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Case Study

Then and Now: Thirty Years Through the Eyes of Patients Who Have Experienced Rape

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Abstract

The number of sexual assault nurse examiner programs have grown dramatically over the last 30 years. There are some processes and approaches that have changed very little over the years. However, there are others that didn't even exist that long ago and have made significant advances in the care of patients that have been raped.

Keywords: sexual assault, forensic nursing

Then and Now: Thirty Years Through the Eyes of Patients Who Have Experienced Rape

The patient's name is Angie. At the time, she was 24 years old and could be your daughter, mother, sister, friend, or neighbor. Angie was returning home one summer evening after spending some vacation time in a nearby state with her family. As she was driving home, two men spotted her, followed her, and rammed her car until it was forced off the road. Then they abducted Angie. She was robbed and repeatedly raped, vaginally, anally, and orally by these two men. Later, they picked up a third man and went to a motel where he too raped her. Two of the assailants insisted on food and money. Angie was forced to direct them to her home where she fixed sandwiches and wrote them a check which she told them they could cash at a nearby convenience store. They wanted her to call the store to authorize cashing these checks. Instead, she dialed the operator and left the phone off the hook to allow their conversation to be overheard. The operator determined something was wrong and called the police. When Angie heard the police at her house, she ran out. When she arrived at the hospital, she was numb and disoriented after her multi-hour ordeal.

Before this midwestern community had a SANE program, Angie would have been taken by police to one of four city hospital emergency rooms where she would have been made to wait up to 12 hours in a public setting with a police officer until more pressing and urgent medical emergencies were taken care of. While she waited, she would not be able to drink anything, shower, change her clothes, or go to the bathroom. Instead, because there was a SANE program, Angie was taken to a private suite of rooms at one specific hospital designated and equipped only for forensic medical exams. In the past, the emergency department physician was reluctant to perform this exam because of the time involved and the possibility that later he or she would be required to testify in court which would necessitate even more time away from emergency practice. Instead, in the SANE room at this location, she was met by a sexual assault nurse examiner who was there waiting to meet Angie as soon as she arrived.

Prior to the SANE program, emergency department staff were trained on a "hit or miss basis". The quality of forensic evidence was not consistently good. Nurses interested in care of the sexual-assault patient attended a course, prepared and presented by experienced SANEs, physicians, police, prosecutors, laboratory personnel, and rape-crisis personnel, followed by clinical experiences. The community police department reported a vast improvement in the quality of evidence collected since the nurses started performing the sexual assault exams. The step-by-step evidence collection process was quite involved. In the earlier setting the emergency department nurse would perform one part of the exam, and the physician would perform others, requiring the patient to repeat what happened again and again. Often it was necessary to collect clothing and shoes as evidence and the victim went home clad only in whatever the hospital could scrounge up. In Angie's case, the entire exam was done by this specially educated, registered nurse. There was a closet equipped with new clothing for her to wear home.

The victim/patient of the past would have received a bill ranging from $300–600. Angie was never admitted as a patient, although the emergency department was nearby in case she needed that level of treatment, so she was never billed for the examination and medications. At the time Angie's exam was performed with the SANE program, the total cost was $150 and was paid by the state Crime Victims Compensation Fund that had been established in 1988 through the Victims of Crime Act 1984 (Ames, 2024).

Prior to the development of the SANE program, the responding officer would be delayed from returning to the field. He could not leave the victim until the exam was completed and he had the rape exam collection kit in hand to preserve the chain of evidence. When Angie was brought in, the officer waited in an area specifically set up to prepare his report while the exam was done. The amount of time until the officer was back in operation decreased from 12 hours to an average of about three. Thirty years later, this is still the amount of time required to provide what these patients deserve—a thorough, compassionate exam that includes a history of the event as well as medical history, a full head-to-to-toe assessment, evidence collection, photography, medication administration, safety planning, and discharge instruction.

Since the mid-1970s when rape-crisis advocates were dispatched to hospitals to provide emotional support to victims, it was often nearly impossible due to the chaotic setting of the emergency department. Many times, the victims simply gave up and walked away. A rape crisis advocate is part of the team that was dispatched to meet Angie in the SANE room. The support provided by a rape crisis advocate immediately following this traumatic experience helped Angie regain a sense of control in a situation where she had absolutely no control. At the time, Angie

was one of about 250 rape victims who were examined each year in that city alone. In the United States at the time, *Rape in America: Report to the Nation* estimated there were 683,000 individuals who could benefit from a program such as SANE. (OVC). Today, the exact number depends upon the resource used, and what they count in their data. This can be seen in the following examples of rates of rape: FBI 139,815; RAINN 463,634); and NSVRC 734,630. What we can conclude is that there has been some change, but not nearly enough. Angie was referred to the counselling services of the local rape advocacy program.

Two of Angie's assailants were apprehended immediately and later tried and convicted of rape and other crimes. Their sentences totaled over 1,000 years. This penalty was handed down before changes in the state law that now says a life sentence is 45 years. The third suspect was identified, and evidence was collected, but due to the techniques used at the time, not enough information was available to arrest him and eventually the statute of limitations ran out. Today, the techniques used in analysis make it easier to collect, are much more sensitive, and faster to analyze. The statute of limitations has changed so there are none if the case involves DNA evidence that can establish the identity of the perpetrator in the future.

Nurses in this program initially spent many hours in team-building activities to become a close, trusting, and supportive group. The skills that each individual brought to the unit varied from school nurse to critical care nurse, to ED nurse, to health department nurse, to educator, and each were willing to share their knowledge with the others to develop new knowledge and skills. Thirty years later, some of the nurses are still with the program and have completed 700–1,700 exams each, making this a highly skilled group of forensic nurses. From the evidence collection perspective, this became evident in serial rapist cases. Over the course of the serial offender's terror, it didn't matter which nurse was on call—evidence was collected that linked them to the other cases and they were ultimately prosecuted.

Early in the program development, the nurses not only developed relationships with each other but also with advocacy and law enforcement. There had always been tension between advocacy and law enforcement. The nurses were able to bridge the culture gap that existed between the two groups. It took some time but eventually everyone worked collaboratively and many of the issues that originally existed in group dynamics went away.

It was imperative that the program stay abreast of new developments in technology, research, medical treatment and program options. In the past, an exam was done if reported within 72 hours. Now that time has been expanded to 120 hours or more, because of the changes in DNA analysis and medical treatment. Laws have changed. Prior to and during the period that Angie was examined, state law required mandatory reporting to law enforcement. Most communities now offer forensic examinations anonymously for those individuals who are over the age of 18 and competent without law enforcement involvement until the patient wants their involvement. This valuable change in law allowed individuals who had a variety of reasons not to want law enforcement involvement to receive medical treatment.

Angie was offered pregnancy testing and emergency contraception. She was offered STI treatment for gonorrhea and chlamydia which was the standard at the time. A follow-up phone call was made about three days after her assault and a follow-up exam was available two weeks after the initial medical-forensic exam to document healing and identify any issues she might be experiencing and referrals made. As the years went by and recommended practices changed, so did the medical protocols of this program. One major change was the assessment and beginning

treatment for HIV. Post-exposure prophylaxis (PEP) is started at the time of the exam and referral is made to a local agency for follow-up treatment. In the past, this program was funded primarily by community support and victim compensation. Many community programs are now funded by federal grants such as the Violence Against Women Act (VAWA) (National Center for Victims of Crime, 1999) and the Victims of Crime Act (VOCA). VAWA legislation has been enacted that addresses requirements for states that receive VAWA monies. Examples of these conditions include not requiring victims to bear the costs for criminal charges and protection orders in cases of domestic violence, dating violence, sexual assault, or stalking. Additional requirements include that survivors of violence cannot be denied assistance, evicted, or have assistance terminated due to their victim status.

Sexual assault kit analysis has changed over the years. Prior to Angie's case, DNA wasn't routinely analyzed since it was new, evolving technology, and did not become standard until a few years later. The ABO blood group system was the primary method used for identifying individuals and involved the collection of blood and saliva samples at the time of the exam and additionally from the suspect. It provided limited data and often was of little benefit to the investigation. DNA analysis became a more reliable way to link a victim to a suspect through the collection of semen, saliva, skin cells, and blood collected at the time of the exam.

Angie's kit was analyzed, but for many other rape victims the kits were never even looked at. They sat on shelves in law enforcement property rooms. At the time, no analysis was done unless there was a suspect, and a blood sample was obtained from that suspect. That changed with the development of the Combined DNA Index System (CODIS) in 1998. Comparison of DNA profiles are used to not only link a suspect to a victim, but to link to other serial crimes, and today it is also used to identify missing persons. A recent example of how this system works was realized when a kit that had been collected in 1999 was tested as part of an untested kit initiative and matched in CODIS to the offender. After all the appropriate steps were taken, the case was taken to trial. To address the problem of the untested kits, the state established the Sexual Assault Kit Initiative in 2017. Over the next few years, all kits that had not been tested were identified and a plan and process for testing and investigation was developed. Now, when a kit is opened and collected it is tracked through a system that identifies where it is all through the process. At the time of the exam, the patient is given a brochure that explains to them that they can check a particular website and see where the kit is and what is being done with it.

This program has never used age as the guideline for adult or child exams. If girls have started a period or if boys are developing body hair, they are post-pubescent and will be examined by adult and adolescent examiners. In 1997, the SANE program expanded to include prepubescent children. Between 1991 and 1997, children continued to be taken to local emergency rooms and were examined by whatever nurse and doctor was assigned. Just as before the SANE program, it was reported that these individuals had little education in forensic medical child exams. The Child Advocacy Network (CAN) was incorporated in 1988 and was the first of its kind in the state. The mission was and continues to include the coordination and comprehensive response to child abuse which fosters hope and healing for all. When the child program began for acutely assaulted children using the guideline of the previous 72 hours, a pediatric course was developed and presented. Policies and procedures were developed and from that point forward prepubescent children were seen in the same area as adult and adolescent patients. A few months into this change, a local detective made the comment that in all the children he had observed in the emergency department they were almost always crying. He went

on to say that in this setting he had not observed even one child crying. He said they came out of that room smiling.

The SANE program and CAN work collaboratively to provide safe, nurturing, and child-centered care. CAN provides physician or advanced-practice care and follow-up of the children seen by the pediatric SANE program.

A few years after the addition of the pediatric SANE program, this community expanded into another area of forensic practice. The title of the program changed from SANE program to Forensic Nursing Services. A drug-endangered children program was added because of the large number of active methamphetamine labs in the community. The same nurses who were seeing the pediatric population augmented their education specific to this population of children. When children were discovered living in methamphetamine manufacturing environments, they were brought to the SANE exam area and evaluated for issues of abuse, neglect, and exposure to drugs and chemicals. The response was a collaborative response by the nurses, child protective services staff, and law enforcement.

Further expansion added intimate partner violence exams to their skills. This role coincided with the opening of one of the first Family Justice Centers in the country. The majority of these patients are now seen in the local Family Safety Center, but the nurses also respond to hospitals when a forensic examination is needed. The program sees three to four times more IPV patients than SANE patients.

The nurse did testify in Angie's case. Early in the program, nurses rarely were called to testify. Today, the nurses regularly receive subpoenas and testify. In the courtroom, the nurse is an objective professional with information that educates the jury.

Many changes have been made over the years that have allowed this program to stay strong, healthy, and grow into other forensic nursing areas. The primary role of the nurse in this program has always been the care of the patient. Although terminology has been added to include trauma-informed and evidence-based concepts, the philosophy which this program has had since the beginning has always placed the patient as the focus of everything that was done. Virginia Lynch visited the program in the second year of operation and instilled into the nurses that the care of these patients must include genuine compassion when they are suffering, safety when they are afraid, trust when they need to be believed, high regard when they feel vulnerable, and confidence that they are not to blame. This ideology continues today, with the goal of putting these patients on a path to healing.

References

National Center for Victims of Crime (1999) Crime Victims' Rights in America: An Historical Overview. U.S. Department of Justice: Washington, DC. Available at: https://ovc.ojp.gov/sites/g/files/xyckuh226/files/pubs/OVC_Archives/ncvrw/1999/histr.htm

Ames, B. (2024). A brief history of the Victims of Crime Act. Available at https://ojp.gov/safe-communities/from-the-vault/a-brief-history-of-the-victims-of-crime-act#:~:text=Acting%20on%20that%20recommendation%2C%20Congress,ago%20on%20October%2012%2C%201984.