

Whose Credibility Is It Anyway: Professional Authority and Relevance in Forensic Nurse Examinations of Sexual Assault Survivors

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Abstract

There is an inherent tension in the information gathering and recording stages of the forensic medical examination of rape survivors. Medical practitioners do not wish to record information that can undermine a complainant's credibility, but at the same time must ensure that they do not problematise their own credibility by appearing partisan (for instance, by omitting information that might be relevant). Drawing upon semi-structured interviews with Forensic Nurse Examiners (FNEs) and their trainers (Forensic Medical Examiners) in England, and Sexual Assault Nurse Examiners (SANEs) in Ontario, this paper will investigate the strategies that both sets of nurses employ in order to document medical, sexual and assault histories, as well as physical phenomena (injuries, tattoos and piercings). FNEs collect more potentially prejudicial information than SANEs; this is a result of their greater anxiety in regards to their perceived credibility and professional authority.

Keywords: rape, forensic nurse examiners, bad character evidence, credibility, tattoos and piercings

1. Introduction

The report produced following the forensic examination of a rape and/or sexual assault survivor is a mine of information for the defence team, who seek to undermine the complainant's credibility during cross-examination (Brown, Burman, & Jamieson, 1993; Burman, Jamieson, Nicholson, & Brooks, 2007; Kelly, Temkin, & Griffiths, 2006; Temkin, 1998, 2000). As part of the medical examination, forensic practitioners ask questions and record information related to (amongst other things) the complainant's recent sexual history, their medications (including contraception), and previous pregnancies. Disclosure of such information to the defence can result in an attempt to undermine the complainant's credibility during cross-examination by arguing that they were complicit in their own victimisation (Estrich, 1987; Harris & Grace, 1999; Horvath & Brown, 2009; Munro & Kelly, 2009; O'Keefe, Brown, & Lyons, 2009; Temkin, 2005; Temkin & Krahé, 2008). Drawing attention, for instance, to the clothing, sexual history or other aspects of the survivor's lifestyle, the defence is able to compare them unfavourably with mythical representations of rape victims as naïve innocents, or the "Madonna" (Redmayne, 2003). (Note 1) The reality of rape as experienced by victims is that there is usually intoxication involved, there is often some form of acquaintance relationship between the suspect and the victim, and the assault usually takes place on one or the other's property. As a result the defence is able to posit that the victim's behaviour or provocative dress was such that it led the suspect to believe that she wanted sexual intercourse, i.e. it was her behaviour, history, etc. that caused the sexual violation. Increasingly, policymakers are getting wise to the tactic of blaming the victim in rape cases and are introducing legislation prohibiting (or requiring judicial approval for) the admissibility of evidence relating to the survivor's sexual history, with varying degrees of success (compare Kelly et al., 2006; Burman et al., 2007 for instance). Nevertheless the forensic medical report can still provide a foundation for an application by the defence to introduce prohibited evidence or can result in problematic questioning in the courtroom without need of such an application. While the potential for the forensic medical report to enable these character assassinations has been discussed in legal and social scientific scholarship (for instance Brown et al., 1993; Temkin, 1998), the question of why this problematic information is still recorded remains. In this paper, I aim to address the deficit by analysing the reasons for the recording of said information by a particular group of medico-legal practitioners: Forensic Nurse Examiners (FNEs, often called

Sexual Assault Nurse Examiners (SANEs) in North America and Canada), who record this information despite the fact that they acknowledge that it is irrelevant and potentially damaging to the complainant's case.

Developed initially in the United States of America in the 1970s as a response to difficulties with recruiting doctors as forensic examiners, FNEs were first labelled as such in Minnesota in 1992 at the first convention of nurses working in sexual assault and death investigation roles (Rutty, 2006). Shortly after this initial meeting, the Sexual Assault Nurse Examiner (SANE) role was formed, with specialist education and training. The SANE programme has continued to develop in both Canada and the United States of America, and is generally considered to have been a positive intervention (see Sievers, Murphy, & Miller, 2003 for instance). In contrast, those responsible for forensic medical provision in the United Kingdom have been more reticent in their adoption of forensic nurses. However, following a successful pilot programme at St. Mary's Sexual Assault Referral Centre in Manchester during the early 2000s, in which a forensic nurse was trained in order to cover the day shift (a time that most physicians find it difficult to provide their services as they are working other jobs such as General Practice surgery), (Note 2) the FNE role is slowly developing in England and Northern Ireland. A small number of FNEs are now working in Sexual Assault Referral Centres (SARCs) (Note 3) and are performing the examinations of survivors (including the recording of medical, sexual and assault histories, the collection of trace material from the body of the survivor and the provision of medical aftercare) and as a result are providing physicians and forensic scientists with all the details necessary to give an expert opinion to the court.

Drawing upon interviews with those involved in forensic nurse work in England and Ontario, Canada, I will outline the variances in the conduct of FNE/SANE work, particularly those relating to the collection of potentially problematic history and character evidence. While it is true that nurses from both countries record problematic information, it is my argument that FNEs appear to record a greater quantity of irrelevant information, which I believe to be a result of their novelty and their inferiority within the medico-legal milieu.

2. Methods

The data cited in this paper derives from a broader study analysing the role and work of forensic nurses in different jurisdictions (Rees, 2011a). While there has been a significant increase in the number of investigations into the forensic intervention in rape and sexual assault cases using observational and interview based methods (Du Mont & Parnis, 2000, 2001; Kelly, Moon, Savage, & Bradshaw, 1996; Kelly, Moon, Bradshaw & Savage, 1998; Mulla, 2008, 2011; Rees, 2010; Savage, Moon, Kelly, & Bradshaw, 1997; Temkin, 1998; White & Du Mont, 2009), all of the studies have focused upon a single jurisdiction with no comparison across nations. One potential reason for this lack of comparison was that different practitioners were involved in the intervention in the past; for instance, SANEs had developed in North America, while Forensic Medical Examiners (physicians (FMEs)) were used in the United Kingdom. Given the rise in the number of FNEs in England, it is now possible to explore the utility and feasibility of comparative international qualitative research with regards to the forensic intervention, as similar practitioners are involved, thus providing a provisional analysis of the way the forensic nurse policy has been implemented in England. In order to achieve these aims, semi-structured interviews were conducted by the author in England and Ontario, Canada. Given the small number of FNEs presently employed (five), it was decided to incorporate a small number of the physicians involved in the training of FNEs. Seven respondents (including the entire population of practising FNEs at the time of the fieldwork period) were accessed via the United Kingdom Association of Forensic Nurses (UKAFN) across five centres (EN1-5) where nurses were working in a forensic capacity relating to sexual assault. Canada was chosen as a comparator, as it has a sufficiently similar legal setting to provide a "most similar" (Pakes, 2009) comparison with England, and Canadian legislation is often cited in English debates on sexual offences and sexual history evidence (Redmayne, 2003; Temkin, 2003 for instance). Ontario was specifically chosen because the Ontario Network of Sexual Assault/Domestic Violence Treatment Centres (hereafter "Network") was known to be interested in this research area, and had been the focus of studies in the past. Eight nurses were accessed via the Network from three hospitals across Ontario (ON1-3). These hospitals were randomly selected from the 33 centres that treat adult sexual assault survivors. Ethical approval was provided by the University of Edinburgh's research ethics committee and the three Ontario hospitals. Interviews were semi-structured, lasted between one and two hours, were digitally recorded and transcribed verbatim. Once all interviews were transcribed, Framework Analysis (Ritchie & Lewis, 2004) was performed whereby the data was reviewed and indexed into six core and 53 subsidiary themes. The development of these matrices enabled comparison between respondents and, crucially, across jurisdictions, enabling the comparative aspect of the project.

3. Proformas and Recording Histories

Since the late 1970s, forensic evidence collection kits and proformas have been employed in forensic medical examinations in an attempt to standardise evidence collection in rape and sexual assault cases (McLay, 1984; Du

Mont & Parnis, 2000, 2001; Parnis & Du Mont, 2002). The proformas serve as an *aide memoire* for nurses, reminding them of the information that must be collected, either for their benefit or for that of others (e.g. forensic scientists). Here I will compare SANEs' and FNEs' documentation practices in order to demonstrate how the latter group's anxieties about their credibility results in the recording of a greater quantity of potentially prejudicial information.

3.1 Ontario

The central focus of the examination protocol in Ontario is the provision of various options to the client (Note 4): these include a medical examination, treatment for sexually transmitted infections (including HIV prophylaxis), contraception, collection of trace material for forensic scientific analysis ("the kit"), and reporting to the police if the client has not done so already. SANEs stress the importance of these options and emphasise that the client should be able to dictate the progress of the examination based upon the options provided. Prior to meeting a client, the SANE picks up a proforma that sets out each of the options available and the requisite steps to take once they have been chosen. Beth (Note 5) explained how she uses the proforma (called "managed care plan" in her centre) to generate and record information:

This proforma is just a checklist of what you do, when you do, how you do it... What I really like about the, um, managed plan that we have is that you can almost go step-by-step... Um, while they are talking, most times, I am filling in the managed care plan, so I'm ticking things off, so they don't have to repeat things 55 times and I don't have to remember, at the same time. (Beth ON1)

Beth completes the form while she is talking to the client. The managed care plan is separated into sections including administrative information (name, sex, number of children), health history (including allergies, immunisations, medications, menstrual history, method of contraception), a history of the sexual assault (including date and time, location, whether a weapon was used, relationship between client and assailant), whether a forensic kit has been conducted and which diagnostic tests have been performed. The SANE asks the client broad questions about the assault and their medical history, and then ticks the relevant boxes or fills in the appropriate details while the client answers. This does not mean, however, that the SANE can avoid asking more direct questions during this early information gathering period:

I mean it starts off even just by, um taking a health history and just by exactly, whether they have allergies, whether they've given birth before... whether they are breastfeeding... are sexually active before, whether they have any pre-existing heart conditions, or any health conditions, you know, with the HIV, um pep meds, if they've got kidney or liver disease you can't give some of this stuff, um so we need to know a lot of this stuff, so that's a lot to do with why we have all this. (Beth ON1)

Beth is doing two things during this phase: she actively listens to what the client is telling her and frames the information to fit with the proforma; (Note 6) where there are omissions, she asks more direct questions in order to generate the information. For example, in order to offer medication, she asks specific questions regarding health history to ascertain whether a particular drug would be appropriate. The asking and recording of these questions are therefore considered essential in order to ascertain the appropriate medical procedure. However, even within Beth's quotation, there is evidence of more alarming questions about previous pregnancies and sexual history. Such questions are justified by nurses as the answers enable them to perform their work. For example, Anne, who worked with Beth, mentioned the following in terms of the questions surrounding sexual activity:

Are they sexually active, and the reason that we ask that... we just find it helpful if we know they are sexually active when we start explaining what we are going to do. Like it or not there is a difference between how you explain things to someone who is sexually active and someone who isn't and never has been, and that is why we ask that question. (Anne ON1)

Anne and other SANEs believe that it is important to record whether someone is sexually active as it makes a difference to the way they perform their work and is therefore relevant.

The relationship between relevance and provision of options was also mentioned in other centres, particularly in discussions concerning sexual history and the history of the assault. In contrast to the active listener role in ON1, nurses in other centres restricted the amount of information that they allowed the client to disclose. Instead of letting clients speak freely about the incident, these nurses asked narrow questions relating directly to the options that they could offer, and their proforma provided blank space for the recording of the answers.

So one of the first things I'll often say to a client is that "I don't want you to think for a moment that I don't care what happened to you tonight, but for your own protection, I'm going to ask you questions specific to

what happened"... I will be very specific, if it's a male or a female, was it one or more, was there penetration of any form, oral, vaginal, anal, those are the basic things that I need to know, the time that it happened, um, I don't want to know necessarily where they were, how they got there, or, sometimes some of that spills out, but as I say, I try and set the parameters right off the bat so they don't, and as long as they know what you're doing they're usually pretty good with that. (Emma ON2)

Although there are differences in practice between the two centres (ON1's nurses used tick boxes to frame the client's narratives while nurses at ON2 only asked direct questions about the assault, medical history, etc.), their aims are identical: the generation of the information to enable them to provide options to the client.

If the SANE has discerned, through the means described above, that the assault has taken place within the past 72 hours, they will offer the client the option of a "kit" to collect trace material from the client's body for forensic scientific analysis. The kit contains another proforma, designed by the Ontario Centre of Forensic Science, and is standardised across the province. Repeating some of the questions and information that the SANE may have asked/gathered beforehand, the kit proforma includes a list of questions to which the answers are "yes", "no" or "I don't know"

Generally speaking when I go through the kit and there are three or four lines asking about date of birth, birthday, and then I say "these questions are here and they are written out and I will read them verbatim and I'm going to tell you now the answers are yes, no and I don't know, there are no right and wrong answers". (Gail ON3)

As with the centre's own proforma, the purpose of the kit proforma is to act as an *aide memoire* for the nurse; in the kit's case, however, in addition to reminding her to collect all the necessary information to fulfil her own role (i.e. offering the options), the proforma ensures that she has collected enough information to ascertain which samples are necessary for forensic scientific analysis, and to provide everything the laboratory will need to perform and interpret said analysis. The kit is set out in a flowchart, asking: where penetration was attempted and where it occurred; whether an assailant ejaculated on any part of the body; whether the client scratched the assailant; etc. The answers determine which samples the SANE will collect from the body; for instance, if the client answers yes to the question about scratching the assailant, scrapings will be taken from underneath her fingernails in order to search for any cellular material that may have come from the assailant.

Likewise, questions that provide information for the forensic scientists are considered unproblematic. For instance, forensic scientists request details of intercourse within the past week and of any conscious consumption of drugs and/or alcohol before or after the assault.

So the kit questionnaire is, very much about the physical aspects, also about the alcohol, drugs, and also, uh, it does ask about, not sexual history, but when was the last time you had intercourse, and we need to make sure we explain to people about why that's there, because they know that if there's different DNA, and if it's more than two weeks, we put more than two weeks, it's not a big deal. (Diane ON2)

While socio-legal investigations into sexual history and bad character evidence have identified that it is exactly these facets of lifestyle (recent sexual history, drug and alcohol use) that defences use in order to responsabilise the victim and thereby undermine their credibility, the SANEs did not consider this information to be a problem. Along with the kit questions, the form explains why this information is needed; because the nurses understand the reasons for collecting it, it is relevant and "not a big deal".

In general, the SANEs spoke very positively about their proformas. For instance, Carole noted that while the documents were not perfect, they were always developing, and some of the more potentially damaging information was being removed from the form.

I love this managed care, it's a work-in-progress, yes, but it has been perfected, it's been revised... Why is it important that the fact this person was wearing a mini-skirt why is that important? And that's where the strides have been made (Carole ON1)

Such omissions were seen to protect not only the client but also the SANE herself. Given the success of the SANE programme, physicians are no longer involved, and so nurses provide evidence for the court; however, very few of the SANEs that I interviewed had actually provided testimony (their documentation being used as evidence), and those few had only attended in a small number of cases. If a SANE is called to court, the design of their documents protects them. An aphorism of nursing is "if it's not documented it's not done". SANEs use this to their advantage in the courtroom, because if it is not on the document then they cannot answer questions about it. Gail described the way she would respond to a question in court: "We would have to refer to our documentation, and I would have to say if it hasn't been documented, or there is no record on it then I can't

comment on it” (Gail ON3). If the question is not on the form, it will not be recorded and therefore the SANE cannot talk about it in the courtroom. For example, Hannah mentioned previous forensic examinations:

we may ask them, or they may tell us that they’ve been seen by a SANE before, a number of our clients are repeat clients, so they’ll say “we were here last year”, but there is no place in our documentation for that to be recorded. (Hannah ON3)

As there is no space upon the proforma to document this information, it is not recorded. It follows that as the information that the client had been forensically examined in the past is not documented, the nurse is unable to comment upon that in a forthcoming trial, although that information had been disclosed during the forensic intervention.

The design of the proforma documents, therefore, determines the information that SANEs consider relevant and necessary to collect. If it is on the form, it enables the nurse to work out which options she can offer, which samples she should take, or which information is required by the forensic scientists. If the information is not on the form it is irrelevant, and (as Hannah’s quotation demonstrates) although it may have been discussed during the examination, the nurse will not recall such information during any future cross-examination. Forms are regularly evaluated, and as Carole’s quotation indicates, the focus is on information that is clearly necessary for either the conduct of SANEs’ work or that of the forensic scientists. Of course, as I have already mentioned, the result of this is that the questions about recent intoxication and sexual history remain, as this is deemed to be of relevance to the forensic scientists. However, it is clear that the Ontario ethos is to limit the amount of information that is asked and therefore recorded on the proforma.

3.2 England

FNEs, in contrast, do not constrain themselves to solely the information requested on the protocol. FNEs perceive themselves as information providers; they are aware that the information they record is disclosed to other parties (including the defence) and feel that it is very important that the clients are aware of that fact.

The limits of confidentiality and making that very clear... highlighting the fact that it’s not like the kind of thing you’d talk to your practice nurse about, it is something that, my medical notes will be used as evidence in court, anything that I write down is potentially disclosable, any of the sensitive data information I collect, will be considered sensitive but again would be potentially disclosable. I also said I could not pick and choose what to write down, anything I wrote they told me I had to write down. Again my job wasn’t to choose which bits were relevant and which weren’t. (Alice EN1)

FNEs believe themselves to provide a choice to the client regarding their own personal information; having informed them of the ways that their information may be used in future, and who may have access to it, it is up to the client to decide whether to mention certain details.

It was a good way that we did it here, making it clear to the complainant that anything could be disclosed, so giving them information, they could withhold it if they wanted to, but it was allowing them to make that choice. (Alice EN1)

At the same time the FNE also outlines the benefits of mentioning information that the client believes to be irrelevant or prejudicial:

the other thing that we did say was um, that if you feel that there is something... something along the lines of “there may be things that you feel will be judged in a certain way, however, it is sometimes better for these things to be highlighted early on, rather than they be brought out in court when you’re not prepared.” (Alice EN1)

In essence, the client is being asked to make a cost-benefit calculation based upon the potential prejudicial risk of their information. The client does meet with a Crisis Worker before being examined by the FNE and is provided with some advice about relevance of information; for instance, a recent training DVD for forensic practitioners suggests that the following is said to clients before the medical examination:

It is fine to talk about things like asthma, diabetes, epilepsy, but if there is anything that you feel isn’t relevant, and don’t want to tell the doctor (Note 7) what happened, then you don’t need to tell. I’m not suggesting that you have, but if you’ve ever had a termination of pregnancy or a sexually transmitted infection, it’s not relevant to what has just happened, so you don’t need to tell her. (King’s College Hospital NHS Foundation Trust, 2008)

Clearly, therefore, best practice is for Crisis Workers to advise clients of the types of information that can be prejudicial, and so, in theory, there should not be any problems with the client being in control of their disclosure; however, the way that FNEs collect information can unfortunately undermine such advice.

While the client is meeting with the Crisis Worker, the FNE takes a first account from the accompanying police officer. The FNE repeats that account to the client who can then confirm information or make amendments. Similarly to SANEs, FNEs have a proforma which serves as an *aide memoire*, setting out the questions the nurse needs to ask. In their experience, the nurses had found the direct wording of the proforma questions problematic and the clients unwilling to answer; to this end, they had found their own ways to generate the information.

I would say to them, I will not directly say, I may say to them “so you told the police officer that the man, this boy put his penis in your vagina, has that ever happened to you before?” or “do you know if he used a condom?”, or I may well say “we have to look at the risk of unplanned pregnancy, do you know what ejaculation means?” based on the way that I say it, you know “oh no because he had a condom on”, “have you thought about an unplanned pregnancy?” “Well I can’t because I’m on the pill” so that’s when it would start to support that without asking a direct question. (Betty EN2)

Betty asks the proforma questions not in a rigid manner as identified in Ontario, but rather in a friendly, conversational, dialogical manner. While this clearly fits with the need for forensic practitioners to be compassionate and empathetic with their clients, it does limit the time and opportunity for clients to make the cost-benefit analysis; as Betty says, the way she asks the question determines the information that she generates. For instance, she went on to provide an example relating to menstrual history:

we say to them “do you have any problems with your periods, have you ever had any pregnancies?” and they may say “well I had a termination ten years ago” *it’s not relevant to the case*, but they’ve told us, so it wouldn’t particularly need to go into a statement but a copy of the contemporaneous notes go with the statement so that it is actually documented there, so in a roundabout way I ask if they have any problems with their periods, have they had any pregnancies, or do you have any children, have you ever had any pregnancies, sort of go round about it that way.... I find most, the majority of complainants will tell you, *they sort of come out with most things*, whether it’s because they know what’s going to happen, they know somebody who has gone through court, they’ll tell you, it’ll come out sometimes, they’ve seen it on television programmes. (Betty EN2 emphasis added)

Betty’s “roundabout way” of talking about personal information may reduce clients’ abilities to perceive the risks in disclosing information that they have already been warned is irrelevant. To this end, as Betty says, clients disclose most things, failing to reflect, as forensic practitioners expect them to, upon the risks of mentioning certain information. Although FNEs, and, indeed, all forensic practitioners, should clearly be friendly to their clients, they should also reflect upon the ways that their rapport building practices can, in fact, produce disclosure of potentially prejudicial information.

Once the client has disclosed information, for example a previous termination, the FNE then has to decide how it should be recorded. The above quotation illustrates the way that Betty manages such information; while the proforma does not provide a space to record terminations in particular, it does request “Menstrual/Obstetric History”, which includes information on periods (frequency, regularity), any pre-existing menstrual problems, number of children, mode of delivery and episiotomy. Betty adds, in that section, that the client stated that she had had a termination. Interestingly, she does not consider this information to be sufficiently relevant to include in her formal evidential statement. In effect, Betty is constructing a division of labour between her proforma and her statement, based upon relevance, so that (what she considers) irrelevant information is available on the proforma for doctors and the court should they require it, but it is not present upon her statement. The reason that this information is documented on the form, despite its supposed irrelevance, is due to the professional situation of FNEs.

The novelty of the FNE role was mentioned by all the English nurses, who felt themselves to be under a considerable degree of scrutiny from other medical and legal personnel. As a result, FNEs are very cautious in their work, and feel it is necessary to record all disclosed information.

So what happens is we have the forensic medical examination form which has got some information about their medical history, um, relevant to the assault but we also have got a medical form which you would take all their medical history, GP details, medical history, general medical history, um, alcohol issues, drug-related issues, which are all sensitive so for me it was important that we note it all down, we don’t know what is relevant later on, you can’t make that judgement then, and certainly as nurses you’ve got to be, you have got to be careful, and doctors too, but I think as nurses, in a new, developing role, I think

you've got to be non-partisan, you've got to be, you know write it all down, you can't make judgements. (Alice EN1)

In this quotation, Alice introduces the issue of bias, or partisanship, in the sense that the omission of information could be perceived as demonstrating an allegiance to the complainant. Providing the client with the rhetoric of choice regarding the information they disclose (disregarding the extent to which this choice is in fact constrained) and recording all that is then disclosed enables FNEs to demonstrate their disinterestedness; they have recorded information upon the proforma regardless of whether they personally believe it to be prejudicial. (Note 8) Additionally, FNEs fit within a network of medical and legal practitioners; in contrast to SANEs, if an opinion is required for the court, a doctor will provide expert testimony based on the FNE's documentation. As it currently stands, FNEs can provide testimony and their documentation can stand as evidence within a court; however, such material is considered "evidence of fact" rather than the opinion evidence provided by an expert. To this end, FNEs produce factual evidence during the examination, upon which a doctor will then rely (assuming the case goes to trial) in order to prepare their expert testimony. As evidenced by Alice's quotation, however, FNEs are cautious about the questions that could be asked during a future trial: "we don't know what is relevant later on". As a result, they consider it prudent to record all disclosed information in order to ensure that the doctor has as much detail as the client is willing to provide.

It would appear, therefore, that the recording of all disclosed information upon the proforma goes right to the heart of FNEs' self-perceived professionalism. Full disclosure of everything that they have been told defends them against any possible accusations from the defendant's legal counsel that they are biased, while at the same time also pre-empts charges that they have not performed a professional job by omitting information that a doctor may need in future in order to produce an expert report. This focus upon professionalism was most strongly demonstrated when nurses discussed the recording of observed phenomena upon the body, in particular tattoos and piercings.

4. Documenting Tattoos and Piercings

In addition to the space for the SANE or FNE to record the client's disclosures, proformas also contain multiple pages of body diagrams so that physical signs upon the client's body can be documented. (Note 9) When asked what they recorded, both SANEs and FNEs offered more substantial statements about what they considered to be relevant. SANEs stated:

When it comes to documentation, my thought... it's just the injury, it's not tattoos, it's not previous surgeries, it's not piercings, it's not anything, injuries. In my head, injuries are related to the assault. If there is some horrible injuries, um, they are from before, which make me question something about, then I may document, I don't think I've ever documented a tattoo, or a pre-existing scar. I know I haven't because, I don't document episiotomies. No I never have, it has to be an injury. (Beth ON2)

Possibly the clearest statement about relevance: "we don't mark tattoos, or markings for piercings or anything like that. We are looking for injuries of the assault, so obviously that's not from the assault". (Anne ON1) Physical information not directly related to the assault was considered extraneous, and was not recorded on the body diagrams. While SANEs could see little (if any) reason for recording tattoos and piercings, FNEs believed it to be essential.

I would put a mark near it, my drawing is not the best, I will even get to the point where if there is a tattoo, I will mark everything, because all it will take is for the defence to say "nurse, you're not very good are you because there's a scar on the left hip"... because that for me as a nurse is the only thing that would sort of swing it "well nurse you're not very good because she's actually got a tattoo on her back with the letters uh, uh, uh" so I literally do everything. (Betty EN2)

As with the recording of history information, FNEs felt it necessary to record all that they observed. Betty's quotation makes it clear that the potential for her credibility to be undermined by the suggestion that she has not done her job properly by failing to record all relevant information makes it imperative that all observed physical phenomena is documented. This necessity to report all physical findings is actually echoed by the professional organisations involved with forensic examinations; for instance, a training DVD provided the following advice:

It is best practice to document any scars or marks, operation scars, tattoos, and piercings. This will prove to the court that you have checked the client top-to-toe. (King's College Hospital NHS Foundation Trust, 2008)

In recording all this information, therefore, Betty is purely following contemporary best practice.

Clearly, it is the demonstration of professionalism and the necessity to do a thorough job that justifies the recording of this information (which in Ontario would be considered irrelevant). The problem with this practice is that, while other evidence may be considered more conspicuously problematic for the credibility of the client (for instance, evidence of previous forensic examinations can be used to imply that the client makes false allegations), the recording of tattoos or body piercings can be combined with other aspects of the client's lifestyle to create an impression to the court that the client is of "bad character" in an attempt to undermine their credibility in the eyes of the jury (Brown et al., 1993). While the introduction of a line of questioning likely to besmirch the character of the complainant is prohibited from admission to court by section 100 of the Criminal Justice Act 2003, or at least requires significant explanation as to why the defence needs to raise the question (for example, whether the client has a tattoo (McEwan, 2005)), studies of the way these laws work in practice demonstrate that in order for the court to prohibit such evidence, the prosecution has, in the first instance, to consider the questioning to be an example of an attempt to introduce bad character. This is sometimes not the case, which therefore results in the evidence not being challenged (Brown et al., 1993, McEwan, 2005). If the prosecution do perceive such evidence as an attempt to discredit the client with bad character material, adversarial gamesmanship may result in them choosing not to challenge the admissibility of the evidence in order to concentrate on preventing other evidence, which they consider more damaging, from entering the courtroom (Brown et al., 1993; Burman et al., 2007; Kelly et al., 2006); even if the questions have been prohibited, the defence may still raise the issues during cross-examination without reproach from the judge or the prosecution (Kelly et al., 2006). Against this background, the practice of recording tattoos and piercings on the body diagrams provides the defence with material that, while not in itself fatal to the complainant's credibility, could be deeply damaging if combined with other similar aspects of a client's lifestyle.

Given the advice provided in the DVD that I mentioned above, it is clearly the case that recording tattoos and piercings is considered best practice for all forensic medical practitioners, not just FNEs; it is unlikely, however, that doctors actually follow this practice. An FME said the following:

You have to be cognisant of things that might be sensitive, that you are writing down that might be prejudicial, that are not actually relevant to the offence that has been committed, so you need to be a bit cagey about what you write down, what you record. (Amanda EN2)

Unlike their nurse colleagues, therefore, physicians do consider themselves capable of discretion in terms of irrelevant and potentially prejudicial information. Clearly, at least in Amanda's opinion, an FME's credibility does not rely on demonstrating the thoroughness of their examination, and so they can omit information that they believe to be problematic. However, the fact that physicians are less concerned about omitting information emphasises the point that it is FNEs' anxieties about their credibility and professional authority that results in their recording of all disclosed detailed or observed phenomena.

I think it is about supporting them (FNEs), because I think they have had their confidence really eroded and I mean all the places you usually go about sexual offences and examiners and nurse examiners, it's constantly "well you'll do this wrong, you'll do that wrong", so they do feel very unconfident as a group. (Belinda EN5)

Belinda (an FME), in this statement, epitomises the reasons behind FNEs' lack of discretionary authority. As they are from a nursing background, there has been an assumption, mostly on the part of certain physicians, that FNEs do not have the appropriate skills (for instance diagnostic skills) for the role, and, as a result, will not do a professional job. Given this pressure, recording as much information as possible and following strategies that demonstrate that they have performed all aspects of the examination appropriately (for example recording tattoos and piercings found on the body) helps establish nurses' claims to be competent practitioners. While they may accept that the information that they are recording is not actually relevant to the case, it is relevant to their own project of establishing FNEs as respected professionals in the face of considerable opposition, as evidenced by Belinda's statement. Clearly, when it comes to recording information such as tattoos and piercings, SANEs and FMEs perceive themselves to have more discretionary authority; this is a result, I would argue, of their establishment as professionals in their own right. FNEs are still undergoing this process of establishment, and as such are mobilising the documentation of disclosed or observed information as a means to demonstrate their capability.

5. Whose Credibility?

Given the exploratory aims of the research and the small sample size, these findings must be considered preliminary; however, there is something quite compelling about the differences between SANE and FNE documentary strategies. It is clear, for instance, that both sets of practitioners hold similar conceptions of what is

and is not relevant in rape and sexual assault cases. Nevertheless, the ways that they act upon those notions of relevance are very different. SANEs, on the one hand, record information explicitly requested by frequently evaluated proformas, while FNEs record all information disclosed or observed in order (I would argue) to combat potential future accusations that they have not performed the medical examination competently. Of course, it should also be remembered that SANEs also record information that can potentially undermine the complainant's case, for instance information about intoxication and recent sexual partners, which is required for forensic scientific analysis. It is clear, however, that the Ontario approach results in the recording of substantially less contentious detail than the English.

This state of affairs could be a temporary result of the novelty of FNEs; given time, and the establishment of their own authority as a profession, they may learn to become more discretionary and rely less on protocol. This is clearly what has happened in Ontario; the departure of physicians from involvement in sexual assault examinations during the 1990s has resulted in the acknowledgement of SANEs as credible and professional practitioners in their own right, able to produce and evaluate their own documentation in a manner that they feel most appropriate. FNEs are certainly not at this stage yet, but in the future, and against the backdrop of austerity measures where both the police and the health service will be required to make cuts, forensic nurses will provide a far more cost-effective model for the forensic intervention than physicians. Whether this happens or not, it is important that FNEs, if they continue to perform forensic examinations, do develop some discretion; in essence the question becomes "whose credibility is more important?" FNE documentation of all disclosed and observed information may improve their credibility and authority, but only at the expense of providing information that embarrasses and potentially undermines the claims of the complainant. While forensic medical professionals consider it the job of judges to keep prejudicial character information out of the court, the adversarial gamesmanship identified by Kelly et al. (2006) and others necessitates that forensic medical practitioners develop a more "cagey" approach to information gathering, particularly with regards to material that is irrelevant.

FNEs are clearly not yet ready for such discretion; as such, a possible solution would be to follow the SANE example and produce a standardised proforma which asks specific questions and provides little or no space for amendments. I would suggest that this proforma is produced by a collective of forensic practitioners, legal representatives and social scientists who are cognisant of the ways that the legislation prohibiting the admissibility of sexual history evidence is negotiated. FMEs and FNEs could then fill in the standardised document, only responding to the questions asked, in a similar fashion to the manner described by Hannah in the section on Ontario. In this way, forensic practitioners could maintain their credibility by appealing to a standardised protocol; most importantly, this strategy would also diminish the likelihood of the complainant's credibility being tarnished by irrelevant/prohibited information.

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Notes

Note 1. For more on rape myths see Rees (2010).

Note 2. For an evaluation of the pilot study see Regan, Lovett & Kelly (2004).

Note 3. See Robinson & Hudson (2011) for a discussion of SARCs.

Note 4. Client is the preferred noun for the Ontario SANEs and while I am critical of its connotations will use it in this paper as it is the actors' category.

Note 5. All names are pseudonyms.

Note 6. See Mulla (2011) for more on the use of the forensic medical proforma as a tool for framing the client's account to the preferred format for criminal investigation and prosecution.

Note 7. In the role-play from which this quotation originates, the examination is carried out by a doctor. The Crisis Worker would say the same thing about an FNE examination, replacing "doctor" with "nurse".

Note 8. For more on the relationship between forensic practitioners and bias see Rees (2010).

Note 9. For a discussion of how this process is achieved (based upon a study of FMEs), see Rees (2011b).