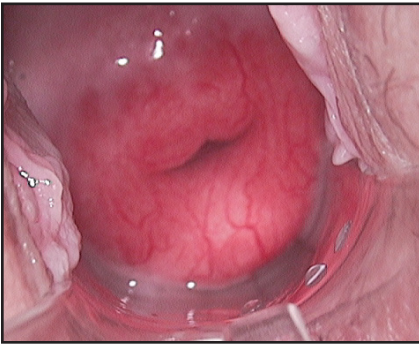


Photo: Courtesy of the DOVE Program, Summa Health System

Hanging Strangulation: strangulation that involves suspension of the weight of the body by the neck. May involve spinal injury, venous obstruction, or asphyxia method of injury depending on the type of hanging.

Hematuria: blood in the urine.

Human Immunodeficiency Virus (HIV): disease transmitted through bodily fluids that results in damage to the immune system and evolves into AIDS.

Human Sexual Response: the Masters and Johnson research that describes, in part, the process of female arousal. The absence of human sexual response is often used (erroneously) as an explanation for why genital injury is present in sexual assault.

Hymenal Bump: elevation of hymenal tissue.

Hymenal Cleft: transection of the hymen.

Hymenal Notch: indentation or depression at the edge of the hymen.

Hymenal Transection: complete or partial tear through the width of the hymenal membrane. May be associated with acute (as seen in this photo) or nonacute injury.

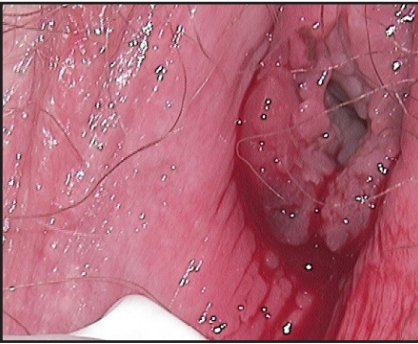


Photo: Courtesy of the DOVE Program, Summa Health System

Introitus: opening of a canal or cavity, as in vaginal introitus.

Impotence: inability of the male to get or maintain an erection, or achieve orgasm.

Inflammation: redness, swelling, heat, or pain resulting from injury to tissues.

Labia Majora: outer lips of the (female) external genitalia.

Labia Minora: inner lips of the (female) external genitalia.

Labial Adhesion: fusion of the tissues of the labia minora. Also called labial fusion/labial agglutination.

Laceration: soft tissue injuring from ripping, crushing, stretching, pulling apart, bending or shearing; not to be confused with *cut*.

Ligature Strangulation: strangulation without suspension by use of some form of cord-like object around the neck.

Manual Strangulation: strangulation using the fingers or other extremity.

Median Raphae: midline external fusion of skin from the posterior fourchette to the anus.

Mons Pubis: rounded prominent area created by the fat pad that lies over the pubis symphysis in the female.

Mounting Injury: a controversial term referring to injury to the posterior fourchette, the first area of external genitalia impacted by the penis with greatest force.

Nabothian Cysts: benign cysts on the face of the cervix, usually non-painful and often found in multiples.

Neovascularization: blood vessel formation in abnormal tissues or locations.

O'clock Designation: method used to identify structures or findings using the numbers of the clock. Twelve o'clock is always superior (top) and six o'clock is always inferior (bottom).

Partner Violence Screen: an instrument used to screen for intimate partner violence. See also *Abuse Assessment Screen*.



Patterned Injuries: an injury that possesses the qualities, such as an imprint, of the object that caused the injury, such as this shoe print-patterned contusion on the patient's neck.

*Photo: Courtesy of
the DOVE Program,
Summa Health System*

Penetration: process of entering within a body part. Legal definition varies by jurisdiction.

Penis: male sex organ, comprised of erectile tissue through which the urethra passes.

Perianal folds: wrinkles or folds protruding from the anus, created by the contraction of the external anal sphincters. Injury is often hidden within the folds, such as these abrasions seen from six to eight o'clock.



Photo: Courtesy of the DOVE Program, Summa Health System

Perineum: external surface of the perineal body, lies between the posterior fourchette and anus in females and scrotum and anus in males.

PERK: an acronym used in some places to refer to the sexual assault evidence collection kit (**Physical Evidence Recovery Kit**).

Petechiae: pinpoint flat round red spots under the skin surface caused by bleeding into the skin. Petechiae are red because they contain red blood that has leaked from the capillaries into the skin. They are less than 3 millimeters in diameter and do not blanch when pressed upon. Often seen following strangulation, although not in every case.

PCR Amplification: method of increasing the number of DNA molecules present for analysis.

Posterior Fornix: vaginal cavity located beneath the cervix.

Posterior Fourchette: a tense band or fold of tissue in the posterior of the vagina that connects the ends of the labia minora.

Prepuce: retractable fold of skin over the glans penis or the clitoris.

Proctitis: inflammation of the rectum, caused by disease or sexually transmitted infection.

Proctorrhoea: mucous discharge from the anus.

Prophylaxis: a measure taken in the prevention of a disease or condition. In sexual assault, treating the patient prophylactically for sexually transmitted infections and pregnancy is recommended.

Prostate: gland that produces semen.

Puberty: process of maturation of the reproductive organs.

Puncture: wound made by a pointed object.

RFLP Testing: form of DNA testing adopted in the 1980s.

Rectum: final portion of the large intestine, terminating in the anus.

Scar: tissue that replaces normal tissue after a wound has healed.

Sequelae: a pathological condition resulting from a disease, injury or trauma; a secondary consequence or result.

Sexual Assault Medical-Forensic Examination: the combination of healthcare and evidence collection available to patients upon disclosure of sexual assault. Many jurisdictions have their own protocols guiding this process; refer also to the National Protocol for Sexual Assault Medical Forensic Examinations.

Sexual Assault Nurse Examiner (SANE): a registered nurse who has specialized education and training to provide targeted health care to, and evidence collection for, patients presenting after sexual assault. The International Association of Forensic Nursing (IAFN) is the professional organization representing SANEs: www.iafn.org. In some jurisdictions also referred to as *SAFEs*: Sexual Assault Forensic Examiners.

Sexual Assault Response Team (SART): community based coordination response to victims of sexual assault. To learn more about SARTs, consider www.safeta.org and <http://www.nsvrc.org/projects/sart>.

Sexual Dimorphism: variation among males and females, especially referring to the hips and pelvis.



Speculum: An instrument used to widen an opening or passage to facilitate examination. Used in vaginal and cervical examinations.

*Photo:
Jansen Medical*

Strangulation: compression of the neck that leads to injury or death due to lack of oxygen supply to the brain; not to be confused with *choking* which refers to blockage of the airway by a foreign object, such as a piece of food.

Syphilis: sexually transmitted infection becoming increasingly common, characterized by an initial painless chancre followed by various stages of disease.

Tanner Stages: classification system of stages of secondary sexual development. Uses breast and pubic hair in the female and scrotal testicular, and penile size with pubic hair in the male.

Toluidine Blue Dye: solution that is used to die the skin and illuminate areas of injury.

Traction: separation of folded tissues to assess and determine injury.

Trauma: (a) an injury (as a wound) to living tissue caused by an extrinsic agent; (b) a disordered psychic or behavioral state resulting from severe mental or emotional stress or physical injury; (c) an emotional upset. (Source: *Merriam-Webster Medical Dictionary*).

Trichomoniasis: common sexually transmitted infection that causes itching, burning, and a yellow-green discharge.

Urethra: opening of the bladder.

Uterus: reproductive organ where fetus grows, “womb.”

Vagina: fibro muscular tract leading from the uterus to the exterior of the body.

Vaginitis: inflammation of the vagina.

Vas deferens: tube from the epididymis to the urethra.

Venereal Warts: genital warts caused by the Human Papilloma Virus (HPV).

Vestibule: almond shaped space between the lines of attachment of the labia minora.

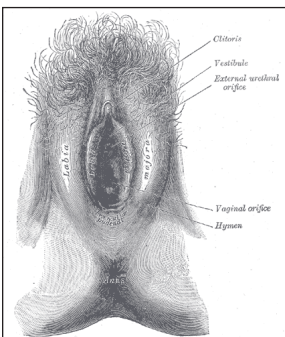


Image: Gray's Anatomy

Vulva: female genitalia consisting of the labia majora, labia minora, clitoris, vaginal vestibule, hymen, fossa navicularis, and posterior fourchette.

Vulvitis: inflammation of the vulva.

Woods Lamp: ultraviolet light that may fluoresce semen and some other substances.

BASIC ANATOMICAL TERMS:

Anatomical Position: the human body in an erect position with hands at the sides and palms and face forward. Descriptive terms (i.e. right, left, etc.) are based on anatomic position and not necessarily the position a body is in.

Superior: above, the top of the body.

Inferior: below, the bottom of the body.

Anterior: in front of, the front side of the body.

Posterior: behind, the back side of the body.

Lateral: side (usually described as left or right), or on the side of something else.

Dorsal: back side of the body, back of the hand or other body part.

Ventral: front side of the body.

Proximal: close to the center of the body.

Distal: further from the center of the body.

Ipsilateral: on the same side as something else.

Contralateral: on the opposite side from something else.

Superficial: near the outer surface.

Deep: penetrates further from the surface.

Intermediate: between two other structures.

Cranial/cephalic: referring to the head.

Palmar: surface of the hand, palm.

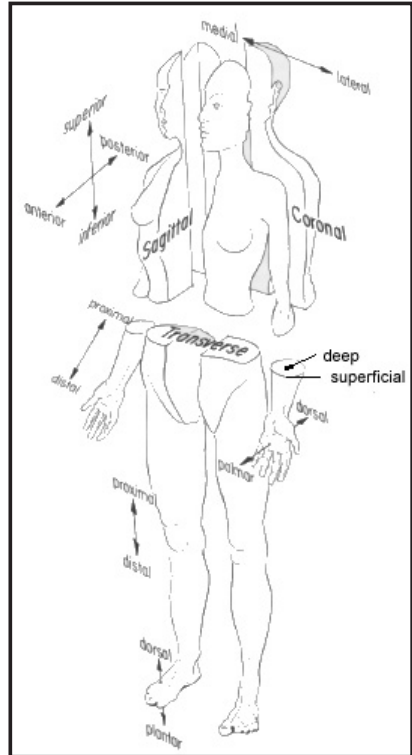


Image: https://courses.stu.qmul.ac.uk/smd/kb/grossanatomy/basic_anat/living_anatomy.htm

REFERENCES:

1. Hammer, Rita, Moynihan, Barbara, Pagliaro, Elaine. *Forensic nursing: a handbook for practice*. Sudbury, MA: Jones and Bartlett Publishers, 2006.
2. Jarvis, Carolyn (2003). *Physical Examination and health assessment* (4th Edition). St. Louis: Elsevier.
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APPENDIX B: SAMPLE DIRECT QUESTIONS FOR THE SANE

QUALIFYING QUESTIONS:

1. State name, occupation, where employed. How long have you been so employed?
2. What degrees do you hold?
3. Where and when did you obtain those degrees?
4. How long have you been a nurse? Do you have a specialty or area of practice?
5. You noted that you are a Sexual Assault Nurse Examiner (SANE). What is that?
6. Did you have to have any special training to be a SANE? Can you describe that training?
7. Is there a special certification to become a SANE?

**Note: Some SANEs will be certified, although this is generally not a requirement. If your witness is certified, this should be discussed.*

8. Approximately how long have you been a SANE?
9. Approximately how many sexual assault forensic exams (SAFEs) have you conducted or observed?
10. Do you belong to any professional organizations?

APPENDIX B:
SAMPLE DIRECT QUESTIONS FOR THE SANE

11. Have you written any publications? If so, were they peer reviewed? Can you explain what it means for something to be peer reviewed?
12. Have you been previously qualified as an expert in the field of sexual assault examination in any court? Which court(s)? How many times?

**Proffer of SANE as Expert: Offer the witness as an expert in the area of sexual assault forensic examination.*

DESCRIPTION OF THE EXAMINATION:

1. What is a sexual assault forensic examination (SAFE)?
2. Can you describe the general nature of a SAFE (i.e., what it is, how long it takes, why it is done)?
3. Did there come a time in (month / year) when you performed a SAFE on (victim name)?
4. Can you please describe the specific steps you took in examining the victim in this case?

**Note: The exam is rather lengthy. To ensure that the testimony is presented in a thorough manner, this may be easier to do if an unused SAFE kit is used as demonstrative evidence. The witness can talk through each step using the envelopes and forms in the kit.*

5. You said that one of the first things you did was to ask about the victim's medical history. Can you explain why you do that?
6. You also stated that you asked the victim about what happened during the assault. Why did you do that?

**Note: The history of the assault guides the entire examination and helps the examiner figure out what to look for.*

For each step in the examination, use these questions (or similar questions) to present to the jury what was done, why, whether anything was observed, and whether any evidence was collected:

1. Please describe what you did first and why.

**Note: The idea is to have the witness explain what was done and what the witness was looking for.*

2. Did you use anything to enhance your ability to see while performing this step (e.g., colposcope, alternative light source, or toluidine blue dye)?
3. Did you make any observations?
4. If so, can you please describe what you observed?
5. Did you document your observations?

**Note: If photographs are going to be used, they should be introduced. If not, a diagram can be used to show any observations.*

6. Did you collect evidence during this step? If so, can you describe it? What was done with the evidence?

After the witness finishes describing the examination:

1. What, if anything, did you do after the evidence collection portion of the examination?

**Note: This question is designed to get the SANE to talk about discharge planning and medical care. It shows that there is more to the exam than just forensic evidence collection.*

2. What did you do with the evidence you collected during the SAFE kit?

**Note: This is asked to establish chain of custody, so be sure the witness talks about sealing the evidence and who the evidence was given to or how it was stored.*

CONCLUSION:

**Note: Be careful that the witness does not try to testify about consent or testify that rape did or did not occur. The presence of injury only means that recent sexual contact occurred, but not necessarily that forcible contact occurred. The witness can say that what he/she observed is consistent or inconsistent with the victim's description of events but the medical witness CANNOT testify about whether or not a victim consented.*

CONCLUSION IF THERE WAS INJURY:

1. Based upon your education, training, and experience, were you able to form an opinion to a reasonable degree of scientific certainty about any of the injuries you observed?
2. Were you able to tell whether the injuries were consistent with the victim's description of what happened? Were they consistent? Why or why not?

CONCLUSION IF THERE WAS NO INJURY:

1. Based upon your training and experience, if there is no injury, does that mean the person was not raped?
2. In other words, is it possible that a person would be sexually assaulted but there would be no injury? Can you explain how this is possible?
3. You testified that you did not observe any injuries in this case. Based upon your education, training, and experience, were you able to form an opinion to a reasonable degree of scientific certainty about whether what you observed was consistent with the victim's history of what happened?

APPENDIX C: ADDITIONAL RESOURCES

Forensic Healthcare Online, *Consensual Sex Injury Clinical Guide*:
<http://www.forensichealth.com/2010/09/21/consensual-sex-injury/>

Forensic Healthcare Online, *Sexual Assault Anogenital Injury Clinical Guide*:
<http://www.forensichealth.com/2010/07/28/clinical-guide-sexual-assault-injury/>

SAFETA Source: Sexual Assault Forensic Examiner Technical Assistance:
<http://www.safeta.org/>

Sexual Assault—Forensic and Clinical Management (DVD). Available for purchase at <http://iafn.org/storelistitem.cfm?itemnumber=27>

Sexual Assault Nurse Examiner (SANE) program goals and patient care practices (2006). Patterson D, Campbell R, Townsend SM. *Journal of Nursing Scholarship*. 38(2):180-6.

ENDNOTES

- 1 For ease of reading, this article will use the acronym SANE, since much of the research cited specifically refers to nursing. Please note, however, that the role of Sexual Assault Forensic Examiner is not limited to registered nurses (RN), but also may include advanced practice nurses (APN) such as nurse practitioners (NP); physician assistants (PA); and physicians (MD/DO).
- 2 International Association of Forensic Nurses, Clinical Forensic Program Registry: <http://www.iafn.org/displaycommon.cfm?an=5>
- 3 International Association of Forensic Nurses and American Nurses Association (2009). *Forensic Nursing: Scope and Standards of Practice*. Silver Spring, MD.
- 4 In a review of the literature, Campbell found that, “for every 100 rape cases reported to law enforcement, on average 33 would be referred to prosecutors, 16 would be charged and moved into the court system, 12 would end in a successful conviction, and 7 would end in a prison sentence.” Campbell, R. (2008). The Psychological Impact of Rape Survivors’ Experiences With the Legal, Medical and Mental Health Systems. *American Psychologist*, 63(8), p. 704.
- 5 Dolezal, T. McCollum D., Callahan, M. (2009). *Hidden Costs in Health Care: The Economic Impact of Violence and Abuse*. The Academy on Violence and Abuse, Eden Prairie, MN.
- 6 <http://www.safeta.org/displaycommon.cfm?an=4>
- 7 Campbell, R., et al. (2009). *A Systems Change Analysis of SANE Programs: Identifying the Mediating Mechanisms of Criminal Justice System Impact*. <http://www.ncjrs.gov/pdffiles1/nij/grants/226497.pdf>
- 8 Masters, W.H. and Johnson, V.E. (1966). *Human Sexual Response*. Boston, MA: Little, Brown.
- 9 For an excellent review of the literature, see: Sommers, M.S. (2007). Defining Patterns of Genital Injury From Sexual Assault: A Review. *Trauma, Violence, and Abuse*, 8, pp 270-280.
- 10 Rossman, L. et al. (2004) Genital Trauma Associated with Forced Digital Penetration, *American Journal of Emergency Medicine* 22(2), pp 101-104

- 11 Most SANEs do not work in forensics full-time, but instead hold other clinical jobs which can be explored to bolster competency and expertise (e.g. emergency, obstetrical or critical care nursing). Even for nurses who do work solely as SANEs, the vast majority have diverse clinical backgrounds, which can be highlighted while laying a foundation for clinical expertise.
- 12 See http://www.cdc.gov/NCIPC/pub-res/ipv_and_sv_screening.htm for a compilation of sample screening tools used in the health care setting.
- 13 International Association of Forensic Nurses and American Nurses Association (2009). *Forensic Nursing: Scope and Standards of Practice*. Silver Spring, MD.
- 14 <http://www.ncjrs.gov/pdffiles1/ovw/206554.pdf> (also available at www.safeta.org where technical assistance on the protocol can be obtained).
- 15 View a chart of Tanner Stages at http://www.addison.ac.uk/endocrine_modules/module1/lecturers_material/html_files/END1.14/img019.JPG
- 16 Refer to <http://www.forensichealth.com/2009/04/19/woods-lamps/> for resources on the effectiveness of Woods Lamps and other alternate light sources.



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