

Documentation: What should be documented as a part of the SANE/SAFE Evidentiary Examination?

Prior to the development of SANE programs in the mid 1970's the paperwork in the evidentiary exam kits was developed by crime laboratories with the intent of obtaining the information the criminal laboratory needed to analyze the evidence collected in the kit. Most kits also included a release of information for the patient to sign giving the hospital permission to release the evidence collected to law enforcement, who then transported the evidence to the crime laboratory for analysis. Hospital emergency staff would often complete this paperwork and provide little additional information to law enforcement, unless there were injuries requiring treatment, which only occurred in fewer than 7% of the cases across studies (Ledray, 1999; Littel, 2001).

As SANE programs developed it became clear to these nurses that valuable information was being missed and that additional information should to be documented and included as a part of the evidence collection. In some states an attempt was made to include this additional information in crime laboratory paperwork provided in the evidentiary exam kit and in other areas SANE programs developed additional sexual assault exam forms that they completed and provided to law enforcement with the evidentiary exam kits. As a result there is no standard documentation and information gathered varies considerably both in content and format.

This paper will address what to needs to be documented and how it should be documented. It will also discuss address the question, *is it possible to document too much information?*

Sexual Assault Exam Documentation

There are three distinct types of documentation necessary for the forensic examiner to complete when conducting a sexual assault examination.

1. Patient consent to do the exam and authorization to release the information to law enforcement.
2. Forensic examination documentation of what the forensic examiner did, saw, and collected.
3. Chain of custody documentation of the evidence collected.

Consent and Authorization

Before beginning the sexual assault exam, the forensic examiner must obtain written informed consent from the patient to do the exam, collect evidence, and take pictures. If pictures will be used for training purposes, this should also be included in the consent. The Health Insurance Portability and Accountability Act (HIPPA) established standards to protect patient health information. It applies to any health care provider and to paper as well as electronic health records. Any “individually identifiable health information” is considered “protected health information” and is covered by HIPPA regulations (HIPPA, 45 C.F.R 164.512).

While obtaining informed consent to share the details of the Sexual Assault Forensic Medical Examination with law enforcement and other professionals is an essential part of the examination, HIPPA also clearly addresses exceptions when covered entities are permitted to disclose protected health information **without an individual’s authorization or permission** (HIPPA, 45 C.F.R 164.512). The circumstances where this is permitted with victims of sexual assault includes:

- Mandatory reporting of suspected abuse by health care providers and others. Disclosure is permitted to government authorities regarding victims of abuse, neglect, or domestic violence regulations (HIPPA, 45 C.F.R 164.512 (a), (c)).
- Law enforcement purposes. Disclosure to law enforcement is permitted: (1) as required by law (e.g. court orders, warrants, subpoenas) and administrative requests; (2) to identify or locate a suspect; and (3) in response to a law enforcements request for information about a victim or suspected victim of a crime regulations (HIPPA, 45 C.F.R 164.512(f)).
- Mandated reporting as required by State or Tribal law (USDOJ, 2001; IHM, 2011).

The Forensic Examination Documentation

It is important for the SANE/SAFE/forensic examiner to maintain an objective and unbiased approach to the care of their patient and to documentation. They are not there to help “prove” or “disprove” a case. As medical providers the forensic examiner is responsible to accurately and completely document what they see, what they do, and the evidence they collect. It is important at the time of the examination to recognize that any case could end up in a court of law and that it is important to document all information that is relevant to the case or could be relevant. The examiner should never assume they will remember relevant information. If it is potentially important it needs to be carefully documented at the time of the exam.

It is also clearly not possible, nor appropriate, for any medical provider to document everything the patient reports during an extensive medical examination that may take two or three hours or more. Especially in a forensic medical exam, it is essential that they document everything that in their opinion is or may be relevant.

Whenever possible the forensic examiner should avoid medical jargon, and instead use terminology that is more likely to be clearly understood by the law enforcement officer, prosecutor, defense attorney, and ultimately the jury. Other medical providers are not the primary audience. For instance, instead of documenting “erythema”, the forensic examiner should document “redness” if this is seen on examination. Injuries should be also documented objectively and concisely, avoiding descriptions that are unclear and can be misinterpreted, such as “small bruise”. Instead a bruise should be documented describing the size, shape, color and location. In addition to the written description, documentation of injuries should also include pictures and indications of the location of the injury on a body diagram (Sheridan, Scafide, Kapur, & Giardino, 2011).

A SANE exam includes a focused medical history including a detailed history of the assault; head-to-toe physical assessment for injuries, diagnosis and treatment or referral for treatment of injuries identified; forensic evidence collection; assessment of risk and offering prophylaxis for sexually transmitted infections; assessment of risk of pregnancy and offering emergency contraception (EC); crisis intervention, support, and providing information about options including law enforcement reporting decisions (ACEP, 1999, Ledray, 1999). An important part of the SANE/SAFE role is documentation of the above for both medical and forensic purposes. Documentation should include the following (Ledray & O’Brien, 2011):

- Place and time of assault
- Nature of physical contacts
- Race and number of assailants
- Relationship to assailant(s)
- Weapons or restraints used

- Where penetration or attempted penetration of which orifice by a penis, object or fingers occurred
- Ejaculation, if known, and where it occurred
- Use of condom or lubricant and brands, if known
- Threats to victim by assailant(s) in quotes
- Statements of victim that help explain what made her afraid to resist
- Activities of the victim after the assault that may have resulted in the destruction of evidence (e.g. changing clothes, showering, brushing teeth or using mouth wash, eating or drinking, douching, or having a bowel movement)
- Consenting sex within past 72/96/120 hours
- Use of tampon
- Contraceptive use or current pregnancy
- Allergies
- Survivor's emotional response during assault
- Patient's appearance, cognitive state, demeanor and emotional response at time of exam
- Physical injuries
- Evidence collected and disposition

Focused medical interview and documentation. An important decision for the forensic examiner is if the medical interview will be a complete medical, psychiatric, and sexual history,

or if a more focused medical interview is sufficient or even more appropriate. It is important that the examiner is aware of the implications of this decision to the patient.

This decision is most clear when considering the patients sexual history. While it clearly is irrelevant if a patient is sexually active, has had consenting sex with other people in the past, has had a past abortion, or has children and is not married, defense attorneys have tried to use the patients past sexual history to undermine their credibility when a case goes to trial. As a result of these tactics, every state has passed a rape shield law to prevent the patients unrelated, past sexual history from being discussed in the courtroom. However, if the forensic examiner asks about, and then documents the sexual history of the patient, they are not only informing the defense of this history, but also potentially making it an issue in the sexual assault case. It will still be the decision of a judge to determine if this type of evidence is admissible at trial. However, in a case with consent as the defense, the defense attorney will likely argue evidence that the victim is sexually active goes to show past consent, so should be considered in this case as well. Unfortunately, all too often, the argument is successful.

The situation is similar with the patient's psychiatric and medical history. If relevant in the opinion of the examiner it should, of course, be documented clearly and concisely. For instance if the patient was assaulted by her physician or therapist, another patient of her therapist, or leaving a therapy session If, for instance, the examiner is concerned about the patients suicide potential the current behavior and statements should be evaluated and documented independently, rather than documenting the patients past mental health history. It is the current suicide potential that is the concern and that is what should be documented.

If the patient discloses she had an abortion, knee surgery, or was treated for depression two years ago, if not relevant there is no reason to document the past medical care as a part of the sexual assault exam. If documented, this too could allow the defense attorney a rationale to gain access to the patients past medical or psychiatric records to “fish” for something that could be used to discredit her at trial. Even if ultimately not allowed, just the threat of this kind of disclosure can understandably feel very invasive to the victim.

Chain of Custody

The purpose of the chain of custody information is to provide a signature record of every individual who has had possession of the evidence in order to ensure there has been no loss or alteration of evidence from the time of collection until it is analyzed by the laboratory or used in the courtroom. Without proper chain of custody it is possible evidence collected will not be admissible if the case goes to trial. It is essential that the forensic examiner who collects the evidence maintains direct control of that evidence from collection until transfer of custody. This includes while it is being dried, packaged, and sealed. They must also carefully document when they place the evidence in secured storage, or transfer custody to another individual. This transfer of custody must include the full name, signature, and date and time of transfer and the full name and signature of the person custody is transferred to, or the location of the secured storage area. The same documentation must occur with each successive transfer of the evidence from the examiner to law enforcement, and laboratory personnel for analysis. It is not necessary, nor appropriate for the law enforcement officer to be in the room during evidence collection to maintain chain of custody. The patient, patient advocate, family members, or other support personnel should not be involved in the chain-of-custody (Ledray, 1999, Ledray, 2006, Ledray & O’Brien, 2011, USDOJ, 2004).

Research comparing 97 evidentiary exams, 24 completed by trained SANEs and 73 by medical professionals without additional forensic training found the SANEs maintained chain-of-custody 100% of the time and the other medical professionals only 52% of the time (Ledray & Simmelink 1997). A similar study of 100 sexual assault cases with 41 evidentiary exam kits completed by SANEs and 59 completed by other medical professionals, found the SANEs maintained chain of custody 100% of the time compared to 81% of the time for the other medical professionals (Griswold, 1999).

Summary

The forensic examiner should expect to be called to testify if the case goes to trial. The most important preparation for this testimony is complete and concise documentation. The forensic examiner will likely be asked to testify about what they did, what they saw, what evidence was collected, how it was handled, and how chain of custody was maintained. The documentation at the time of the examination will be the basis of their testimony.

Since the purpose of the medical interview is to guide the patient's exam and evidence collection, the forensic examiner should ask questions that will assist with identification of injury and potential evidence that can be collected. Clearly everything that is discussed during this time period cannot and should not be documented. It is, however, essential that the forensic examiner is consistent and unbiased when deciding what will and will not be asked and included in the evidentiary exam documentation. The decision must always be to document everything that in the opinion of the forensic examiner is or might be related to the assault in question. The decision to document cannot be based on what will help or hurt the case. The forensic examiner must always remain unbiased in collecting evidence and documenting the patient's history of the assault.

Fortunately, it is not the examiner's job to determine if the patient is telling the truth or if the patient was or was not raped. It is the forensic examiner's job to document a complete history of the assault to guide the examination of her patient, to identify injuries, to collect evidence, and to provide medical treatment to her patient. All medical records are also, of course, important evidence if the case is charged and prosecuted.

Areas that are controversial and where documentation decisions vary include the past medical history, past psychological history, and sexual history. However, it is the opinion of this author that the decision is clear when the decision is based on the recommendation to include only the information that is, or may be related to the current assault in question. If in the opinion of the forensic examiner other information volunteered is not related to the assault, to the medical-legal examination she will be conducting, or to the care she will provide her patient, it should not be documented on the sexual assault exam report.

Reference List

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