MEDICAL FORENSIC SEXUAL ASSAULT EXAMINATIONS: WHAT ARE THEY, AND WHAT CAN THEY TELL THE COURTS?

By

Lynn Hecht Schafran, JD, Director,
National Judicial Education Program, Legal Momentum

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Rape is an epidemic crime with grave consequences for victims female and male,[1] and those who identify as transgender.[2] Few victims report,[3] and even fewer see the inside of a courtroom.[4] When a sexual assault case does come to trial there are often expectations about the kinds of injuries a "real" rape victim sustains, how the victim will present on the witness stand, the kind of medical evidence that will be offered and by whom, and what the medical evidence can "prove." These expectations are often at odds with reality and undermine fairness in the trial process. The findings of a medical forensic sexual assault examination and the testimony of a specially trained Sexual Assault Nurse Examiner (SANE) can provide useful information to help the judge and jury reconstruct the events at issue. However, there are important legal limitations on the scope of SANE testimony, as well as limitations as to what the examination findings can actually prove.

The medical forensic sexual assault examination is first of all a medical examination focused on the patient's immediate, short term, and long term health and safety needs, physical and mental. The examination integrates evidence collection into the medical examination because combining these steps is best practice from the viewpoint of patient-centered care, sparing the patient from a subsequent long and harrowing examination if she decides to report to

law enforcement. SANEs report that many, if not most, of their patients want medical care, but do not engage with the criminal justice system.[5]

Optimally, the examination is conducted by a specially trained health care provider. This may be a registered nurse or nurse practitioner – hence SANE (Sexual Assault Nurse Examiner). If the trained examiner is a physician or physician's assistant, the term is SAFE (Sexual Assault Forensic Examiner). SANEs complete rigorous classroom and clinical training based on guidelines developed by the International Association of Forensic Nurses (IAFN). The field is constantly evolving and SANEs participate in extensive continuing education.

SANE programs emerged in response to the poor treatment rape victims encountered in hospital emergency rooms. Although victims are instructed not to bathe or urinate after an assault in order to preserve evidence, victims were often made to wait for hours because their cases were not seen as urgent. Uneducated medical staff asked victim-blaming questions and did not understand that absence of bodily injury did not mean the victim was not profoundly injured psychologically. Untrained medical personnel were inept at evidence collection and sometimes resentful of the complex, hours-long examination and detailed documentation required.

SANE programs were first established in the 1970s and flowered in the l990s. Today there are approximately 700 programs, far fewer than needed. Many communities cannot afford to establish or maintain SANE programs, and many victims are still examined by whomever is on duty in the ER. Researchers are trying to address this unmet need with telemedicine

Components of the Medical Forensic Sexual Assault Examination

Understanding what a medical forensic sexual assault examination entails is crucial to understanding the value and limits of testimony from a SANE or SAFE in a sexual assault case. The following section provides an overview of the examination process as specified in the

National Protocol for Sexual Assault Medical Forensic Examinations, developed by the Department of Justice Office on Violence Against Women.[6]

The patient is first examined, assessed, and treated for immediate, acute medical needs. If the patient reports circumstances indicating drug-facilitated rape, urine and blood samples are collected immediately. Each step of the examination is recorded on a comprehensive Sexual Assault Assessment Form, usually specific to the jurisdiction. The SANE must obtain informed consent to begin the medical examination and then separately for each subsequent step, including evidence collection and releasing evidence to law enforcement. The patient may consent to one part of the examination but not another, and may withdraw consent to the examination, or any step of it, at any time. For example, she may consent to the SANE swabbing an area where the assailant licked her, in order to obtain a DNA sample, but refuse consent to photographing her internal injuries.

After the examination is complete, the patient is asked whether she wishes to release the kit to law enforcement or have it stored for possible future release. If she wants it stored, she must be told for how long the hospital in her jurisdiction will store the evidence collection kit before destroying it, so that she knows how long she has to make a decision about reporting to law enforcement.

Patient's Demeanor and History

After attending to the patient's immediate medical needs the SANE records the patient's orientation, general appearance, behavior, and responsiveness to questions. Ascertaining the patient's orientation – does she know the date? the president's name?—is essential to determining whether she can give informed consent.[7] If the patient is confused and not

responsive to questions it may mean that she was drugged, calling for urine and blood samples to be collected.

Next the SANE takes the patient's detailed medical history.[8] This is essential for guiding the examination, understanding examination findings, and administering prophylactic medications at discharge. For example, reproductive/genital surgery and health conditions affect the appearance of genital structures; medications prescribed at discharge may interact negatively with medications the patient is currently taking.

SANE Documents Patient's Account of the Assault and the Assailant

The SANE records the patient's account of the assault because, once again, it guides the medical examination, evidence collection, treatment provided, and discharge planning. The SANE's role is not to investigate on behalf of law enforcement to determine the veracity of the victim's account. SANEs make no judgment as to the veracity of a patient presenting with a complaint of sexual assault or the patient's account of the assault. Taking patients at their word is not unique to sexual assault cases. It is the basis for the Medical Hearsay Exception which assumes that patients tell their healthcare providers the truth because it is in their own best interest to do so.[9]

The SANE records the circumstances surrounding the assault: date and time, physical surroundings during the assault, whether patient had the ability to give consent, consumption of drugs/alcohol. How did the assailant compel submission: overt threats to harm the patient or others, implicit threats based on history of violence against the patient, threats with weapons, or physical force such as grabbing, hitting, slamming, biting, torture, or strangulation? The SANE next records the specifics of the assault. Are there areas of the body where the assailant bit, licked, or spat on the patient that should be swabbed for DNA? Was there oral penetration which

would require mouth swabs? Was there anal penetration, requiring an anogenital exam? The SANE also documents information about the assailant: name, if known; relationship to patient; number of perpetrators if more than one. Knowing who the assailant was is essential for discharge and safety planning, described below.

Head-to-Toe Assessment

Using visual inspection and palpation, the SANE conducts a head-to-to, front-to-back assessment of the patient's physical condition based on the patient's account of the assault and areas where pain is noted. Using body maps, the SANE documents, draws, and photographs any injuries observed, from tenderness to trauma, including location, size, shape, color, swelling, redness, tears, abrasions, and bruising.

Visible physical injury findings can range from none to severe. Bruising, tearing, abrasions, swelling and petechiae (small red or purple spots from minor capillary bleeds) may be seen in external and internal injuries. Pain, alone and/or with activity and decreased range of motion, are injury symptoms patients commonly describe after a sexual assault, even in the absence of visible injury.

Contrary to stereotype, rape victims rarely sustain severe physical injuries. In a large-scale, national study funded by the National Institute of Justice, only 6% of drug-facilitated/incapacitated rape victims and 16% of forcible rape victims reported serious physical injuries.[10] Most rapists employ only instrumental violence, meaning the minimum threat or force needed to make their victims submit. Often victims do not resist because fear-induced psychophysical states render them passive or paralyzed: in a freeze (deer in the headlights); in a dream-like state called dissociation in which the victim relinquishes all initiative and struggle; or literally paralyzed by tonic or collapsed immobility.[11] Some victims make a strategic decision not

to resist because they fear severe physical injury or death, or to protect someone else who has been threatened, like a child. The absence of genital injuries is discussed below.

Detailed Genital Assessment

SANEs are trained to examine both female and male sexual assault victims. The SANE examines the patient's external genitals, anus, vagina, and cervix for injury, utilizing aids to accurate visualization as described below. Using genital maps of external and internal genitalia she documents and describes any injuries, again noting location, size, and appearance.[12] The principle aids to visualizing and recording genital injuries are the colposcope with photographic capabilities, the digital camera, and Toluidine blue dye.

•Colposcope: A magnification device used to view possible external and internal genital injuries, such as abrasions and lacerations, which are difficult to see or easily missed with the naked eye.

•Digital Camera: Many SANE programs use a digital camera only. Photographing genital injuries is controversial because of the risks to patient privacy. [13]

•Toluidine blue dye: This is a staining technique in which dye adheres to small areas of abraded skin and microlacerations, resulting in identification of otherwise invisible injuries.

Many female victims have no genital injuries when they are examined due to factors such as the elastic, muscular, anatomical structure of the vagina; healing that occurs between the assault and reporting; and the victim's age and health.[14]

Sexual Assault Forensic Evidence Kits

Kits are known by various names such as Sexual Offense Evidence Collection Kits (NY), and Sexual Assault Evidence Kits (NM). The kit is a cardboard box or large envelope containing

the equipment and containers needed to collect and store the biologic and non-biologic evidence from the patient's body and clothing.

Kit contents vary by state and locality and are periodically updated to reflect new evidence collection techniques. A typical kit includes: precise instructions for each step and storage; bags and sheets of paper for evidence such as victims' clothing; swabs for collecting fluids from lips, cheeks, thighs, vagina, anus, buttocks; combs to collect hair and fibers; envelopes for hair and fibers; blood collection devices; and documentation forms. The SANE changes gloves between each step to avoid cross contamination of evidence. She places each type of evidence in its own bag or bindle and, as she goes along, seals and labels each item with the type of evidence collected, the date, and her initials.[15]

Times Frames for Evidence Collection

New techniques are constantly expanding the time frames for evidence collection. Until recently the standard evidence collection cutoff time was 72 hours from the assault. Now many jurisdictions have cutoff times of 120 or 134 hours (5-7 days). Traces of certain drugs can now be detected in a urine sample up to 120 hours after assault. New DNA technologies are also enabling forensic specialists to analyze DNA from sexual assault examination kits and other types of evidence long in storage, often due to the failure of police departments nationwide to test these kits in a timely manner.[16]

Discharge and Safety Planning

An essential part of the medical examination is the discharge plan, which SANEs prepare for sexual assault victims as they do for all patients. SANEs provide these patients with treatment to prevent sexually transmitted infections and pregnancy and instructions for wound care, if needed. If there was strangulation, the SANE explains the serious sequelae that may emerge after

discharge, ranging from the need for speech therapy to brain damage. The SANE makes recommendations for follow-up examinations, counseling, advocacy services, and safety planning. Referrals for follow-up and counseling are extremely important because of the significant physical and mental health consequences of sexual violence, ranging from chronic pain to suicide. Victims have described rape as "soul murder."[17]

Part of discharge planning is safety planning to ensure patients are going to an environment where they will be safe and receive any necessary follow-up care. When taking a rape victim's account of the assault, SANEs ask about her relationship to the perpetrator in order to craft a plan specific to the patient's health and safety needs. The victim of an intimate partner rape may need a referral to a domestic violence shelter or help to identify another safe place to which to return. Because intimate partner sexual assault presages increasing physical and sexual violence and potential lethality, individualized safety planning for these patients is critical.[18]

SANEs IN THE COURTOOM

The SANE's role is to be an objective, neutral healthcare professional prepared to testify for the prosecution or defense. A SANE may testify as a fact witness, a fact and expert witness, or an expert witness only. As a fact witness the SANE may relate the patient's account of the assault under the Medical Hearsay Exception,[19] not for the truth of it, but to explain how the account guided the SANE's medical examination, evidence collection, and discharge planning. The exception for statements made for medical diagnosis or treatment generally applies to statements made by a patient to a SANE during a medical forensic sexual assault examination or a follow-up. If the patient is not available to testify there may be challenges to the SANE's testifying as to the patient's account of the sexual assault. This is discussed below under *Crawford v. Washington*.

As a fact witness only, the treating SANE may testify about anything observed or said during the examination or follow-up, but may not offer an opinion as to the causation of any injuries observed.[20] After describing her own training and experience the treating SANE testifies about what she did and what she observed in each step of the examination including:

- Patient's demeanor at start of and during exam
- Patient's appearance and that of her clothing when she arrived
- Why patient was asked to undress while standing on an evidence collection sheet
- Bagging clothing for evidence collection kit
- Head-to-toe and front and back examination and findings
- Photographs of any external injuries
- Genital examination and findings
- Use of Toluidine blue dye, Colposcope, and/or digital camera to better visualize and record possible genital injuries
- Why and how the SANE swabbed certain body parts for fluid evidence, and how she dried and stored those swabs for collection

A SANE testifying as a fact witness only may testify, for example, about bruises observed at various sites on the patient's body and explain that she asked the patient to return for a follow-up examination to more accurately document the bruising because bruises are not fully visible until a few days after the causation event. The SANE may not testify that in her opinion the bruises were caused by blunt force trauma.

The SANE as an Expert Witness[21]

A SANE's qualifications to be an expert should be assessed from the standpoint of actual experience and currency in the field rather than academic degree. SANEs are sometimes

challenged because they are not doctors, but a SANE who has conducted multiple medical forensic sexual assault examinations, participates in continuing education, and uses the latest equipment is an expert. An ER or private doctor who lacks specialized training and has conducted only a few of these examinations is not, nor is an inexperienced SANE. Because many jurors assume that medical evidence must be presented by a doctor, or that doctors are always more knowledgeable than nurses, judges should allow time for whichever party is proposing the SANE as an expert to fully elicit her credentials before the jury during qualification.

If the treating SANE is qualified as an expert, she may testify as a fact witness about anything said or observed during the examination and, as an expert, offer a limited opinion as to the cause of any injuries observed. For example, if the examination revealed bruises on the patient's body, a treating SANE qualified as an expert may offer an opinion that the bruises were caused by blunt force trauma. Though the SANE cannot opine as to the ultimate issue of fact (discussed below), she can testify as to whether or not an observed injury is consistent with the patient's account of the assault and with the injuries related to sexual assault described in the medical literature. An expert SANE may also explain aspects of the medical forensic examination that may be puzzling to judges and jurors. She may explain, for example, that it is common for a sexual assault victim to delay reporting or seeking medical care, to display nervous laughter or no emotion at all during the examination, and to have no physical or genital injuries after the assault.

Non-treating SANE Experts:

A non-treating SANE qualified as an expert may offer an opinion on the examination findings, and explain puzzling aspects of the examination, in response to hypothetical questions based on the facts offered in evidence, as the following example demonstrates.

Injuries Observed Case:

Q: Now, I want to ask you a hypothetical question. For purposes of this question, assume the following facts:

> Patient is a 24 year-old woman who presents at the ER with complaint of rape 12 hours before the examination. Patient stated that perpetrator held her down by the shoulders, bit her left breast and forcibly penetrated her vagina with his finger and penis. The following injuries were noted: 5 cm abrasion on left breast consistent with bite mark, erythema on the right labia majora, [22] 2mm laceration on the posterior forchette.[23]

Based on your education, training, and experience, are you able to form an opinion to a reasonable degree of scientific certainty about whether the injuries observed are consistent with the history of the assault the patient gave? What is that opinion? Can you explain why you formed that opinion?

A non-treating expert SANE may also be called to testify in a case in which there was no medical forensic examination, either because the victim never sought medical treatment or sought treatment after the cutoff time for a forensic examination. She can minimize the "CSI Effect"— the expectation that extensive forensic evidence will be presented that can help "prove" whether or not a sexual assault was perpetrated — by explaining that many victims live in communities that cannot afford to establish or maintain SANE programs, or in rural communities with no access to medical care. She can explain that victims often do not seek medical care because they fear the police, fear not being believed, or fear being deported. Victims assaulted by someone they know may require time to come to grips with the fact that someone they trusted, such as a friend or intimate partner, betrayed them.[24] An expert SANE can

also help fact finders understand counter-intuitive victim behavior that may have been an issue in the case such as delayed reporting, post-assault contact with the perpetrator, or why the victim displayed a flat affect while testifying.

The Ultimate Issue of Fact :

Whether testifying as a fact witness or an expert, SANEs may never offer an opinion as to a defendant's guilt or innocence. This is the ultimate issue of fact for the judge or jury to decide. "Rape," "sexual assault," and "consent" are legal conclusions, not medical diagnoses that can be determined from a medical examination. Cases in which the SANE has stepped over the line have resulted in mistrials, reversals, and remands. In *State v. Hudson*, 2009 Wash. App LEXIS 1358, the defendant appealed his third-degree rape conviction for anal rape on the grounds that the trial court improperly allowed two SANEs to opine as to his guilt. The examining SANE documented deep vaginal and anal lacerations, but neither she nor her supervising SANE, who also testified, limited their opinion to whether the victim's injuries were caused by blunt force; they testified that the sexual encounter was not consensual, which was the only disputed issue. The appellate court asserted that the nurses' "sole reason" for believing that the victim did not consent was that the sex must have been extremely painful. Such reasoning was not based in medical or any other specialized knowledge that was beyond the average layperson. The judgment was reversed and remanded for a new trial.

DNA Analysis and Testing for Drug-Facilitated Rape:

A SANE is not a DNA expert. She collects swabs and samples from which a DNA laboratory determines whether DNA is present, and, if possible, to whom it belongs.

A SANE is not a toxicologist and cannot say whether a patient had drugs in her system. When a drug-facilitated rape is suspected, the SANE takes blood and urine samples for a

laboratory to analyze. The SANE may testify as to the aspects of the examination that led her to suspect drug-facilitated rape; for example, the patient's having no memory of the time between swallowing a drink handed to her at a party and waking up in a parking lot. The SANE may answer questions such as whether there are drugs that can cause memory loss. She can explain the protocol for collecting samples for a toxicology screen in her jurisdiction.

In *Bullcoming v. New Mexico*, 564 U.S.36 (2011), a DWI case involving a blood alcohol test, the U.S. Supreme Court ruled that only the laboratory technician who performed the analysis can testify as to the findings. For sexual assault cases, this ruling applies to laboratory tests for DNA and for drugs administered in drug-facilitated rapes.

What Can a Sexual Assault Medical Forensic Examination "Prove"?

A medical forensic sexual assault examination cannot determine whether or not a sexual assault was perpetrated. It cannot "prove" source or causation of injury. It can provide objective documentation of examination findings that, when considered in the context of all the evidence, will assist the judge and jury in reconstructing the events in question and determining whether or not there was a sexual assault. The limitation on how much a medical forensic sexual assault examination can tell the court is not only due to the fact that "rape" and "sexual assault" are legal conclusions, not medical diagnoses. Often, some or all of the examination findings can be interpreted by the prosecution and defense as having different theories of causation, as the following examples demonstrate.

Non-Genital Injuries:

The patient has no memory of the time between ingesting a drink handed to her in a club and waking up in a parking lot. In response to the SANE's questions about her voluntary alcohol consumption, the patient reports having several drinks before the drink in question. In response

to the SANE's question as to whether she vomited, the patient reports that she vomited copiously. The SANE's examination of the patient's mouth reveals that the back of the upper part of the mouth called the soft palette was very reddened and appeared to be irritated.

During trial, the prosecutor elicits the information about redness and irritation from the SANE, who has been qualified as an expert, and asks if she has an opinion as to the cause. The SANE responds that the findings are consistent with blunt force trauma. The prosecutor thus creates the implication that the patient was subjected to forced oral penetration by the defendant's penis. On cross-examination defense counsel asks the SANE if the redness and irritation at the back of the patient's throat could also have been caused by her copious vomiting, and the acid coming up from her stomach. The SANE replies that it could. [25]

This is as much as the SANE is able to tell the court based on the examination: the redness and irritation on the patient's soft palette are, in the SANE's opinion, consistent with blunt force trauma, but they may also have been caused by copious vomiting. It is now up to the prosecution and defense to integrate the SANE's testimony into the narrative each presents in its closing, placing it in the context of all the other facts addressed. The jury or, in a bench trial, the judge, decides which explanation of this particular injury to the patient they find most credible.

Genital Injuries:

The medical forensic sexual assault examination can document findings, if any, of injury to the external and internal genitalia. But injury itself is not definitive for sexual assault; the types, quality, or location of injury do not necessarily allow SANEs to differentiate injury from assault from injury from consensual sex. The majority of anogenital injuries identified on exam are nonspecific, meaning they could have been caused by either consensual or non-consensual contact. On occasion, the SANE may note injuries difficult to ascribe to consensual contact, such

as deeply seated lacerations in the vaginal vault, or extensive injury requiring surgical repair. But even then the SANE, who must have been qualified as an expert, can only comment on whether or not the injuries are consistent with the patient's account. Research is ongoing with volunteer heterosexual couples who are examined shortly after consensual vaginal-penile intercourse to determine whether and where they have tears, bruising, or other genital injury, and to compare these findings with data from injury patterns recorded for women subjected to non-consensual vaginal-penile penetration. [26]

Confrontation Clause Issues - *Crawford v. Washington*

If the SANE's patient is unavailable or unwilling to testify and be cross-examined, may the SANE testify as to the patient's account of the assault under the medical hearsay exception? *Crawford v. Washington*, 541 U.S. 36 (2004) and its progeny [27]established rules for when such testimony is and is not permissible for Confrontation Clause purposes. This is rarely a problem in adult victim sexual assault cases because prosecutors rarely go forward without the victim/witness. However, if, for example, she is seriously ill or died before trial, whether the SANE may testify depends on whether the court characterizes the victim/witness' account of the assault to the SANE as "testimonial" or "non-testimonial." "Testimonial" means the statements were made for the primary purpose of establishing past events in furtherance of a future prosecution. "Non-testimonial" means the statements were made for the purpose of receiving help in an emergency. When a SANE is perceived as acting as an arm of the law, the victim/witness' statements will usually be considered "testimonial." When a SANE is perceived as acting as a healthcare provider for whom the forensic evidence collection is secondary, the victim/witness' statements will usually be considered non-testimonial. If the victim/witness

refuses to testify because of threats from the alleged assailant if she does so, her statements may be admissible under the doctrine of forfeiture by wrongdoing.

- In *State v. Stahl*, 111 Ohio St. 3d 286 (2005), the patient died before trial from causes unrelated to the rape. The SANE's testimony about her examination made clear that she was first and foremost conducting a medical examination. The patient's statement was held to be non-testimonial and the SANE was permitted to testify about the patient's account of the assault.
- In *State v. Bennington*, 264 P.3d 440 (Kan. 2011), the court held that because the Sexual Assault Comprehensive Arrest Form the SANE utilized during the examination was developed by local law enforcement, the patient's statements were testimonial and the SANE could not testify as to the patient's account of the assault.

The Importance of SANE Testimony

Although a SANE's testimony is limited in scope, nothing better demonstrates the importance of admitting expert SANE testimony to educate a jury and promote fairness in deliberations than what might be called a tale of two judges. Several years ago a Bronx, N.Y. sex crimes prosecutor wanted to call an expert SANE to explain that the victim's absence of injuries in the case at bar did not mean she had not been raped. The judge refused to allow it on the ground that injury was not an element of the crime. The jury acquitted and told the prosecutor that the absence of injury was a key point in their decision. Recently a Virginia judge presented a judicial education program for the new judges in her state based on the National Judicial Education Program's publication *Judge's Tell: What I Wish I Had Known <u>Before</u> I Presided in an Adult Victim Sexual Assault Case.*[28]A few weeks later, one of these new judges told her that he had just presided in his first sexual assault case, and had he not attended her program, he would

not have believed the victim was a victim, because she did not have the terrible physical and genital injuries he had always believed were the hallmark of non-consent. [29] ■

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[1] According to the Centers for Disease Control, 1 in 3 U.S. women and 1 in 71 U.S. men has been raped at some point in her or his life, in the vast majority of cases by someone the victim knows. MICHELE C. BLACK, ET AL., NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL, CENTERS FOR DISEASE CONTROL AND PREVENTION, THE NATIONAL INTIMATE PARTNER AND SEXUAL VIOLENCE SURVEY (NISVS): 2010 SUMMARY REPORT, (2011). Because the vast majority of victims are female, this article uses female pronouns when referring to victims.

[2] According to the Office on Victims of Crime, 50%-66% of transgender people have been raped at some point in their lives. *Responding to Transgender Victims of Sexual Assault*, OFFICE FOR VICTIMS OF CRIME, OFFICE OF JUSTICE PROGRAMS, U.S. DEPT. OF JUSTICE, *http://www.ovc.gov/pubs/forge/sexual_numbers.html*.

[3] A national study of rape victims found that only 18% of forcible rape victims and 10% of drug-facilitated/incapacitated rape victims reported the crime to law enforcement. DEAN KILPATRICK ET AL., DRUG-FACILITATED, INCAPACITATED AND FORCIBLE RAPE: A NATIONAL STUDY, at 43 (2007), www.ncjrs.gov/pdffiles1/nij/grants/219181.pdf.

[4] An extensive study of attrition between victimization and conviction found that for every 100 rapes, 5%-20% were reported, 0.4%-5.4% were prosecuted, 0.2%-5.2% resulted in conviction, and .02%-2.8% resulted in incarceration., Kimberly A. Lonsway & Joanne Archambault, *The 'Justice Gap' for Sexual Assault Cases: Future Directions for Research and Reform*, 18 VIOLENCE AGAINST WOMEN 145 (2012), *available at*: http://counterquo.org/reference-materials/sexual-violence/assets/files/Justice%20Gap%20paper%20Lonsway%20Archambault.pdf.

[5] Because many victims seek medical care but do not report to the police, VAWA explicitly bars states from requiring victims to cooperate with law enforcement in order to receive a medical forensic sexual assault examination.

[6] The *National Protocol for Sexual Assault Medical Forensic Examinations* was developed by the Department of Justice Office on Violence Against Women, pursuant to the Violence Against Women Act (VAWA), to ensure that all sexual violence victims receive trauma-informed, compassionate, competent medical care, and that forensic evidence is correctly collected and maintained to be available if there is a report. The *National Protocol* is available at: https://www.ncjrs.gov/pdffiles1/ovw/241903.pdf.

[7] Patients of all kinds are brought into the ER in a disoriented or even unconscious state, unable to give informed consent. ERs usually have their own protocols for determining how to care for these patients.

[8] In a trial the defense may seek the victim's medical history to show that someone other than the defendant is the source of semen, disease, or injury, raising rape shield law and confidentiality issues. Judges should require an offer of proof as to why the defense believes these records are needed, and examine them *in camera* if that next step appears warranted. Access to any released records should be kept to the absolute minimum with sanctions for anyone leaking records to the press or internet.

[9] Federal Rule of Evidence 803.

[10] KILPATRICK ET AL., *supra* note 3, at 31-32.

[11] Rebecca Campbell, *The Neuroscience of Sexual Assault*, Webinar for the National Institute of Justice (2012), http://nij.gov/multimedia/presenter/presenter-campbell/Pages/welcome.aspx; David Baldwin, *Primitive Mechanisms of Trauma Response: An Evolutionary Perspective on Trauma-Related Disorders*, 37 NEUROSCIENCE AND BEHAVIORAL REVIEWS 1549 (2013).

[12]Diagrams and a glossary of terms for female and male genital structures are included in the online curriculum from which this article is condensed. These terms are used in recording findings from and testimony about a medical forensic sexual assault examination. National Judicial Education Program,

Medical Forensic Sexual Assault Examinations: What Are They, and What Can They Tell the Courts?, https://www.legalmomentum.org/training-materials/medical-forensic-sexual-assault-examinations-what-are-they-and-what-can-they-tell [hereinafter *Medical Forensic Sexual Assault Examination Curriculum*].

[13]Access to any released photographs should be kept to the absolute minimum by establishing strict rules, such as photographs may only be seen by the defense attorney in the courthouse or the prosecutor's office, and making clear that anyone leaking these photographs to the internet or the press will be strictly sanctioned.

[14]*Medical Forensic Sexual Assault Examination Curriculum*, *supra* note 12.

[15]A detailed explanation of the contents of a typical kit is available in the curriculum on which this article is based: *Medical Forensic Sexual Assault Examination Curriculum*, *supra* note 12.

[16] Editorial. *Victims Deserve Better than the National Rape Kit Backlog*, L.A. TIMES, March 10, 2015, *available at*: http://www.latimes.com/opinion/editorials/la-ed-rape-kits-backlog-20150310-story.html.

[17] Lynn Hecht Schafran, *Maiming the Soul: Judges, Sentencing, and the Myth of the Nonviolent Rapist*, 20 FORDHAM URB.L.J.439 (1992), *available at:* http://ir.lawnet.fordham.edu/ulj/vol20/iss3/5.

[18]According to the Centers for Disease Control, 1 in 10 U.S. women has been raped by an intimate partner. BLACK, ET AL., *supra* note 1; Lynn Hecht Schafran, *Risk Assessment and Intimate Partner Sexual Abuse: The Hidden Dimension of Domestic Violence*, 93 JUDICATURE 161 (2010), *available at*: http://www.legalmomentum.org/resources/risk-assessment-and-intimate-partner-sexual-abuse-hidden-dimension-domestic-violence; National Judicial Education Program, Legal Momentum, *Intimate Partner Sexual Abuse: Adjudicating This Hidden Dimension of Domestic Violence Cases*, Web Course, www.njep-ipsacourse.org.

[19] Federal Rule of Evidence 803.

[20] Federal Rule of Evidence 701.

[21] Federal Rules of Evidence 702 and 703.

[22] Erythema: Redness of the skin or mucous membranes due to capillary congestion and increased blood flow to the area. The labia are part of the female genitalia. They are the major externally visible portions of the vulva. The SANE explains the meaning of medical terms during her testimony.

[23] Posterior fourchette: Fork-shaped fold of skin at the bottom of the entrance to the vagina.

[24] Sally Bowie, et al., *Blitz and Confidence Rape: Implications for Clinical Intervention*, 44 AM. J. PSCYHOTHERAPY 180 (1990).

[25] Case study from the DVD *Sexual Assault: Forensic and Clinical Management* (2008), A Virtual Practicum based on the *National Protocol for Sexual Assault Medical Forensic Examinations* (1st ed.) developed by Dartmouth Medical School.

[26] Marilyn Sawyer Sommers, *Defining Patterns of Genital Injury from Sexual Assault*, 8 TRAUMA, VIOLENCE & ABUSE 270 (2007); Sarah L. Anderson, Barbara J. Parker & Cheryl M. Bourguignon, *Predictors of Genital Injury After Nonconsensual Intercourse*, 31 ADVANCED EMERGENCY NURSING J. 236 (2009).

[27] *Davis v. Washington*, 547 U.S. 813 (2006); *Giles v. California*, 554 U.S. 353 (2008).

[28] NATIONAL JUDICIAL EDUCATION PROGRAM, JUDGES TELL: WHAT I WISH I HAD KNOWN BEFORE I PRESIDED IN AN ADULT VICTIM SEXUAL ASSAULT CASE, (2011), *http*://www.legalmomentum.org/node/205.

[29] These examples are on file with the author at the National Judicial Education Program/Legal Momentum.