

In The Beginning

The Sexual Assault Nurse Examiner

Just because we can't see the evidence, doesn't mean evidence is absent.

Carl Sagan

The President's Task Force on Victims of Crime had just been released. The 1982 report charged the scales of justice for being out of balance. In general, victims of crime were not being treated with fairness, dignity or respect. Sexual assault, escalating more rapidly than other violence, was made the focus of the United States Senate Judiciary Committee Report: "Violence Against Women: The Increase of Rape in America...."

Despite this acknowledgement, these victims, continued to be treated with indifference, shunted aside. It was this neglect that brought many nurses to realize where our priorities lay.

The ER had finally calmed down after a hectic night: Two cardiac arrests, a drunk injured driver, one lady in labor, a psychotic outbreak, a teen attempted suicide, and a nasty motorcycle accident on the freeway, were among the admits.

Finally, taking a rare moment to breathe and gather her thoughts, Malinda W*, the

*Fictional name. Although everything in this book is based on real events and cases, all names and locations in this book have been changed to protect the privacy of those involved.

nursing supervisor of the ER, stood looking at the admit board. There was still one room occupied and nothing was written on it.

“What are we doing with 4?” “Oh, I don’t know, “ one of the other nurses came to stand by her. “Donna, “ she asked the ward clerk, “whose in 4?”

“Just a sec.” The over worked ward clerk was busy putting together of the chart that the attending had just admitted to ICU. “It’s uh...a Miss James.”

“But what’s her problem? Are we drawing blood? Doing X-rays? What?”

The clerk flushed. “Come read the chart yourself if you want to know, Mal. I’m no doctor.”

Malinda walked over to the circular desk in the middle of the room. “Miss James is a rape victim. She’s been here for nearly three hours and we haven’t done a damn thing.”

“Well, Christ lady,” the other nurse responded defensively, “it’s not like we’ve been twiddling our thumbs. We had just a few critical patients in here, you know. And it is just a rape.” The whole attitude of the room had changed.

Malinda rolled her eyes. “Yeah, I know. I also know that a rape victim, in her own way, is as fragile as the wounds of the drunk driver we treated. Maybe more so. She didn’t ask for violence. He, at least, chose to drink.” She flipped through the empty pages. “Has the intern even checked her out? There’s nothing written on the chart.”

For many health care workers the evaluation and especially the evidentiary exam was discomforting and even threatening. A lack of forensic experience, confusing recommendations and no definite protocol, time constraints here and the possibility of

future court testimony loomed before them not the least of which was the victim's distress. All this, and more, played factors in the treatment of sexual assault crimes.

Malinda realized she was just as much at fault. She had heard the police officer stroll in and yell, "Hey, we've got a rape here. Who wants her?"

No one had said or done anything to tell him that his attitude did not help.

"Has anyone called the advocate?" Malinda asked, still unsure how to proceed.

"12:02 and at 1:20. I beeped her twice," Donna said, hurt to think that anyone would accuse her of not doing her job.

"And what about the detectives? Have they been notified?" The police had long departed, feeling that they had more important things to do.

"Uh. Yeah. They said they'd be along when they could."

Malinda sighed. "Well maybe have Doctor P. check her out to make sure there were no physical injuries? He hasn't written anything on the report yet."

"Oh, yeah. He asked me to page the OB on call."

"And?"

"What are you, Girl? A one woman rape crisis center?"

"No, I just think we need to take care of these victims, too. I can't believe we haven't done anything for her yet. I'm going in to check on her. Please page the OB resident again, Donna. Tell him that I will report him to the Chief if he's not here in 15 minutes. Call the detectives and tell them that they need to come and make a report NOW. Please." Malinda made an effort to smile. "And please call the advocate and tell her she, too, is needed immediately."

The rape crisis advocate, a volunteer, would be there for the victim, holding her hand, guiding her through the system, supposedly explaining procedures and events to her as she was able. The trouble was the advocates, being volunteers, did not have uniform training or abilities and sometimes, not understanding what they were doing, caused more problems for the victims.

“You act like you’re blaming us for not doing our jobs. We’ve been a bit busy you know.” The other nurse stood to her own defense.

“Yes, we all have been, but we need to recognize these victims, too. Something different has to be done with them. I’m not crazy about taking care of rape victims either. I know that we all see the victim and think, “There but for the Grace of G-d go I.” We’re all afraid that by taking care of these women we’ll be tainted or open ourselves up for attack: Or we find ways to blame them and say if they hadn’t dressed like that or if they hadn’t been at this bar or if they hadn’t walked to their car at midnight, nothing would have happened. But none of them invited the violence. None of them deserve that. The fact is we are nurses. We are supposed to take care of everyone who comes to the ER.”

Malinda was right. She believed that the victims were not being taken care of in the best possible manner. Their rights were being violated by the none or poor collection of evidence and by the sloppy documentation. Their cases could not go forward without the proper evidence, and they, themselves could not heal from their psychic wounds.

There was a better way to take care of rape victims. Only Malinda wasn’t sure what it was. Like others struck by the lack of caring and attention given to victims of

violence, Malinda struggled to find some way to mesh her skills with the needs of the victims. She talked to police; she talked to the rape advocates, all without knowing that she was practicing forensic nursing.

The lecture she attended given by Virginia Lynch on Forensic Insight of Trauma Nursing was what turned Malinda around. She realized that a sexual assault response team had to be started in her area.

“You’ll never do it. You’ll fall flat on your face.” The rape advocate director told her. “Honey, don’t you think I’ve tried. For years I’ve talked myself blue. I got nowhere with these police. Give up. I have. They just walk right passed and ignore everything I’ve done. And I’ve more clout than you in this town.”

The director fought Malinda’s program for over a year, putting up obstacle after obstacle. Even though, as a nurse practitioner, NP, and almost reached the top of her professional career, Malinda felt she had to reprove herself.

“You would have thought that she would welcome help with the caring and treatment for the rape victim, instead the director felt threatened.

Malinda pushed forward despite everything negative. Talking to her friends in the Medical Examiner’s office she realized that she had to push forward no matter what the cost. She learned the hard way that you don’t accept no for an answer. “There is always a way around, a new way to do something. We have to be open to learning.”

Starting out in 1994 with guidance and support from Virginia and others in the budding forensic nursing organization, Malinda went forth like Joan of Arc with her banner high.

One of the fastest growing violent crimes, sexual assault jumped from 17:100,000 in 1960 to 71:100,000 in 1980. In 1990, rape represented 6% of all violent crimes and was estimated, according to reports, to occur every 6.4 minutes. Unfortunately less than 50% of all rapes are reported. (Some studies put this as low as 10% reported.)

Why? Probably the most frequent reason is embarrassment and humiliation felt by the victim, followed quickly by fear of the courts, which historically projected women as being at fault, and not least on the list is the disappointing rates of arrest and conviction.

All that has started changing, thanks to the sexual assault response teams and the nurse examiners who work them.

In the mid-1970's many hospitals still turned away rape victims, often sending them to the county general hospitals rather than the private places where they had first gone to be seen. Most hospitals did not, at this time, have any protocol for rape victims. Afraid of making a mistake with the evidence collection, and leery of court summons in case they had to testify, many hospital personnel avoided these cases.

Victims, fearful of being turned away again, would secrete themselves away and become lost in the system.

The first sexual assault clinician/examiner programs were developed in the late 1970's by nurses, like Melinda, concerned about the lack of adequate care following such a crisis.

The first programs, as discussed in the chapter on Pioneers, were developed simultaneously, yet independently, in Memphis (1976), Minneapolis (1977) and Amarillo, Texas (1978), but it was not until many years later when they met in 1992 for the initial meeting of what would be the International Association of Forensic Nurses, that the originators began to collaborate and compare ideas, concerns and develop strategies for the future of this new area of nursing.

What is A SANE/SANC examiner?

The sexual assault nurse clinician or examiner (titles vary with program and preference of the nurses) is always a registered nurse. One program wants their nurses to be nurse practitioners (nurses with a master's degree specializing in one area and able to make simple diagnosis and prescribe some medications). Other programs prefer nurses with bachelor degrees, but most institutions will train any competent registered nurse (three year program RNs and two year program RNs) and do not believe that advanced nursing degrees are necessary for understanding and performance as a SANE.

The nurse then is taken through 40 hours on intensive training helping her to provide comprehensive care to sexual assault survivors. Certified by the local institution, she to demonstrate ability to do a comprehensive evidential exam.

SANE nurses cooperate with medical facilities working, either as independent contractors, going from hospital to hospital on-call as the need arises, or are based in hospitals that see a lot of rape victims.

Whenever a sexual assault survivor comes to the emergency department of a participating hospital, the staff pages the sexual assault nurse examiner on call. After treating any urgent physical injuries, they make the victim feel safe and comfortable. All additional services are provided after the SANE arrives.

Since most rape survivors are women, female nurses are usually employed as SANEs. A male nurse originally had been on call for the male victims, but they, too, were distrustful of men and preferred being seen by a female SANE.

Malinda now works out of two different hospital sites and is the owner of a private forensic nursing consulting company, but for years pawed at closed doors like an orphan kitten on the basket in the doorstep that needed a home, trying to get someone to accept her in.

In response to the Senate report the Department of Justice, Office for Victims of Crime began encouraging development of a national protocol for forensic-medical examinations of sexual assault victims.

The responsibility for evaluation and treatment of these crime survivors fell to the physicians and nurses in the emergency room...but since the nurses were the ones who spent the most time with the patients, it was up to them to be aware of the physical evidence to be collected.

Marilyn R., a 22-year-old African-American college student came to the emergency room late on a Saturday night. Her initial complaint was vaginal soreness and some bleeding.

Lucky for her, and because of the increase of rapes at the college, the hospital had a Sexual Assault Nurse Examiner (SANE) on call. They only had three nurses trained in sexual assault working the area and one of them was off for sick leave. That meant the other two nurses, Alexandra and Jennifer had no time off and often had to double back from their regular hospital shifts, getting very little sleep or down time.

Even so, the nurses realized that the need was there. Something had to be done. They were both passionate about seeing justice done and having the victims treated holistically, respectfully.

happened to be working 11 pm to 7 am shift that night. Exhausted, Alexandra realized that with only three SANEs working the area, and one of them off for sick leave, it meant none of them had much free time away from the hospital. But Alexandra and her co-workers were passionate about seeing justice done and making sure that the rape victim was treated humanly and holistically.

As nurses they knew the importance of taking into account all of the psychosocial elements as well as the physical aspects of trauma.

During her time working in the emergency departments, Alex had seen too many rape victims shuffled aside, ignored in favor of acute physical dramas. She had witnessed

too much evidence unwittingly tossed aside. Because of this too many perpetrators were left to freely walk the streets because no one cared to take a stand and go to court.

She had always known that there had to be a better way to treat and deal with rape victims but it was only after she had taken sexual assault training and done an internship, studying how to do pelvic exams to search for evidence, that she realized what she had been missing.

Alexandra was similar to many of her colleagues who were SANE nurses now. They had known there had to be a better way to help the rape victims and they had found it.

Since forensic nurses are trained to always have a high index of suspicion, Alexandra, after taking Marilyn's blood pressure and other vitals, took her to the back room reserved for sexual assault exams.

Here Marilyn would have privacy to talk to the nurse without the prying ears of other patients and staff.

"Do you want to tell me when this soreness started?" Alexandra asked. She reached for a sealed rape sexual assault evidence kit in case she needed it. Alexandra couldn't do anything without the girl, her patient, telling her that she had been raped and that she consented to a forensic evidentiary collection but she wanted to be ready.

The girl, Marilyn, shook her head. She recalled nothing. "My mind's a blank," she said. "I went to a party on Friday night with some of my friends and I...I don't recall what happened after that."

Alexandra nodded. “Did anyone give you anything to drink at the party? Or did you leave your drink alone for any length of time?”

“Just when I went to the bathroom.” Marilyn said. “But my friends were at the table.” She protested.

“Did they recall anyone coming near your glass?”

She shook her head. “I don’t know. I didn’t even think to ask.”

“Marilyn, what do you think happened to you?” Alexandra asked, using her nursing observation skills to scan the young woman’s body for signs of injury. She saw nothing, but that didn’t mean nothing had happened.

The young woman shrugged. In a voice quieter than the wind whispering in the trees, Marilyn said, “I think I was raped. I mean I...” Her voice trembled. “There was this guy staring at me all night at the party I mean. I don’t remember what he looked like.”

Alexandra kept her voice calm so that it would help calm the patient. She could see the victim was becoming agitated. “Would you like to make a report to the police?”

She shrugged. “I don’t know. I mean, who will believe me? I don’t have any proof. I.” There was a note of hesitation mingled with distrust.

Alexandra sat down on the rotating stool. She was just below eye level. “I can’t say for sure, Marilyn, until I examine you, but it is quite possible you were raped. There are drugs which can cause some memory loss of events.”

“There really is such a thing as drug induced amnesia?”

Alex nodded. A single 1 ml dose of Rohypnol or flunitrazepam, originally produced by Hoffman-LaRoche, can be detected in the urine for up to 72 hours. Sometimes longer if the conditions are right. But Rohypnol is just one of many memory-altering drugs among them is GHB, cannabinoids (marijuana), cocaine, amphetamines, barbiturates, and other benzodiazepines.

The GhB or Rohypnol might be found on the Styrofoam coffee cup or beer bottle; as residue would be on the bottom. But these are fast acting drugs with high efficacy at a low dose.

Like most hospital labs, the SART clinic, was not equipped to do the testing properly but those crime labs. Rohypnol is not approved by the FDA and is distributed here only illegally but is available in other countries. Hoffman LaRoche, though, has other similar products that are for sale in the US.

“In most, if not all states, nurses are mandated by law to report crime related injuries. The nurse must notify law enforcement. Also many SART program have a policy to call the advocate immediately. Then the client can decline the advocate’s services after they meet. It’s very difficult for the client to make so many decisions at that moment. If you would like me to call the police, I can do so. I can also call the rape crisis line and have an advocate here with you while myself, the police and the doctor talk to you.”

Alexandra continued to explain the difference between the SART nurse, who was always a registered nurse with advanced training in sexual assault exams, and the rape advocate. The latter, while they are usually in the social services, maybe because they,

themselves had been raped or knew someone who had, or just felt strongly about the issue, were usually not nurses or doctors and did not have the medical knowledge necessary to do an exam. Their purpose was to “hand-hold” victim through the process of filing the complaint, the court, and the healing.

“I..I don’t know.” Marilyn hesitated. “I’m still not really sure anything happened.” She shrugged again, her voice barely audible. “Maybe I just imagined it all. Maybe I’m getting my period or something?”

“And maybe something really did happen. You know if it did, you could be saving a lot of other women trouble. And you would help the police build a case, perhaps get this person off the streets.”

There were tears in her eyes now. “But I didn’t even see what he looked like. I don’t have any idea who he is. I don’t remember anything. I don’t even know if anything really happened.” She pushed herself off the gurney. “Maybe I should just go home and stop being a problem.”

Alex put her hand gently on Marilyn’s shoulder. “I tell you what. Why don’t you let me do the exam? If I find something, if there is something that can possibly help the police find out whom it is...I can call them. Even if we don’t find definite proof, you still might find it easier for your healing to make a report. We also check for sexually transmitted diseases (STD) and in our program we give you the morning after pill as well to make sure no pregnancy results.”

“Yeah, maybe.” Marilyn sighed.

“Have you showered since the incident?”

The young woman shook her head. “When I got home I was so groggy that I fell right back to sleep. It was my roommate who insisted I go. She drove me over when I woke up.”

“Where are the clothes you were wearing the night you went to the party?”

She indicated that she wore them still. “I was too shocked, too upset to do anything.”

“Okay. I understand how you are feeling. But it’s good for us if you did not shower because that would wash away evidence. I’m also glad that you are wearing the same clothes since we might find something in or on your clothing that could corroborate your story.” Alex took out both her Polaroid camera for instant pictures so that they could see something develop immediately and the 35 mm Nikon with the macro lens, which she used for photo documentation of bruises and injuries.

Both cameras had their role to play. The 35 mm was more versatile and could enlarge easier if they went to court. Copies could also be made for the police. It was easier to attach the 35 mm to the colposcope for magnified photos of injuries as well.

Of course with her 1:1 copier on the Polaroid, she could make duplicates, too.

On the colposcope, which she would use later, Alexandra had a 35 mm mounted for taking magnified photos of any injuries. This too could be used in court.

Originally the colposcope had been used only for detecting of vulvae and cervical cancer. In recent years, doctors had started using it to document child abuse. But with the start of the SANE program, and the research done by Dr. Laura Slaughter, it had

become a standard of practice for identifying genital trauma associated with adult rape and sexual assault.

More victims with injuries invisible to the naked eye were now able to prosecute and see justice done as a result of the colposcopic photos. It was true that some saw the instrument as yet another invasion measure, which might create more psychological problems for the victims, but careful preparation by the nurse and the advocate had avoided much of the doom and gloom predicted.

Despite the research, there were still facilities (she knew of one in a southern state) that did not have, did not use, or did not believe in the colposcope's ability. One site even went so far as to say that they would not even consider a rape exam from someone who was intoxicated with alcohol or drugs. Even though the nurses there were trained as SANEs they would make judgments about the way the victim dressed, where she went, the time she went someplace or allowing herself to be picked up as a hitchhiker as being a cause for her assault.

Alex was shocked when the nurse from that area had said that she was disappointed in the women for making themselves targets and weaving deceptions.

To Alex's thinking, no one, even if they went into the street naked, was asking to be a victim of violence.

Alexandra hoped that Marilyn would file a report with the police. Partly the reason was a selfish one. Since they were a hospital-based SART (Sexual Assault Response Team) their funding was not independent.

If no report was filed, in this jurisdiction, the hospital would not be paid for the three to six hours it would take to do a complete forensic evidentiary exam. Neither did they get their supplies reimbursed nor did Alexandra receive her SANE stipend for her time and her report.

Reimbursement of costs for the forensic exam is a complex issue. In some states fearing that they would have to pay a share of the costs was a barrier discouraging victims from seeking medical examinations to collect evidence that could be used in prosecution. In other states if there was not enough evidence to file a case, the victim had to pay a share. In still other places, if the report proved false than the alleged victim was sued for the costs.

But even if, by the end of the exam, Marilyn still hesitated, Alexandra would still need the Department of Justice seven page forms including the sexual assault exam report with the chain of custody paperwork; the evidentiary exam consent, which also included a consent to release evidence to and communicate with law enforcement, pregnancy prevention consent, laboratory forms; including a specimen chain of custody; and follow up materials.

It was not unheard of for a victim to return in a few days, maybe even in a few months and want to file. The completed rape kit would be kept up to 30 days.

However, if Alex did not take the specimens correctly now there would be nothing to pursue...and maybe another girl or woman would find herself in Marilyn's situation. Maybe the new victim would not be as lucky.

Fear, Alexandra had learned, could be a motivating factor for some of these victims in doing just what the offender asks of them, which is often a reason that evidence of a struggle is not found.

Even if the victim felt she could not report the crime, just being at the ER with someone skilled as a SANE would speed her recovery and prevent any secondary injury or illness. She had the right to the same medical care, as did someone who made a report.

After taking a preliminary medical history and a history of the events as the patient recalled, Alexandra explained to the patient that she would be doing a brief physical exam. She was not looking for any diseases. Evaluation and diagnosis of anything suspicious was beyond her capabilities role. Further care of any physical trauma required the physician.

Only minor injuries and those that she could document as items of possible forensic evidence would be of concern. “If I think there is anything the doctor should know, than I will have him come in and see you before you are signed out. If there is any injury that I cannot deal with simply, I will call the doctor. If medications are needed, perhaps to prevent STDIs (socially transmitted diseases) or pregnancy conception, he will prescribe them.”

Had Marilyn come into the ER with blood loss, unconscious, or with numerous physical injuries, her care would have been instituted by the emergency room doctors, being careful (Alex hoped) to save clothing and whatever evidence they could. The nurse would only have done the sexual assault exam after the victim had been stabilized.

She was glad this was not the case tonight since the doctor on call had not shown much support to the SANE program. He was one of medical personnel who had a phobia about court and therefore avoided becoming involved with anything which would bring him into contact with the justice system.

After taking her first photos while the patient sat, Alex then had the young woman stand on two sheets spread out on the floor. This was to collect any evidence that might fall from her clothes as she disrobed and put on the hospital gown for the exam. Then pictures were taken as Marilyn stood.

So far no injuries were visible to Alex's naked eye. But that didn't mean nothing had happened. And it didn't mean nothing existed. Carl Sagan had said, "Absence of evidence, does not mean evidence is absent. It only meant you had to look a little harder for it."

As a SANE skilled nurse, Alexandra had been trained to assess injury, objectively document the health history to determine the risk of medical and psychological problems, objectively document the history of the crime, screen for sexually transmitted diseases, collect and preserve forensic data, and by making the proper referrals help the client/victim regain control of her life.

As the victim-patient undressed, the nurse put each item of clothing into a separate paper, not plastic, bag. Items that were damp from sweat, blood or any other source would be air dried first before being wrapped and stored. The paper bags kept evidence present from degrading too rapidly. SANEs had learned, by talking to the crime lab, that plastic often eroded the evidence and destroyed it.

Until such time as the nurse had sealed the bags with evidence tape, dated, labeled, signed with her name and her rank, initialed and handed over to police or put into locked storage they would stay within Alexandra's sight so that there could be no tampering.

If she did hand them over to someone, she would make sure that he signed off on whatever he was given including time, name, date and department. This chain of custody for the rape evidence exam kits had been first instituted in Amarillo, Texas, by one of the SANE pioneers, Edith Rust.

Because of this procedure, the forensic nurses found they collected a higher standard of evidence. Something both the police and crime labs appreciated. It made their job so much easier. Such evidence also increased convictions. Faced with the knowledge a SANE was doing the rape evidentiary exam, many perpetrators confessed on the spot.

Because Marilyn was African-American her skin did not show bruising as easily as a Caucasian might. Judging from the way the girl grimaced as she was being examined, the nurse suspected bruises.

Turning off the light, Alex swept an alternative light source from Omnichrome over the girl's body. Shining in the dark, it picked up secretions on clothing and on skin showing where both semen and other body fluids had been.

Being that the Omnichrome's run \$18,000 plus dollars it was a fight to get the hospital to pick up the cost, especially considering that they made no money from these forensic exams.

Since it had been over 24 hours since the reported event, in all likelihood bruising had started to occur. Most of the bruises could not be seen yet with the naked eye but with the light penetrating the first layer of skin, she could see the marks starting. With a special camera, the nurse photographed what the light source showed.

“Where else do you have pain?” Alex asked.

Marilyn pointed to her side.

Sweeping the light over that area, Alex could see three fingerprints clearly on the skin though they were not visible with the normal light.

These would be harder to photograph but she could measure them and determine the approximate size of the offender’s hand. This was validation of the victim’s story.

Alex also lite up the area between Marilyn’s inner thighs where the assailant might have used his hands to push her legs apart and perhaps hold them. She used a variation of the black light here and realized that without her SANE training she would not have even thought to look here. Even though her light wasn’t as strong as the one the police would use, it was enough. There were fingerprints there.

On her SART report, the nurse marked all the places where questionable areas appeared.

Alexandra was pleased. This, she thought, was good corroborating evidence, but unless she took photos, the case would probably not go to court.

Several times during the initial exam, Marilyn was asked if she would like the nurse to call in the advocate.

Marilyn wasn’t ready yet.

Alex then took swabs of all the areas including inside the vaginal vault. She had learned that sometimes sperm could remain there up to five days. Not all states do the process of washing, but it can help to get more evidence.

As a SANE, Alexandra had to remain totally objective in her care of the patient, noting only items that could be effective in proving or disproving what they suspected had happened. She could not appear to be biased in any way. If the case ever went to court, the defense attorney would sniff out with the ferocity of a hunter dog, any leaning on the side of the nurse.

Whereas the advocate, often an unpaid volunteer, could be there with the patient, hold her hand, guide her through the legal and medical systems and keep her calmed. It wasn't unusual for a victim to have what Dr. Ann Burgess described as Rape Trauma Syndrome. This included nightmares, depression, low self-esteem and numerous other difficulties in readjusting to life. The advocate often was there, standing by the victim, and making sure she received proper treatment. The advocate had the liberty to believe everything and anything the victim said without question whereas the nurse had to find evidence for any fact she stated in her reports.

A bit later in the exam, when she was doing the pelvic, Alexandra explored the victim's genital area –both the exterior area of the vagina and anus and the interior.

Combing the public hair onto a clean sheet of paper, the nurse checked for anything foreign or unusual. Several hairs had clumped together near the opening.

Since many rapists in this modern age of DNA were savvy enough to use condoms, sperm was often not found within the vagina. But sometimes it spilled over into the pubic hair or the inner thighs.

The rape evidence kit provided for swabs and other specimens but not for pubic hair. But Alexandra knew there could easily be semen or some other body fluid on the hair. Snipping off the questionable strands, she folded them into a clean white paper and bundled it into an envelope. Writing on the envelope what she had found, the time and date and her name as well as the patient's information, Alex placed that with the evidence. She felt good about her find and knew that only someone skilled in sexual assault exams would have picked up on this.

Next came the internal exam. She used the colposcope, an instrument that magnified images up to 250x. If she saw anything worth noting, she would take a picture of it.

Originally used by obstetricians and gynecologists for checking on vulvae cancer, this microscope with a camera mounted on it found favor with those doctors exploring child abuse. But not until the SANE nurses started using the instrument for examining adult victims of sexual assault did the colposcope come into popularity.

Seeing a slight redness at the mouth of the cervix Alex photographed that even though this might have happened from a normal sexual encounter. However, Marilyn told the nurse this was her first sexual experience. She was a virgin. Even in this day and age, Alexandra saw no reason not to believe her.

She could see neither tearing nor anything abnormal about the hymen.

Grandmother's stories told of the hymen's being ruptured by horseback riding, tampons and sex. She recalled being told about the bridal night with the sheets bathed in, or at the very least, spotted with blood. The true physiology is that the hymen was seldom seen as a solid membrane. Yet even though she was a nurse, until she had taken the SANE training, Alexandra, herself, had believed the tales.

Facts were, the nurse had learned, the hymen was similar to a hair scrunchy that expanded to capture whatever it was supposed to encircle. More or less elastic the stretching would depend on how much estrogen the woman's body was producing. Newborns to two years old had pinkish estrogenized elastic hymens. Two to eleven (or the beginning of menses) showed a pale, thin membrane that was often painful to touch. All through the years of menstruation, unless the woman had hormonal problems, and until late into menopause, the hymen remains easily elastic, expanding and contracting as needed. Only after the estrogen stopped did it return to the pre-teen period – pale and thin.

Blunt force injury with a foreign object such as a penis or even something as crude as a coke bottle or baseball bat could and often did rupture the hymen and cause tearing or tags but the normal hymen did not need to rupture with sex as it already had the opening needed to release menses.

In an attempt to catch any minute injuries that she had not been able to see with the magnification, the nurse used Toluidine blue dye to stain the area. An injured area would take up the dye, showing it more clearly. The rest of the dye would wash away.

To the nurse's disappointment, nothing showed.

Of course, she could always have the young woman return for a follow up visit in a few days in case the internal bruising showed up then. But the nurse knew it was time to decide if Marilyn would make a police report tonight or not.

All during the exam, a nagging thought had bothered her. Despite her attention, whatever it was eluded her.

“Do you think anything is there?” The student asked.

“Possible. It’s hard to say. I would very much like for you to call in a report but you have to make that decision yourself. Perhaps you’d like me to call the advocate first and you can talk about it with her.”

“I don’t know.” The girl hesitated. “Maybe I should ask the doctor?”

Alexandra did not want to put the doctor down but the fact was most doctors had little or no experience with trauma and evidence collection. Not even the doctors who specialized in emergency medicine could say that they were completely comfortable with preserving evidence in a timely and useful fashion.

Even fewer physicians were at ease on the stand as expert witnesses although the courts, ignoring their lack of training in forensics, still called them more often than the advanced skilled forensic nurse.

“Sure, “ the nurse said. “I’ll get him.” Without leaving the patient or the evidence, which she had collected alone, she went to the desk and dialed for the doctor.

It took nearly a half hour for the doctor on call to come in. Alex knew that the ER was not busy. She wondered what was keeping him but she did not want to show dissent to the patient.

Taking the physician over to the side, Alexandra gave the ER doctor a brief history of the event from the patient's perspective and a list of her findings.

"You did the pelvic, Nurse?" His brow rose.

"Yes, I did a pelvic exam to look for trauma, Doctor. I did not look for anything but the trauma." She said, trying to remain pleasant. Was it just that he didn't want to be involved or was he really ignorant of what sexual assault was.

He had never wanted to do rape exams before and now he was upset that she was doing it?

"I'm sorry, Nurse, but you are overstepping your boundaries. Why is the coloscope in place? Surely you didn't use that, too?"

Alexandra closed her eyes for just a moment to gather her thoughts and calm herself. Doctors had never wanted to deal with the rape patients before. Now suddenly they were questioning nurses on the use of the colposcope. "Doctor, I did not do colposcopy. I used the colposcope for seeing the trauma."

"So you saw trauma."

"No." Alex sighed. "I did not see any signs of trauma."

"So you saw no trauma, nurse?"

"I saw no internal trauma, Dr. G., except for the redness by the cervical os."

"Which as we know can be any number of things including consensual sex. Right?"

Alex flushed. "Correct. But there is plenty of evidence of bruising. Doctor if you would like to do the complete exam it only takes about three to four hours..."

“Three hours? You have to be kidding.”

“Three hours, at least, doctor. If you wish, I am happy to release the patient to your care. But then of course, you will be the one called into court should there be any questions.” She handed him the multi- page OCJ forms that needed to be filled out for any sexual assault reported.

“Doctor in the Journal of Emergency Nursing I think you will find a column addressing your concerns. We only do pelvics for the purpose of the rape exams. We do not look for cancer or other abnormalities. We only use the colposcope for taking evidentiary photos and exploring for trauma that we cannot see with the naked eye. I’ll put the article on your desk, too.”

The doctor rolled his eyes.

“If you’re quite ready, Doctor, let me show you what I have found.”

She told the patient that she was going to turn off the light and use the Omnichrome again.

“Hmm. Hmm.” The doctor repeated several times. “Had some rough sex, did we, dearie? Into to S and M, maybe?” He looked at the bruises on her wrists.

Then the physician glanced at his ER chart. “When *was* the last time you had sexual intercourse, Marilyn?”

“Dr. G, I told you. Marilyn states she is a virgin.”

The doctor rolled his eyes. “Nurse S, you forget this is a college town. The only virgins here are the ones under the age of 12 and even then...” He left the sentence hang.

To Marilyn he said, “Are you sure you didn’t just have a problem with your boyfriend and decide to get checked out?”

The patient looked as if she was about to burst into tears. “I...I don’t have a boyfriend. I am...I was...a virgin. Am I still?” She looked first to the doctor and then the nurse.

“Of course...” the doctor started.

“—You are.” The nurse finished.

“Marilyn, I am going to call the advocate for you. She’s just down the street. So it won’t take long for her to get here. And then.... You can decide if we call the police.”

“I...”

“Nurse S., if there is no trauma, than there was no rape.”

“Dr., haven’t you read the report by Dr. Laura Slaughter? I put a copy of it on your desk the other day. Just because there are no physical findings doesn’t mean rape did not occur. In this case we have bruising especially on her inner legs and her breasts where I have taken swabs. We also have redness of the cervix and possible body fluids on the pubic hair. I think we have a case. I would like her to make a police report but the choice has to be hers.”

He didn’t even hear her. “Or maybe she’s like most....” He paused. “And just not a very clean person.”

“Excuse me.” The patient glared.

His laughter burned like hydrochloric acid on plastic. “You’re excused. I’ll give her the usual for STDs and pregnancy prevention.” He signed the chart with an egotistical flourish. “Now I have patients to see who really need me.”

As a mandated reporter of violence, the nurse had to notify the police of the events of the night. But the victim did not have to talk to the police if she did not want to do so. “It’s within your civil rights not to speak of the matter. But I hope you will. It could help us to get someone dangerous off the street. You survived. The next girl might not be so lucky.”

Finally the patient agreed that seeing the police was the best thing.

It didn’t take long for the detectives to arrive. Alexandra knew them on a first name basis already.

Once again, the nurse went over her chart with them and the specimens she had taken. The advocate had just arrived as well and so with the multidisciplinary team in the room, the patient told her story...what she recalled of the events from the prior night.

Alexandra was glad that everyone had come together. It was often hard for the patient repeating the story over and over. Even when going over the same ground the victim would sometimes recall different things and sometimes she’d forget other points. This made her look as if she was fabricating or adding elements when in fact the victim of Rape Trauma Syndrome often found as she rehashed the events some things became clearer.

As Alexandra was finishing her notes and signing over the evidence to the police, she recalled what had nagged at her. It had been another case, just the month before. She had done the exam, too. The MO had been similar. Only the party had occurred at one of the local frat houses.

The exam had been similar...external bruising and redness but no actual tears or injury seen. And the victim had also been unable to recall the events. Only with that case there had been no body fluids trapped in the hairs.

She was glad that the girl had finally agreed to talk to the police since it was easier for them to make a case with Marilyn's participation. Even though she didn't believe she knew much, her body, the crime scene, had told them volumes.

The police told her that they still had no leads on that case and thanked her for thinking of it. They would check into it to see if there were similarities. Often, she discovered, the rapist will pick victims that are similar to one another or have some kind of link, no matter how tenuous.

Since the grass roots organizations have made police more aware of rape, it was rare in a city of this size that the police would ignore any complaint. But often the case was not charged or the perp pleaded immediately and no one knew about it.

Just because someone has been accused, however, does not automatically make them guilty. We need to examine them as well to see what evidence they carry, what scratches they have, which will verify the victim's story.

In this case, although it took several months for all the tests and the investigation to be completed, the DNA from the hair matched with saliva swabbed off the first girl

and off yet a third girl. The perpetrator, a senior in the frat house where the first party had occurred, pleaded innocent until he realized the evidence they had on him.

The SANE nurse had the satisfaction of knowing she had stopped a serial rapist.

In some areas, the prescription drug Rohypnol has been abused as a rape drug. Because of its similarity to others, it has not been sold in the United States, except illegally. From the same family as Valium, Xanax, Halcion, and Librium, in other countries it is often given for sleeping disorders. It's street name pappas or potatoes and refers to the mental capacity of someone who is taking the drug. Both the Valium and Rohypnol are sold as "roches" and slipped in drinks.

As a forensic nurse, Alexandra had also examined suspects brought in by the police.

It's important that when examining either victim or suspect the nurse keep an open mind, collecting only evidence that can be tested and would stand up in court. More than once she had been able to prove that the man brought in as a suspect was actually innocent of the particular crime he had been accused, as in this instance.

The police had been ready to arrest Mark K because he wore a bright red jacket as the victim had described her attacker wearing. He even wore his hair the same way. She had identified him in the line up. He admitted to having sex recently but with his long time girlfriend.

Because of the suspicions, Alexandra asked if the girlfriend would consent to a forensic exam. She did.

The evidence swabs taken from his penis revealed vaginal skin cells. They did not match the victim's. Nor did his DNA show up on the swabs she had taken from the victim.

An innocent man was freed because of the evidence taken by the SANE nurse. Often she helps to weed out the suspects from the real perpetrators but she seldom gets credit. When the media pick up the story of a rapist they seldom indicate where the forensic evidence that freed the man came from.

In San Francisco, the SANEs there helped put away a man for long-term sentences.

Standing on Capp Street in the Mission District of San Francisco on the night of Oct 4, 1997, 21-year-old Amber M, a prostitute, had been warned about the danger but like most of us, she never thought that it would really happen. ¹

When the white Cadillac pulled up driven by Jack Bokin, a plumbing contractor, she batted her eyes. He offered her \$150 for her services. Needing clothes for her child, she agreed and got into the car.

Little did she know that he was free on bail from three earlier sexual assault cases including a former girlfriend. He had a criminal history dating back to the 60s including five trips to the state prison, state hospital for assaults, and a recent assault on another prostitute. Yet during the day he was a plumbing contractor who liked Chopin and Rachmaninoff, who quoted Camus and Sarte.

Shy around girls growing up, he had married a schoolteacher and had two children. People around him claimed he could "charm the pants off a rat." He would rape

his victims and go home to his wife as if nothing had happened. He believed, as did many, that by attacking the prostitutes whose credibility was often in question, he would have no problem.

When she asked him to go to her place, he said no.

Instead the contractor drove to an area off Bayshore Blvd.

After tying her hands with telephone cord, he raped her twice. As she cried, he called her cruel names but when it was over, he cradled her like a baby and asked if she would like to see him again. "Everything's going to be okay," he said.

Eventually, he forced her from his car telling her again that he loved her and asked if she loved him.

"Yes," she said, petrified for her life. "Yes."

Forcing her head between her legs Bokin began beating her with what she thought was a hammer. "My head pounded. It sounded like an egg cracking." Blood gushed from her wounds. Putting her back in the car, he wrapped her in plastic garbage bag like a sack of potatoes.

Then he stopped at a car wash and doused her with water.

She bit through the plastic in two places in order to breathe. Unable to jimmy the lock she had to wait until the car stopped.

She collapsed, remaining as motionless as she could. She hoped he would think her dead and leave her or "throw her against a garbage can, like they did in the movies." But he didn't.

Instead, the contractor drove to Pier 9. He pulled her out of the car and pushed the bag and her over the Embarcadero into the freezing bay.

She waited what seemed like an interminable time, hoping that he had not stayed around to watch her drown.

Dizzy with the blood loss, she clawed her way out of the bag, swam to shore, climbed over a fence and hailed a passing motorist. Her only thought was to get to the hospital.

Because of the way the SART team in San Francisco functions, she was ambulated to SF General where the majority of the sexual assault cases were seen and examined by one of the nurses from the Rape Treatment Center of the Community Health Center.

The victim's body was the crime scene and as such told the story without her having to say a word.

Semen had been washed away but as the SANE nurse said, there was still plenty of other evidence to find despite her tumble into the bay.

Her skull bore round indentations left by the blows of the hammer. The SANE nurses were able to take photographs of the evidence and with their help in identifying the patterned injury, the police were able to discover the weapon used and trace it back to Bokin.

Traditionally, prostitutes are loath to complain to the police because they fear being arrested themselves or they fear not being believed. Many a hardened cop or attorney has thought that the prostitutes were lying and that they were most likely jilted

for money. That their report is a way of revenge. But because they are preyed upon so much, more than anyone else they need to come forth. The forensic evidence, the silent language of the crime, verifying their attacks will be there even without their speaking of it.

Bokin faced 40 charges in connection with a string of attacks on four women dating back to 1993. Despite his history, the judge had been lenient with him. Like many sociopaths, Jack had a charming nature. And like most, he felt sure the prostitutes would not want attention drawn to them. So for him they were ideal victims.

Not all the charges were substantiated but thanks to the help of the five SANEs who treated almost all of Bokin's victims facts and pieces were put together to build a case.

The DA was pleased.

Just recently Bokin was sentenced to 60 years. They suspect that he killed and injured many more people than they have accounted for and are glad to get him off the streets.

Since the SANEs had started their forensic exams, the prosecution of cases had gone way up. When for budget reasons, the SART (Sexual Assault Response Team) they worked for (not headed by a forensic nurse but by a non-medical administrator) wanted to return to using residents and doctors for their exams.

The DA refused. Not only that, it was easier to bring the nurses to court, he said, but the random residents who frequent the ER on irregular basis are difficult to find a

year or two later when the case is heard. Often when they are found they are loathe to attend the trial.

Col Robert Ressler of FBI profiling fame stated, "Often the best way to approach a profile is through victimology, through looking at the victim's background." The SANE nurse who sees the victims and talks to them at length sometimes can provide the key to a case.

Shortly after the same area was plagued by a gay basher. The perp would go to gay bars, drug the men he fancied, bring them home and shave their bellies and pubic hair. Being ashamed that they had been taken in, the men refused to file police reports.

The SANE on duty recognized the pattern. It was the same MO she had taken care of last month. She explained to the patient that as a mandated crime reporter she had to give the police the face sheet of the DOJ (Dept of Justice)923 (the California form used) to the sex crimes division so that they could be aware of a problem. The victim could speak to the officers himself or not. Officially if there is no report, there is no police contact.

It's difficult to do anything unless a police report is filed, however, the SANE nurses here were firm in protecting their patient's rights. Evidence is important but we must support their decision. No victim has to do anything they do not want. "Control was taken from them once and we help them to get it back in their lives." ‘

As Alexandra did in the above case, rape kits are often opened and evidence taken once the victim is at the SART office since the earlier the evidence is taken the easier it is to prosecute. Should the victim later decide to do so the opportunity is there. Some

things like petechiae and hemorrhage in the eye or on the face from strangulation will disappear in a day or so. If photos are not taken, the evidence will be gone.

Thinking as a SANE, the nurse who took care of these patients checked their mouths for trauma as well as their genitals. “Many clues are subtle. Not finding trauma is often the norm. Someone afraid for their lives will cooperate with the rapist. In fact, a majority of rape cases require little medical treatment. This is another reason why the ER doctor prefers the SANE to do the exam.

Often ER personnel not skilled in sexual assault forget that forced oral sex is rape as well and while there often usually isn't any semen left after 6 hours, there can still be damage to the inner lips from the rubbing of the teeth and other evidence of bruising that can substantiate a story.”

“Nurses,” she said, as she completed a chart, “must learn to think forensically. Not to bag clothes all together. Not to lose evidence. Nursing schools must have courses in how to think forensically. There has to be a forensic nurse on every hospital staff to train the others. It is the wave of the future.”

There is no denying that forensic nurses, by their interactions, have saved lives and saved cases for the police.

Because victims are often in a state of panic when they enter the ER, they forget crucial parts of the events. It is not that they are fabricating more, it's not that they are adding stories, it's that the retelling of the events often clarifies things.

“The more I talk with the patient, and the more at ease she becomes, the more I learn. Often I hear things that the cops don't know. The victims tell me things that they

think they might have told the police but they have forgotten just what they said and did not say.

“By the time I have finished the exam, a good three to six hours, the victim and I are on first name basis. I tell her, I know you have already told this to the police but I am charting this. I will be going to court on what you say and what I write. I want to understand it exactly as it happened. So I need to ask you a few more questions. This is what my testimony is based on.

“After I said that, this one girl told me about how the rapist used an old tee shirt to wipe off his penis. He had thrown it into the bushes near the river edge where the incident had occurred. She hadn’t mentioned this to the cops because she was so shocked and frightened about the events that she had forgotten about the old tee-shirt until we began talking about the rape.

“I asked the detectives afterward what they did and did not know. I told them about the tee-shirt. Sure enough, they were able to go back to the scene, find the shirt just where she said it had been. After testing it for the sperm, they were able to make an arrest.”

Having just taken care of a horrific teen rape that had been a textbook case, she admitted that the job was difficult to stomach at times. Had the adolescent girl not passed out, she might have been murdered. Finding petechiae, red measles-like dots under her eyelids and in her eyes told the story of her near strangulation. The petechiae, especially here, are something often missed.

The nurses often suffer by vicarious traumatization and experience some of the fear and symptoms, as do their patients.

“This is mankind at his worst. It needs to be acknowledged that the work is difficult. Sometimes it’s nearly impossible to take. If you have enough nurses to back you up you can take a break when things get too tough.”

If the nurse does not know how to talk to the patient, she will not hear what the patient is saying either verbally or silently. Luckily, we are skilled in translation of medicalese. Part of our job is patient teaching and to teach patients, we need to speak their language.

“It’s important that we talk to them in their vocabulary. Many people don’t know the word sodomized but they can relate to, “Did he put his penis in your butt?”

What do negative results really mean? What does it mean when we don’t find sperm? Does it mean the woman was not raped? Does it mean it happened so long ago that our evidence is lost?

The SANE needs to think beyond the actual insertion and sex act. What type of evidence can she find beyond (besides) the genital injuries?

Here the art of history taking is important even when someone seemingly cannot tell you what is going on.

CASE HISTORY

In a long-term care facility, Martha, an 80-year-old Alzheimer’s patient, often cried out with, it was supposed, nightmares. She would say that her husband, long dead,

was in her room, kissing her and having sex. None of the staff wanted to believe her. After all, she was old. She was senile.

The scenario went on for nearly three years until one of the kitchen help delivering a lunch tray stumbled on something. Martha was obviously more distraught than usual. But the door was locked.

The kitchen help, Cora, could hear someone there. She recognized the voice of Thomas H., one of the male LVNs coming from the room. Martha pleaded. "Help. Help me."

Cora tried the door again. Still locked. She knocked and jingled the knob. "Are you all right, Martha? Martha? Thomas?"

Almost immediately the door swung open. "Yes, Cora. Ah, lunch." He smiled at the housekeeper. "I was just helping Martha to dress."

"But why was she screaming for help?" Cora asked, looking at the nurse's own disheveled appearance. She bent to pick up some crumpled tissues by the bedside and put them in her ample coat pocket. There was a strange smell in the room but she could not identify it. She studied the nurse as he pushed his hair out of his eyes. "And why was the door locked?"

"Do you want everyone walking in on you when you're dressing?" He asked.

"Cora. Cora," the patient said. "You remember Raymond. Raymond's my husband. You remember him, don't you?"

"Miss Martha, this ain't no husband of yours. This is Thomas one of the nurses here."

The nurse shrugged. “Of course she knows who I am. She’s just having one of her moments.” He took the tray from the housekeeper. “Come on, dear. I’ll help you with your lunch.” He sat down at the bedside, smoothed the patient’s brow and took a spoonful of soup to the old woman’s lips.

Like an obedient child, Martha opened and swallowed. “That’s a good girl. That’s my Marti.”

She patted his hand. “Raymond. Raymond.”

The nurse turned toward the housekeeper and shrugged. “It’s okay. I have everything under control now. We’ll call if we need help.”

Still hesitating the housekeeper left the room. Something was not right.

Cora walked to the nursing station and waited patiently for the head nurse to get off the phone with her boyfriend. Five minutes. Ten minutes. Finally.

“Yes, Cora.”

“Something’s not right. Miss Martha is...”

“Okay. Okay, Cora. I’ll go check.” She stood, not even letting the housekeeper finish her sentence.

This Cora knew was not going to work.

Back in the kitchen, Cora asked the others if they had seen anything strange around Martha’s room.

One of the others recalled a few weeks ago when the room to another patient had been locked. This woman, a new arrival, also was senile. But, she, too, had told the staff

that her husband had come to visit her the night before. Unfortunately, the staff had not seen who, if anyone, had been in the locked room with the patient.

Cora waited a few more days wondering what to do. She had no proof of anything wrong but it still seemed so strange.

Nearly a week after the incident, Cora happened to arrive at the nursing station just as the day shift was reporting off. She cornered the director who frowned and took some notes.

Thomas was not working that day.

The director and the housekeeper went into to see the patient. As the director expected, Martha did not remember anything unusual. She didn't even seem to know who Thomas was although she did tell the head of the home that her husband came to see her often and that he was going to come and take her away from this wretched place.

At a loss of what to do, the director decided that an inquiry should be held. She called the LVN at home but he didn't recall anything unusual. His story was the same that it had been when Cora had surprised him. He was just helping the old lady dress. The fact that she still was not dressed when the door was opened didn't seem to faze him.

Martha, the director decided, should be examined by the new SART team she had been hearing about and called.

The patient was uncooperative. She could not give any oral history. She didn't know even why she was there. But the SANE nurse noticed that the labia, lips, of the old lady's vaginal area were swollen as if from blunt force trauma...the kind of trauma that might occur with an erect penis hitting un-lubricated flesh.

“Sorry,” the DA told the nurse and director, “but that isn’t enough for me to set a case on. I can’t arrest anyone just because of swelling. She might just have an infection.” Martha was sent back to the home.

Thomas, it looked like, was off the hook.

The following day, the SANE called the director and asked if Martha could be brought back in.

Because Martha had not been able to give a history of any wrong doing, the nurse had only checked her vaginal area, which seemed the most likely for any sexual misconduct. She realized that not only had they not done a rectal check but also they had not done proper swabs of the other para-sexual areas.

The SANE was not surprised to find some serious anal tears.

“Do you think he did it?” The DA asked. “How can we get him?”

Cora recalled the tissue in her pocket and handed it over to the lab. But there were no semen present. The person whose fluids were in the tissue had had a vasectomy. So had Thomas. But there was still no proof. They had to run DNA tests.

Thomas claimed he had had a cold that day and spit up in the tissue.

If the SANE could not come up with anything more positive than they would have to release the guy, the DA told her. The LVN did not meet any of their profiles and there was nothing on the tissue that could hold him.

One last attempt.

The SANE thought about the sexual act and thought about foreplay. Even though Martha had not been a willing partner in all this, one of the rapist typologies, power

reassurance, likes to fool himself into believing that his actions are encouraged and even wanted. This rapist fantasizes that this is a true equal relationship. He will often engage in foreplay because it feels then like the sexual act is a normal culmination.

On that chance, the SANE took swabs of the breast areas where during foreplay a man might suckle as well as the inner thigh area hoping for some saliva remnants.

The nurse asked that the LVNs saliva be tested.

She processed the swabs and waited.

It didn't take long. The DNA came back as a positive match.

Excited, the DA leaped from his chair. "All right!"

Thomas, it was discovered, had gotten this job under forged papers. He had several alias...two of those had been arrested in other states for sexual misconduct with patients in homes where he had worked and two others were under suspicion.

A lot of counseling had to be done with the staff who themselves felt violated, betrayed...and guilty. They had ignored Martha and the other women for years.

The SANE nurse is often the one who can relate to the police when a story does not make sense, when there is no physical evidence to back it up.

Jasmine A dragged herself into the police station. She looked like a street urchin with mud streaked hair and torn clothes.

"I woke up in a ditch and I...I don't know what happened to me."

The officer observed her wavering gate. "Have you been drinking?"

“I...I don’t think so...I...some men grabbed me. “My kids, I...I think they’re at the house.”

“Who is taking care of them?” Officer G asked.

Jasmine shrugged. Her speech was slow, hesitating.

Office G could not smell any liquor but drugs might be involved. He offered the woman a chair. “Tell me about these men. Why did they take you? What do you think happened? What do you remember?”

Jasmine shook her head slowly as if she was in pain. “I hurt.”

“Where?”

“All over.” She pointed to her head and her crotch. “I...I don’t know. I think maybe I was raped. I was hit over the head and... I don’t know. I don’t remember anything.”

Being new on the force and unsure of how to handle this situation he conferred with a colleague who reminded him of the SANE nurse that had talked to them during their academy training.

The cops agreed that since the woman was unsure of her situation it would be best for her to have a medical exam and a sexual assault exam for forensic evidence.

Notifying the SART clinic that he was bringing a patient over, Officer G escorted Jasmine to the ER’s separate entrance for rape victims.

Jasmine, it turned out, had three children, who had been left alone for the three days of her disappearance. No one had bothered to call saying that their mother was missing. As a mandated reporter, the nurse called social services.

Jasmine was examined thoroughly by both the doctor and SANE. There was no evidence of any concussion or anything else that could corroborate her story.

Outwardly, her appearance indicated that her story was plausible. But despite the fact that she stated she had gone directly to the police her under clothes were clean. She admitted then to having gone home and showered. She had tripped and fallen getting dirty again and had neglected to tell that to the officer. Her children who had been left alone all that time were now sleeping, she said.

No sperm or saliva or any trace evidence could be found on her. Her head bore no evidence of having been hit, and there were no marks of restraint on her wrists.

Finding numerous scar marks on her arms, as well as some bruises older than three days, a blood test was taken. Her toxicology level showed that she was on significant levels of illicit drugs.

Interviews could elicit no definite information about the men who had reportedly abducted her. Not even the area where she had been kept could be identified.

When social services returned the nurse's call it was discovered that Jasmine had a previous history of disappearing.

Finally the woman admitted that she had gone on a drug binge and said she had been abducted and raped because she feared her kids would be taken from her.

Like Martha, those who cannot speak for themselves are often the easiest victims and the cases that are the hardest to prosecute. Often SANEs are called in to inpatient mental health units to assess a potential victim. Sometimes here the problem is the

person's capability to consent to the exam. The consent is needed for either a sexual assault exam or for a criminal sexual conduct report.

In these instances the SANE must function as a psychiatric role to determine if the person has enough reasoning skills to understand the nature and purpose of the exam and proposed treatment and what will happen if treatment is not received. If not their conservator must sign the consent forms.

Many of these inpatient victims, both adults and children, are unable to make decisions for themselves and therefore have court-appointed legal guardians. Unable to consent for medical procedures on their own, they certainly have no judgment ability to consent to sexual contact.

Barbara was one such case. A head injury as a child had caused Barbara to be developmentally delayed. Her younger sister, Liz, was her legal guardian. Her only other relative was an elderly father...accused of sexually molesting his retarded daughter.

Living in a residential home, Barbara begun suffering from delusions and was transferred to a closed unit until her medication could be reassessed. The staff knew Barbara from previous admissions and were not concerned that she often forgot which was her room.

But occupied with a take down of an assaultive patient on another unit, no one watched as she headed out of the women's area into the men's side.

She was found a few hours later undressed in the bed of one of the male patients, but it was not known if she went into the room on her own or was brought in there, perhaps by the male patient.

Barbara's simple words indicated that something, perhaps the sex act itself, might have occurred but she didn't seem to be able to quite say the words she needed.

How was the unit to protect itself and make sure that Barbara was safe? They knew that if something had happened, than the male patient, Tony would face charges. To be safe, they had to get Barbara checked but no one could reach the sister.

"What do we do?" The floor nurse asked Alexandra, the SANE that'd come in to do the exam and determine if there was any evidence for the police to pursue a case. Just the fact that they suspected penetration meant they had to make the police report. The staff were uneasy about blame and law suits.

After checking the chart, Alex tried herself unsuccessfully to call the sister. No luck. The team discussed what to do. They did not think it appropriate to call the father. The main reason for calling a family member was support and hand holding for the patient

It was decided that Alexandra would talk to the patient and see if she could help Barbara to understand what they were doing. Time was of the essence collecting evidence in the case both for the civil law suit for failure to protect but also to prove Tony's innocence or guilt.

During the few hours they spent together, the patient began to trust the SANE. Alexandra learned that Tony had threatened Barbara once she had entered his room. In talking to her, Alexandra helped Barbara to understand that if the attention she received was not something she liked, she could help keep other women safe if she allowed them to examine her.

Not enough evidence was found in this instance to make a case and neither Barbara, nor her sister who was finally reached, had no wish to press charges against the hospital.

One of the things a SANE is trained to do is check for patterned injury...injury, which because of the pattern it has made on the skin helps us to more readily identify what caused that pattern.

40-year-old Hannah came into the ER of a large teaching hospital at 2 AM saying that someone she knew had raped her. (More than half of rape victims are, in fact, assaulted by someone they know. Not always a “date rape,” where the man thinks he is “owed” it for an evening on the town, or where the man believes the woman has been “leading him on” these acquaintance rapes can sometimes have just a slight knowledge of each other...a hello to someone in the elevator, a nod to the grocery delivery boy.)

Alexandra T., the SANE nurse on duty the night Hannah T. came in collected the evidence as instructed and did a genital exam using the colposcope both before and after using toluidine blue dye.

She started at the top and worked down, oral, vaginal and rectal examinations. Since it may be several years before a case comes to court, the SANE nurse is trained to do things in a routine order so that when she is called to testify, she can say that she noticed this and that because of where it fell during her exam of the patient.

The exam and documentation of body injuries was last since she was anxious to get the evidential swabs and air-dry them as quickly as possible.

The victim had already been medically cleared except of course for the injuries resulting from the sexual assault.

Charting is done by an imaginary clock. Just inside the vaginal lips on what is referred to as the posterior fourchette, the nurse noticed a 2 cm tear.

Redness in an area usually means an increased blood flow because the area has been injured perhaps by hitting, slapping or pounding. The redness on the cervix and posterior extended from the 5 o'clock to the 7 o'clock area.

The SANE noted a positive uptake of the dye, meaning that the dye colored the area of injury rather than being washed off. Only areas of injury that were fresh absorbed the dye and this was how the SANE could tell the difference between an older event and this one.

Using the speculum, she found the exam revealed petechiae of the cervix with some minimal bleeding located at the os, mouth, of the cervix. The presence of petechiae (little red measles-like spots often found in injury) also indicated a lack of oxygen to the area resulting from pounding or bruising. There was clear indication here of nonconsensual sex.

As was her custom, the SANE took colposcopic photos of the injuries and charted her findings.

Despite positive identification of the perpetrator, the case did not go to trial until May 13, 1998. The defendant was charged with second-degree rape.

At the pretrial conference, the defense attorney gave the DA and SANE two photos of the defendant's penis with a metal ring through the base of the glans.

“Miss. T. after viewing the photo of my client, wouldn’t you agree that the injured area you discovered on Miss M was the result of my client wearing this metal ring around his penis? Wouldn’t you say that the injuries, because of this ring, could have occurred during consensual sex?”

“Objection, your honor.” The DA rose. “My client states that the defendant was not wearing the metal ring through his penis on the night in question.”

“Maybe he was and she just forgot. You know, in the heat of passion,” the defense said.

“Do you think Miss. T. that the injuries you claim to have observed could have been caused by this ring? Specifically by the clasp of the ring? I would think that would hurt ” He grimaced and the court laughed. The lawyer glanced at his client. “I don’t think I would like it but everyone has their own tastes.” He paused. “And maybe Miss M’s taste runs to S & M. Maybe she liked it. Maybe this was consensual sex and then she changed her mind. Maybe the ring and the clasp caused the injury. What do you think, Nurse?”

“It’s possible. But I would like to see the photos again, if you don’t mind, Counselor,” the SANE said.

The judge nodded and the photos of the ring through the glans were brought to her.

She studied the photos of the ornament and then at the enlarged photos of the injuries still on the evidence board.

“It’s possible but the injuries that you see here, these tears,” she pointed with the light stick, “are more consistent with blunt rather than sharp trauma. A tear caused by this ring would be sharper, cleaner.” She glanced at the DA. “May I ask a question, Your Honor?”

The judge nodded.

“I would like to know if the ring is inserted from the same direction each and every time it is used.”

The defense attorney had an expectant look of victory on his face. Everyone looked at the defendant.

He nodded. “Yeah, Man. I always do it like this.” He moved his hand in a wave from right to left.

“So then, Miss T, you agree that the injury could have been caused by consensual sex with the ring in place.”

The SANE smiled politely at the defense attorney. “Actually,” she paused. “I don’t. It’s highly unlikely given that he always puts it in from right to left. The injury, if he had worn the ring, would probably have been at the 7 o’clock position rather than the 5 o’clock.”

The face of the defense attorney fell momentarily but he regrouped as he continued to grill her for a total of four hours. At the end of the three-day trial, the jury called the SANE back for further clarification of the issues regarding the right and left side of the injury as she had presented in the medical evidence. They requested the photos and medical records as their only source of further information.

It took only two hours for the jury to return with a guilty verdict.

This case represented the first successful prosecution of an acquaintance rape case in the county. Understanding the mechanism of injury played an important role in the examination of this victim and others. The SANEs expertise in interpretation of the patterned injury helped to convict one more rapist.

In Tulsa, President-Elect of IAFN Kathy Bell's sexual assault team works directly out of the vice and sex squad of the city police. Theirs is a near model program.

As a nursing supervisor she had first been impressed with the medical examiner's office. Death investigation had always fascinated her but sexual assault investigation has won her over.

One of the few places that did not experience turf wars with the doctors fearing they were losing revenue from the SART exams, and doctors fearing that the nurses were taking over, Tulsa had an easy transition. The timing was right.

Luckily the MDs were pushing for the SART team to be established. They liked the idea of giving up court time and not having to spend the time it took to do a proper forensic exam and of freeing up an ER bed. Because of the doctors' encouragement, the hospital CEOs became involved.

The community had had enough of the violence around them and with the media's help the sexual assault response team was founded.

The fact that this SART is not just owned by one agency but owes its allegiance to many makes it work. The DA was a member of the original task force and sat in on the development of it. There was not just one agency ramroding it through.

Funding for Tulsa's SART came from a variety of sources including federal government grants. The law offices provided for the evidence kits, the hospital provided for medications, and treatments while the prosecutor's office covered expert testimony.

Community based, their SART does exams at just one hospital but covers the geographic area of five.

Unless the victim needs medical treatment, she does not have to interact with anyone at the hospital directly except for the SANE nurse, the doctor and the lab. All the services of the hospital are there, should they be needed.

It was originally thought that the SART clinic would not even be in the main hospital at all but in the university setting. But then the idea of security arose. After all most of the exams were done in the middle of the night when there was not a lot of staff around.

However, an area with a separate entrance has been found to be optimal for the victims so that they don't have to traipse through the ER to be ogled by everyone. The best SARTs have places where the victim can clean up, have fresh clothes to loan her since her clothing is now evidence and must be packaged away for analysis, and have resources for her follow and be followed by.

Kathy has been known to have contact with a victim for as long as several years afterwards.

“Of all the cases I see, the majority of the sexual assaults are kids and teens from 13 to 15 years. Most of them have been assaulted by someone they knew...it could have been a party that got out of hand, it could have been one of their peers, but usually it is an older person often such as a family friend. Because of the trust broken in these issues, this type of assault is the most damaging to the psyche of the victim.”

To Kathy, whose office is in the police department’s sex crimes division, the hardest part of the job is dealing with cases that you can’t prove one way or the other. You have evidence but it is not enough to shepherd the case through the justice system.

She reports directly to the detective division major but in reality she is part of the mayor’s office on loan to the police.

The first coordinator of the SART team here was not a nurse and therefore did not understand the importance of melding the two – police and nursing science into one firm handshake. Why is a nurse so important in this position?

One is her ability to translate medicalese. Those reading and needing the information from the sexual assault reports are not, for the most part, fluent in medical terminology. Kathy cautions her students to write in plain English. If the police and prosecutors can understand what is being said, the paperwork doesn’t land in Kathy’s office for translation. “It’s important for the officers to see that given this scenario, this and this type of injury would result.”

“It’s also important for nurses in the ER and in critical care to recognize evidence and know how to handle it. The more we are familiar with the other side of our teams (police or nursing) the easier it is for us to work together.” A marriage like this can be

made in heaven but we all have to work at it for it to succeed and that means talking to each other.

Victims with questions or who need further follow up also come to Kathy's attention.

Since, in a city the size of Tulsa, the time needed to coordinate the SART is not 100%, Kathy spends a good part of her hours in community education and out reach. She teaches at the local police academy and in the surrounding areas.

“Everyone here knows what to do with a rape victim and where they go. There is no jealousy that this hospital is getting more patients than that.”

As president-elect of IAFN 2000-2002, Kathy sees that we as nurses have to reach out our hands in friendship to the police and the law so that we can function as a team, we need to educate others in the medical profession on what a medico-legal case is and how to work together with others, and we need to do more research into understanding the violence and in ways to problem solve for the victims of crime. Like the police, we need to study the victims and their histories, how they are chosen as victims, and why. We need to study domestic violence and it's effects not only on the victims, but the children as well. We need to understand grief and how it relates to death investigations and what we, as nurses, can do to help the survivors through the night.

We can tread into the police pool and they, in turn, can swim with us so that all the victims dragged from the waters will be resuscitated by both.

Because the study of victimology plays such an important role in finding these rapists, all of the forensic nursing programs have study modules on this. But it is the nurse who often assists the police in putting the pieces of the puzzle together.

Living or dead, those sexually assaulted are still victims.

In a class on courtroom communication, we learned how to best present ourselves in court, how to pause for effect in our presentation of the facts, how to avoid giving opinions unless we are asked as expert witnesses, and how to talk to the jury. We also learned that the defense attorney, even though we might not like what he is doing at that moment, is only doing his job. He is trying to get his client freed and that means anything in his power, even if it comes to attempted discreditation of the witness.

As SANE nurses we can be one of two witnesses: either an expert witness, which means that based on our specialized, advanced skills and our experience we have expertise that we have developed over many exams, or as a fact witness, which means that we simply state the facts of injury as we see them.

As expert witnesses, once the court qualifies us, we can state our opinions as to the cause of injury and make judgment calls that others are not qualified to do.

As fact witnesses, again, “we only state ’em as we see ‘em.”

Since nurses are thought to be so empathetic and sympathetic, we are often the one whom the victim tells the events to. We hear what is a “fresh complaint.” That means we are the first to be told the complaint.

As a result of this we are sometimes privy to information that she has not told the police yet. And it is our job to make sure the police have all the facts at hand.

No matter if we are fact or expert, we are testifying not for the victim, not for the defense, but for justice. For this reason, and for our credibility in court and elsewhere.

DA's, as Henrico County's Sherry Will from the Virginia Commonwealth Attorney's Office are so supportive of the SART program and the SANE nurse that they offered willingly to have other DA's speak with them.

Not all DA's spend the time needed to speak with the SANE nurse before her testimony though it was found that those who did ended up with a higher percent of successful prosecutions.

During the pre-trial discussion, one important facet is what the SANE has learned during the exam. A good DA will work with her and prepare the types of questions that would most likely elicit the information the nurse needs the jury to hear. Often the DA, who might only have sketchy medical information, needs to be taught the basics of human sexuality, himself.

After all, if we, nurses, fell for the closed hymen = virgin myth, think about the other educated people who have also.

During their coursework, they deal with the basic human sexual response, which gives them basis for some of their exam ideas. Sometimes, the SANE has to try and put herself into the offender's shoes for just a moment. As she listens to the recital of the events she knows where to look for clues on the body of the victim.

The SANE nurses were called upon to exam the young girl and to testify in court because even though it was consensual on the part of the teenager, she was not old

enough to consent. Despite the fact that it was consensual, Mary, just entering her teenage years, still had injury because her body was not hormonally ready for sex.

Physical evidence and DNA convicted Emir as did a prior history.

Crossing state lines to come to Mary made it a federal offense and brought the FBI in.

Often the person we least expect is the offender.

While it is rare that females are the offenders in sexual assault, it does happen. Most of the accounts we have are from the prisons. However that is not the only venue for the female aggressor.

When Susan came in stating that she had been raped while on a date, everyone in the ER including the police were quick to say what did “he” look like. Patty, on the other hand, did not refer to the male offender but used the term, “your partner”, and “the offender”. She knew that, although rare, females can be the perpetrator and especially in gay and lesbian couples or in a place where a high percentage of gays lived it was best to use neutral terms until the victim said he or she.

The same, Patty knew, was true when a person came in with a domestic abuse issue. Until the person indicated the sex of the abuser or offender, it was best to keep the offender neutral.

In the case of Susan, Patty found significant bruising and tears from the insertion of a blunt foreign object. She did not, in the end, file charges against the other woman. Part of the reason could have been that she was not ready to come out. Nevertheless, she

was treated for her injuries and talked to Patty several times afterwards in counseling sessions.

One reason they do is the study that Dr. Ann Burgess and her colleagues did at Boston City Hospital. Gail Lenehen, RN, EDD was there helping her from the beginning.

“As psychiatric nurses, they were free from the usual hassles of the ER and were able to concentrate on the psychosocial problems of the rape survivors. In the first year of the study, they followed over 140 victims. The psyche nurses were the first on site SANEs, although they were not yet called by that name. As the psychiatric clinical specialists we could take care of the rape victims with no MI waiting for us. We staffed the ER 24 hours a day, 7 days a week just waiting for victims so that we could learn. If there was a psychiatric patient who needed help, we let the psyche resident take care of them.

Because they could not allow themselves to be distracted by the trauma patients they realized that regular staff nurses from the ER would not fit the bill...at least not right now. They had too many other responsibilities to deal with and could not give the rape survivor the full attention needed.

After all if you worked staff at the emergency room and you had a rape come in, your colleague had to take up the slack where you concentrated on the one patient. This created a lot of tension and it was never quite fair to the victim.

Then they began mentoring a group at Boston City Hospital to follow in their footsteps. The goal of the new group was primary care of the rape victim. While the

resident and gynecologist would still be called in for pelvic exams and general medical care of the victims, those of this new group oversaw the primary patient care.

It wasn't long before the residents found it much easier to just let the nurses do the pelvic exams, unless of course there was something radically wrong. Then the docs would be called in.

Besides doing the actual evidentiary exam, they would do post trauma counseling for a couple of days or even a few weeks thereafter. They would go with the victims to court and support them, much as today's advocate does. Largely volunteer, their only perks were knowing that they were helping others and the time off from their regular duties. Of course they did get straight pay.

The nurse manager of the ER, Pam McLean Johansson, would often schedule them off when they needed to be in court. She gave them leeway to do the research they needed to do.

Most of the non-SANE emergency nurses did not want to do the assault exams and were more than happy to allow those with the passion for justice and the "tedious" paperwork to take the 3 to 6 hours to do a proper exam. Because they lacked the knowledge and feared going to court, the non-SANE nurses felt uneasy and nervous when they were forced to deal with rape survivors.

"At times we were used in court as a "fresh complaint witness"...the first one to hear the utterances of the victim who had been attacked. Sometimes, we are used as experts. They would ask us what the chart meant and if everyone was tested for STDs or if everyone was given antibiotics...or if they could not read someone's writing.

Assuming that was the case, we would say that in our (never to be humble) opinion, this person's symptoms, both physical and emotional, were consistent with someone who was sexually assaulted, but that, not having physically been at the crime scene ourselves, we could only report on what we saw."

And that is what forensic nurses do...report only the facts as they see them. We take seriously the words of Dr. PCH Brouardel, a late 19th century French Medicolegaist, who said, "If the law has made you a witness, remain a man of science. You have no victim to avenge, no guilty or innocent person to convict or save. You must bear testimony within the limits of science."

"At the time we were starting out with Ann in 1971-72 we did not have kits. Then in 1973, there was only Johnson and Johnson, the one company that made rape evidence kits. The kit then was airtight. No one knew then that evidence eroded with the plastic. Chain of evidence was even more crucial then because so few nurses knew about it or understood it. We kept copies of our records and photos in a private file. The rest was shipped over to the police.

"On the edge of the new wave of police work, we often consulted with police and they would ask us questions about sexual assault and sexual homicide. We had a good enough relationship with the Boston police. Often the victims asked us to call for them. At time we had to be able to set the scene for them and encourage their sympathies. For example, "You know she's pretty shaken up about what happened tonight. It was pretty bad. I know she's a prostitute but this is not something that anyone, even a prostitute, should have to go through." Because we were sympathetic, they would be more so.

They came to understand that just because a girl is standing on a street corner doesn't mean she wants to be raped, or that just because a girl is scantily clad, doesn't mean she is giving an open invitation.

“Counselor, our job is to take care of people not just to believe them. The belief comes only when we see evidence to corroborate the story of the events.”

They learned from the victims that the victims, or survivors as they preferred being called, got upset when people treated them with the awkwardness one usually reserves for a situation that you, yourself, have difficulty handling. Following Ann Burgess and her work, the SANEs at Boston City learned how to compassionately ask the questions and how to give the survivors the respect they needed to help regain their self esteem.

Over the years the SANEs have moved away from counseling the survivors post trauma, and from the support we gave them. We have allowed others the privilege of doing that now.

Boston City Hospital wasn't the first rape crisis center. In fact, there were maybe a handful around the country at the time. Like an idea whose time had come, the community was responding more to rape victims in a real fashion. But we were still fighting against a tidal wave of superstition and stereotypes and each program was reinventing their own wheels. Most of them came to the same conclusions, eventually but not easily. That's one of the reasons why it is so important that the IAFN helps the SANE nurses to standard their programs and certify those taking the training.

Five years ago, Rene was a clinical nurse specialist in the emergency room when she started to explore what it was that we did for rape victims. She began to see how uneven, variable and unpredictable the treatment was. Mostly it was based on how busy the ER was that day, who was there and who was willing to do the case. She looked into the protocol for the department and found there was none.

Going to the state capital, she asked them for guidelines. To her amazement, they had none. Rene set about developing a program with guidelines. “They probably didn’t believe I would accomplish anything, so they gave me carte blanche to do something. I did a training video for the whole state. I showed nurses and others how we had to collect the evidence and what had to happen to make the evidence good. Most nurses knew nothing about forensic technique back then. I recognized poor practice and I knew it had to be improved.

I copied a model that was being used in New England. It hadn’t been widely accepted but the assistant DA for Sex Crimes told me to “go for it.” So we developed a pilot program 4 years ago that called for SANE funding by the Department of Criminal Justice.

“The program was still rough around the edges. I had someone directly out of the nursing school. She knew what rape was but she had never dealt with the forensic aspect of it. There had to be more depth. I subscribed to the journal of forensic medicine and read up on child abuse and forensics. Basically, we had to teach ourselves what it was we were lacking and then we had to find the skills to fill in.

“By the time we had done 60-100 exams we had a good basis for teaching. We knew what we were looking for and how to collect the evidence.

“Were we ready yet? Hardly. We trained for adolescent and adult sexual assault but not for pediatrics yet. Kids are our next step. Yet in spite of not knowing, we knew more than the local doctors at the ER who would come to us and say, “Can you look at this child for me.”

“Like being thrown into the fire, we had to cook or burn. Informally, we became quasi experts in what the doctors and other staff did not want to learn.

We had plenty of interaction with the police and plenty of time to educate them about the aspects of rape. I imagine we had an easier time of it then some of the smaller communities where the nurses didn't have as much contact with the police.” The more interaction, the easier it is for the police and nurses to understand each other, to see how they worked, what they needed and where they were coming from. By communicating with the police, we learn what they do and they learn what we do. The respect just naturally follows. We both are working for the same goals so we need to remember that and join a team together. Not fight one another.

“You can't be defensive with them, I learned,” Gail said. “Sometimes they would make a comment that I might think to be sexist or outrageous. I found if I would turn it around and say something like: “It sounds like you don't believe her. What do you think is fishy about the story?”

Gail, doesn't it sound strange that she was driven home by the perp?

“On the contrary. Of the hundreds of victims we’ve seen it happen at least a dozen times. It’s not unheard of for the rapist to be solicitous after the event. Some of the men have the mistaken belief that they are in a “real relationship.” They even ask the women if they would like to see them again. If they don’t drive them home, they ask them where they want to be dropped off and they take them there.”

“You’re kidding!” The cop responded.

“Really,” I’d say. It gave me a good feeling to know that I was educating the cops but I was also giving credibility to the girl’s story.”

Although they did not start out as advocates and have since learned that it was better for the SANEs credibility not to be an advocate for the patient, you can’t talk to hundreds of patients and hear their stories and not become an advocate.

In the early years, we did not pretend to be neutral in court but did the same thing we do now...related the facts as we saw them without interpretation. Our objectivity was questioned then but not as much as you might think.

Julie H is one of the lucky ones to have been able to make her career as a SANE a full time position but it took many hours and lots of work. “I’ve always been committed to assessing interpersonal violence in the community. People shy away from child abuse and domestic violence issues but I was in public health before I became a nurse practitioner. I saw first hand the devastation of domestic abuse and I have always had the well being of the whole person at heart in my nursing problem solving.” That’s why Julie had gone for a degree in psychology before she even entered nursing school. She

soon found that she needed to have a more concrete way of helping people not just emotional and psychological.

As a family nurse practitioner, she began by assessing domestic violence. “Our area had had an increase in DV cases over the past few years and that was pretty surprising since we’re a fairly rural community. As a result Julie began gathering support for a local SART team.

“Sherry Ardnt (one of the IAFN founders and a respected SANE nurse) was speaking in Nevada. Several of us, including our DA went. She was so jazzed by what she heard that in 1994, that she and law enforcement helped us start the SART team.”

They quickly formed a working committee and decided to pattern their group after the successful one in Santa Cruz, Calif. The hospital agreed to buy the colposcope if the DA would run the program and pay the bills. “We were even reimbursed for attending the monthly meetings. We developed a quality assurance program for our SANE nurses and had mandatory photo colposcopy training. If a nurse did not do a certain number of exams a year, she had to attend an annual update. In addition, every case was reviewed in detail by the coordinator both for the quality of the photos and for the outcome of the cases as they followed protocol.

This local team coordinates pediatric and adult exams and found that due to their efforts more suspects were being apprehended. As a result they began doing the suspect exams, too. While other teams in nearby communities fell apart, Julie thinks theirs survived due to good interagency collaboration. “It wasn’t uncommon for me to get a

call from the cops, the hospital, and Children Protective Services all within five minutes of each other about the same case. The strong leadership of the DA also helped.”

For many years, Julie’s SART office was located in the DA’s office. As head of the SART team, she was hired by the Health and Human Services and on loan to the DA. The respect helped her to establish a leadership role in her community and educate people more about violence. As a result more of their cases went to court and those that didn’t plead guilty from the start.

As head of the SART team, Julie was the only full time person with ten other part-timers on staff. The most difficult thing for the other staff has to work two or more jobs to keep their hand in this. But these exams come in waves...we might have three in one night and then not have any for weeks. If you’re the only one on, it really wipes you out.

When not doing exams, she trained and recruited other nurses, did quality assurance, held monthly meetings, budgeted the process, signed bills, stocked the hospitals.” This SART team was not hospital based instead they worked out of two different local hospitals. They did not have a dedicated space but took whatever room in the ER that was available to them moving their equipment from place to place on a set up cart.

After hearing some of the problems other programs had had, she was pleased as to how supportive their doctors were. We saved them from the horror of four-hour exams and of going to court. Now that they realize all we do, they appreciated us.

Julie, herself, trains the nurses to do pelvics (for injury observation) and holds annual pelvic exam training, as well.

Julie believes that one of the successes they have is their cooperation with law enforcement. We talk over everything and try to make our interviews patient or victim centered. Then we come to the conclusion if there is evidence and history that is consistent with evidence of an assault. Because they see Julie and the other SANE nurses as experts, the police now call upon them with questions outside of the realm of sexual assault.

“They’d start to call me and ask my opinion if an exam should even be done. They would say this and this is the case and do you think evidence can be found.” Usually I would give it a shot because sometimes evidence survives beyond the arbitrary date or time we have set.

Julie learned early on to trust her instincts.

While most of the SANE nurse’s patients fall in the category of living forensics, she also deals with the dead, too.

Just a few months ago, a final verdict was reached in the case where Margaret had done a post mortem culposcopy. Now that is a whole different sort of exam.

Not too many people are trained to do this and there are plenty of turf battles here. Even the coroner doesn’t always think to do this because he is not thinking as a sexual assault examiner, but if you see bruising, especially in the thigh area, its always worthwhile to check it out. It could be postmortem trauma, but sometimes it’s not.

The coroner's office is hard pressed to see the use of culposcopy in their work. They told me that there was no place for it there.

The victim was a 40-year-old woman found along the roadway. It was made to look like a hit and run accident. But we had our suspicions and I asked if I could do an exam.

At first I was stonewalled. But finally they let me.

If I had not gone down there and looked we never would have caught the guy. It was her husband.

Granted the findings were visible without the colposcope but you had to know where to look. It has to be someone who is comfortable doing a genital evaluation to understand what the bruising, especially when it is unilateral, on one side, of the labia.

After taking my pictures in the morgue, we sent them to another pathologist for his opine. He agreed that this was consistent with trauma. We called in yet another nurse examiner.

My photos were blown up for court. She testified that this was consistent with the trauma of a rape victim. This was a domestic violence/rape case. The guy got sentenced to life.

I felt good about this and passionate about it especially since the victim could not speak for herself. She couldn't get up and say, "He did it." But with my help, she just about did. I was her voice. Most of my clients do speak for themselves if I listen carefully enough.

A lot of it was the ability and knowledge to use the colposcope and get good pictures.

Barbara S became interested in forensic nursing after she lost her sister to a robbery attempt by someone who used to work for her and was angry. Shot in the head, she was still alive when taken to the hospital and transferred to ICU. “We could see them working on her, but we weren’t allowed in to talk to her even though they and we knew she might expire at any moment. I didn’t like the way my family was treated by the nurses and doctors at the hospital when my sister died. I was working as an aide in the ED at the time. I realized some changes needed to be made and so I went to nursing school.”

If there is a victim in the ER, I let the family in to see them even if we are doing the resuscitation since it might be the last time they see them alive. The family needs to know that you are doing everything possible to save them and if they are shoed out of the room, they don’t know that you’re not just standing around and doing nothing.

“While working as a maternal and child nurse I was exposed to a lot of domestic violence, sexual assault and child abuse. The hospital I worked at didn’t want to set up any program. It took ten years before I was able to convince the hospital to do something.

Working together with Planned Parenthood, we wrote a grant for \$25,000, which we got from the department of criminal justice. The hospital foundation then found a donor to supply the culposcopy. We renovated a special room for us and showed the hospital administration what a community service they would be doing.

Barbara and her friend were the only two to start the program. Being on call 24 hours/7 days a week was rough. In 9 months they saw 50 cases, several convictions, and “I felt validated.”

At first law enforcement did not understand what we were doing, but today they ask our opinion and our relationship allows us to attend programs offered for the police. We also do programs for them. We often talk to the newly promoted detectives and explain what we do, educating them as to the role of the forensic nurse examiner, how we document, what we document. We are just the mediator and document facts, I told them. We write down what evidence we find and document their stories to see if it coincides with the evidence.

Now the police come in and say, “what do you want us to do?” Most of the time, we can let them go on with their work and we will page them when we are finished with the exam. They like this since it frees up their time and they don’t have to wait around for the doctor, x-rays, etc. If it’s a ballistic case or homicide, we take the bullet, label it, sign it and save it for evidence processing it through the chain of custody.

When one of the SANE nurses is on duty in the ER and a victim is brought in, she is given that job and willingly released from her other duties since she is trained to take care of it. If there is more than one case coming in, a back up will be called. There is still a reluctance on the part of the others to care for a rape victim especially when they have not been skilled in the arts and even more reluctance to think they might be going to court.

Since Barbara is now the Nurse Manager of her ER, she can incorporate the SANE work into her clinical practice. As a diploma school (3 year program) graduate, Barbara has had hands on experience. She was not petrified of being with the patients; she was not afraid to try new techniques. While there is still some question as to whether a diploma or a university (four year program) nurse makes the better sexual assault examiner, she feels that it is just important for the passion and willingness to learn to be there.

Now the doctors are grateful to have us and they become upset when one of us cannot be reached for a case. Our local planned parenthood has the rape crisis advocate line.

Talking to several schools, we have educated teachers about sexual assault and the emergency it causes. Sometimes we meet with reluctance and rejection, sometimes with acceptance.

We reach out and talk with college students, especially freshman about date rape. One of the biggest concerns of the college student is that they do not want their parent to know even though the treatment would be covered under the parents insurance. It worries me that the students are afraid to talk with their parents but we have set up payment plans for several of them to pay for the services without their parents knowing.

At the frat and sorority houses, she has lectures on the signs and symptoms of GHB abuse. They need to know what rape is and when to come to the ER.

Now that the SART program is under way, they want to establish a domestic violence program.

The police now respect us and come quickly when we beep them.

Barbara and her group were ecstatic when the ME invited them to the morgue. One of the police officers had listen to their plans and helped them to expand their services to a new level.

Working in a high crime area of North Philadelphia, Pat R has had a lot of experience with sexual assault, not all of it good. Two friends of her daughter were raped. "I saw first hand what it did to the family."

One of my first exposures in the ER was a woman who had survived a gang banging. Each member of the gang had initialed her with a magic marker. This went to court and I was able to give evidence that helped put some of them away."

"It's gruesome work at times and if your focus and your heart isn't in it, you shouldn't be doing it. I spend a lot of my own time doing lectures, inservice to police, labs, woman's groups, schools, helping others who want to take the training, not to mention the every 3rd month Saturday meetings of the Sexual Assault Program, and the DA office when we have a case.

Going out to the high schools I was able to finagle a \$23,000 grant from the city. But that didn't even cover the tip of our costs.

"The contract we managed to get for our hospital includes infants, women and children. But we are not part of the crime victims association and so we only get \$11,000 a year for working when our actual budget runs about \$220,000.

“I got called from a reporter who wanted to do a story about rape and the Philly police. He kept asking negative questions. I had to tell him that the police have gone 110 degrees better than before. There is now a special unit, which handles only sexual assault. Because of what Dr. Ann Burgess has done rape is now elevated to a legitimate crime.

“I’m sure that there are one or two cops who still don’t understand what the fuss is about but there are always going to be hold outs no matter where you are, people with piss poor attitudes.

Unlike some of the other SANEs, Pat has the support of her medical director and head nurse. Some of the earlier director thought that rape was too offensive to deal with and that it was just hookers not getting paid. The people weren’t interested in helping them. But she showed them that it happened to everyone not yet hookers but to middle class and upper class victims as well.

Rape hits close to home and people often don’t want to deal with it. But rape is living forensics.

Still it’s hard for people like the nursing supervisor of Casey H’s day job to understand why she needs time off for court and for speaking with the DA.

“She doesn’t support the SANE program and she puts tons of stipulations on me, like no ER time can be used for SANE cases. This makes it difficult if a case comes in before my shift. That means I am not allowed to clock in until I am finished with case. I loose money and time like that. I’m also not allowed to be on call for SANE while I am on duty in the ER and that can make coverage difficult.”

As one of the Georgia Network to End Sexual Assault (GNESA) nurses, Casey has taken over the training here. Having worked in the ER for over 27 years, she has seen her share of rape, abuse and violence.

“I hated the way the victims were treated in our ER but I didn’t feel I could do anything more than what I was doing. I hated the way they were just “cut loose” to drift through the system. “I always dreaded going to court. Several years back I was approached and asked if I would like to train to a SANE.

“There were several other nurses with me, I am the only one of my original group still working. They said the hours and pay stunk. It wasn’t worth killing themselves for despite the passion they had for justice.

(Everything the SANE did or does in most places is above and beyond her regular job, which she had to keep because the pay for being a SANE, despite the fact it that it required so much more training, observation, time, and work is so much less than a regular nurse’s salary. Much of the time, you aren’t even paid at all for things like going to the DA office to make sure that they will cover the right things in the trial or understand what you can bring to their trial.)

“I define my role as being an evidence collector,” one of the nurses said. “As a SANE nurse I am not a patient advocate. I leave that to the rape crisis people. Of course I want to help the victim but I want to put my concentration on collecting any possible evidence. Identifying, labeling and delivering the evidence to law enforcement are how I can play an important role in the conviction of these offenders. I don’t want any “slip ups” when we get to court.

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Sometimes it takes several tries for a SART to get off the ground. Moving to another state after working in a successful SANE program, Robin felt frustrated that there was no formal program in her new home.

When two-year-old Imelda was brought into the ER after having been brutally assaulted, the police suspected it was a family member. No family members were in on the exam.

Because she had to win the girl's trust, Robin instituted play therapy.

The exam took nearly 6 hours. Afterwards Robin was exhausted both mentally and physically. No one really understood what she was doing until she finished and came up with the evidence she needed that would convict the stepfather.

It was this exam that made her realize that there needed to be something in place to help the victims more.

She networked and pestered the various agency players for over eight months. A lot of people said it had been tried before and they were weary of the fight. Some people said they would help her and then backed down. Others came around and filled the spots left vacant.

The detectives, themselves, were concerned with interference in the investigation. They didn't want some uppity nurses or advocates telling them what to do. The advocates and the agencies were at odds with each other as to who would provide what service. And often no advocate was called at all even for a violent rape.

Having lost a sense of balance, the sheriff's department and the advocates went head to head. No one was quite sure what was happening where or with whom.

Painstakingly and convinced that the program which had worked in her other home could work here if she could get the support, Robin went to one person after another until she found someone in each of the agencies who would support her cause. When she located one, she would hold on to him and get him together with the others she had gleaned in her travels.

“I went first to the DA and got him interested. Then to the sheriff.”

She made them all give her letters of support and put together a formal presentation. Her statistics were impressive. She had listed how many sexual assaults in the area, how many had been prosecuted, how many had won and lost, she gave them prices, too. The average cost was \$975 for the ER and \$100/hour for the nurse. Then the court hourly rate was a conservative \$1500 –2500. Then she showed them the stats of the other areas where the SANE programs had been in effect for a few years and how the prosecutions and won cases nearly doubled and tripled.

She did not want to volunteer “her nurses” even though many of them did volunteer and took time off and out of their own pockets to do the training and the follow up court exams, etc. because she feared that since we, as nurses, are considered the nurturing sort, people come to us and expect us to volunteer. But this wasn't a bake sale they were talking about; this was peoples' lives.

Then came the problem of training. None of the nurses in the local hospital knew how to do exams and none of them were particularly excited about getting the expertise. Finally she garnered 39 who wanted to study the program.

The important thing was consistency in the exam. Once the process was learned and each agency knew who was doing what, it was easier to pick out inconsistency in the victim's stories. "If she was tightly tied up for 12 hours, how come there are no marks on her wrists."

"Sometimes I would come to work and find parts of the rape evidence kit strewn across the room. It concerned me. I knew that we had to raise the standard so that we had credibility and so that we collected the evidence in the correct way. Each exam had to be done the same way each and every time.

I knew that once we did this, our court time would decrease drastically. No defense in his right mind would want us because it would just damage his case. And the DA wouldn't need us because we would be so consistent each and every time that he would have the complete information he needed.

Many of the nurses dropped out after a time. The hours were terrible. Robin found herself taking call five nights in a row and being worried about her safety on the job. She had the policy rewritten so that the advocate showed up everytime as well and a few others nurses came on board.

None of the nurses, even those who really wanted to continue, could afford to do this job alone, so they all had to work other jobs. "It was a hard row."

She now has 10 nurses who work with her and she takes call when she can but as a single mom, it's not easy. The ones who truly believed in the cause of justice and in the facts were willing to make the sacrifice. The DA now has only glowing things to say. Robin isn't about to remind him how long it took for him to see the light.

Now, instead of fighting with the detectives, they call her at the house and tell her they have a sexual assault victim coming in and does she want to head on up to the hospital. Now, with the streamlined set up they collaborate not on the patient story but on the process, communicating much better and more effectively.

It even gives them a chance to go out for coffee and pie (or solve a few other crimes) while the nurse is doing the exam since they no longer have to hang around the ER waiting and waiting and waiting.

"Probably the most important thing is educating the public on how we work," Robin said. "If they understand that the SANE can help them get their case solved quicker, they will know to ask for us. We offer an unbiased approach for collection of evidence that is gotten in such a way that it can be used if they need it now or later.

They will also know what the definition of a rape is," she said referring to domestic violence rape. Too many women who are married believe that it gives their husband the right to use them anytime they want. Many of the abusers seem to get off on the pain and humiliation they cause their wives.

In fact, that is Robin's next step, a domestic violence clinic. Approaching tactfully, diplomatically, and establishing a rapport with the police is one of the most crucial things a SANE can do. "I don't want to do their job and they don't want mine.

We need to let them know that we are not out to get them. We just need to work together to make a stronger case.”

The death of her friend Nancy, who was a driving force in the creation of the local SANE, was what propelled Sara forth. They had been frustrated with their jobs as ER manager and head nurse but didn't know what to do about it. Both had gotten caught up in the passion of Virginia Lynch's speaking and began a journey, searching for anything about forensic nursing that they could get their hands on.

Taking their SANE training in a nearby state, they worked diligently to get a program set up near them. Sara felt that she had to go back and get her master's. With an NP, she had more clout, but she also felt anxious to get the program started. Her plan was to have a SANE nurse on call for every shift. Easier said than done especially with not enough to pay them.

She finally convinced the hospital to approach the Governor's Office where a crime commission had been set up. She supplied them with facts, figures and stats about the number of rapes, prosecutions, etc.

One of their crowning glories was getting the crime commission of the state to pay for the colposcope. There was still the issue of where to have the victims brought since they had no separate room that was really theirs.

Lingering still as an ER nurse, Sara was approached by the Pediatric Department to start a child abuse program. They wanted a SANE to do the exams. Still, there was no money. She knew she had to take it one day at a time.

Finally one of the university hospitals donated the space.

The doctors here were eager, it seemed, to let go of the rape exams and hand them over to the SANEs especially when it came to that ever present 2 am call and those long hours in court.

“It’s real gratifying when we help to convict a guy.” She said about a case where she had recently been to court for the first time as an expert witness. The suspect received 18 years because the nurse had found multiple peritoneal lacerations. Her testimony had swayed the jury.”

The jury needs to know in layman’s terms what different parts of the body are and what exactly the posterior fourchette is at the bottom of the vagina. They also need to know that the nurse is doing the exams because she had the time to spend with the patient.

There are still the others in the ER who need to be educated. They had a rape victim come in recently and had already admitted her upstairs with intubation. The tube was taped in such a way that it would have caused necrosis, dead tissue, near her mouth. This had to be documented. Yet no pictures of the victim had been taken.

Once the injuries are addressed, the exam and history has to be taken as soon as possible afterwards. Anything that was done to repair the injury has to be noted on the chart so that it will not be confused with harm done by the offender.

“I do drawings with my charting so that I can write down accurate measurements and a description of where on the body the injury is as well as any force used. Actual quotes the victim says are among the most important.”

It's gratifying when the detectives come in and rather than throwing the rape victim to the winds of the ER general staff, they now know to ask for the SANE to be called. "We act as though they are part of our team. If they want to sit in on the exam, we're happy to let them though most chose not to do it." Sara also feels that it is important for the nurse to do ride alongs so that she can understand better what the cops experience, how they do their jobs, and their hierarchy.

Having had people in her own family assaulted, Nan found herself uncomfortable at the way they were being treated. She realized that the community needed a liaison between them and the advocates.

After hearing Sandra Goldstein's lecture, Nan was inspired to start her own training program.

It failed miserably. No one in the community saw the need or if they did, they didn't want to do the work.

"At least they were able to focus on domestic violence and Nan is happy getting started in this area." She knows now that you can't force a program like this on an area. They just don't have the ability to look at rape right now. They don't want to see it as a problem here.

In spite of that, Nan has been asked to testify on a couple of cases including one where she found sperm in the vagina after an acquaintance rape.

The worst thing is when the victim, herself, lacks credibility. "I had one hell of a case a bit ago. There was so much evidence it was unreal. Bite marks to swab, motile

sperm. Plenty of DNA but because the woman was a crack addict and had been going to get her supply for the day the DA did not want to press charges. I've seen cases like that more than once. We have to educate the DA, the police and the public that no one deserves this kind of violence happening to them, no matter who they are or where they were going when it happened. And everyone has the right to say no."

Nan still hopes to get a SART going one day but to do it right they'll need a colposcope, which costs more money than the infant program had.

Right now she's content to talk with the residents and with police on a regular basis, training them to ask about drug, alcohol and sexual history as well. She points out places of injury and possible evidence while the resident does the actual collection.

Sandra O decided to set up a SART unit rather than do a thesis for her master's. "I wanted to do something that would make a difference in peoples lives. So I asked various colleagues in the ER what would make the most difference. One of the risk managers suggested investigating sexual assault.

"As soon as I found out about it, I was sold.

"Doctors," she says, "are constantly astonished at how much they miss. Even so, it took them five years to come around. Many of them remained territorial for some time. They were regarding the victims as their patients even though they didn't want to serve them. They felt they were losing something when they weren't.

"Now they are sending us patients and are so spoiled that they have a fit if the nurse can't do the pelvic. That feels good.

“The prosecuting attorney was reluctant to put nurses up as expert witnesses. He was not familiar with the concept and feared that the MD s would get territorial. We were told the fact-finding group got as far as a task force.

“What would convince you? We asked.

“Jurors understanding that the nurse could be as effective as the MD.”

“He never expected to hear from us again. But we fooled him. We went to every grass roots meeting in the county. We sent out letters to newspapers, talked to woman’s groups, talked to church groups, schools, universities, or any place that would have us. We met with nurses all over as well. And we set up an information center with key facts about the various cultures in the area, too. We asked each and every person we talked to, to write letters to the DA s office.”

Finally, they got the approval of one hospital who was willing to take the up front risk and sponsor them. “They were still afraid of being run into the ground financially. But we promised we would get the billing squared away so that they would not suffer. We were able to convince our hospital attorney to talk to the DA. Both being attorneys they talked the same language. She helped me gather other letters of support from other attorneys.

“One thing that sold the DA and the police was our willingness to go over all the sexual assault medical records for him. In the past, he had been at the mercy of the medical librarian who really did not know what was important or not in proving rape.

Reading those records helped us to realize how important the clients excited utterance, or actual words made. It was a good collaborative effort. We learned from the police and they learned from us.

“I remember that final day when we met with the DA. I was on jury duty and supposed to be in the on call room, instead I was on the phone calling everyone for letters of support.”

“We had one detective who had been working sex crimes for a while and saw the horrors of it and had seen some awful treatment of the rape victims by some of his colleagues who should have known better. He did so much volunteer work for us, it was amazing.”

The next step for them is starting up a DART (Domestic Abuse Response Team). Staffing and budget are the biggest obstacles for both. “Maybe we can get some of the lawmakers do something about this.”