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Forensic nursing: an option for improving responses to reported rape and sexual assault

Linda Regan
Jo Lovett
Liz Kelly

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Child and Woman Abuse Studies Unit, London Metropolitan University

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Foreword

In 1998 the Home Office announced the Crime Reduction Programme (CRP), which aimed to develop and implement an integrated approach to reducing crime and making communities safer. As part of this programme, the Violence Against Women Initiative (VAWI) was launched in July 2000, and specifically aimed to find out which approaches and practices were effective in supporting victims and tackling domestic violence, rape and sexual assault. Thirty-four multi-agency victim focused pilot projects were funded and aimed to develop and implement a range of interventions for various population groups in a number of different settings and contexts. The projects were originally funded until the end of March 2002; however, 24 of these projects had their funding, and in some cases their evaluations, extended until the end of March 2003. A further 24 'Second Round ' projects were funded in March 2001; however these were provided with specific service provision funding and were not evaluated by the Home Office.

For evaluation purposes, the projects were divided into nine packages, and projects with similar solutions or strategies, as well as those that were operating in the same contexts, were grouped together. Seven different independent evaluation teams were commissioned to assess the projects in terms of their development, impact, overall costings and cost effectiveness. The findings from all of the evaluations have been collated and a series of research reports and concise practitioner guides are planned for both the domestic violence and rape and sexual assault projects.

This report is one of a series of reports, which specifically report on the findings from the evaluation of a number of projects, which were funded to support victims in the aftermath of rape. This specific report focuses on findings from an evaluation of a forensic nurse intervention at St. Mary's Sexual Assault Referral Centre (SARC) in Manchester. The key aim of the research was to assess the impact of a nurse conducting forensic examinations, with the additional objective of providing a prompt response to victims of sexual violence requiring a daytime medical examination.

Previously published CRP: Violence Against Women reports

Rape and sexual assault

Lovett, J., Regan L., and Kelly L. (2004) *Sexual assault referral centres: developing good practice and maximising potentials*. Home Office Research Study 285. London: Home Office.

Regan, L, Lovett, J. and Kelly, L. (2004). *Forensic Nursing: An option for improving responses to reported rape and sexual assault*, Home Office Development & Practice Report 31. London: Home Office.

Domestic violence

Douglas, N., Lilley S.J., Kooper L. and Diamond, A. (2004*). Safety and Justice: sharing personal information in the context of domestic violence - an overview.* Home Office Development and Practice Report 30. London: Home Office.

Acknowledgements

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Our sincere gratitude goes to the victims/survivors who chose, at a difficult point in their lives, to take part in social research. Their generosity of spirit was remarkable, and we hope that this report contributes in some way to their interest in improving responses to rape.

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- St Mary's Sexual Assault Referral Centre opened in 1986 as a joint partnership between Greater Manchester Police (GMP) and the Central Manchester Health Authority. The origins of the forensic nursing pilot at St Mary's lie in historic problems around provision of a daytime forensic medical examination service for victims of rape and sexual assault. At a national level the potential of forensic nursing has been recognised as a means of addressing the linked issues of waiting times for victims, recruitment and retention of forensic medical examiners and provision of female examiners.

- The forensic nursing intervention involved training a nurse to conduct examinations, document findings and assist criminal justice agencies where necessary by preparing statements for the police and giving evidence in court. The aims were to enhance daytime service provision, improve documentation of internal injuries through use of a colposcope and inform national policy and practice about forensic nurse examinations.

Evaluation methodology

- A multi-methodological strategy was used linking quantitative and qualitative data. The two base samples are 6,438 cases prior to the evaluation in St Mary's historic database and 1,442 cases during the evaluation, which were tracked prospectively through the Criminal Justice System. Sub samples of victims/survivors opted into a series of questionnaires and in-depth interviews (a total of 66 participated). Within this group, forensic reports were also accessed, where possible. These data were supplemented by expert interviews with key informants and police officers (n=34). Comparisons have been drawn between the pre- and post-intervention periods and between the forensic nurse and forensic doctors during the evaluation.

- There were some delays in data collection due to agreeing research instruments and protocols with St Mary's and the Ethics Committee. A lower than hoped for number of service users took part in questionnaires and interviews, although the participation levels compare favourably to other studies. A forensic feedback form was later introduced to try to increase service user feedback.

Process evaluation

- The project was implemented with relative ease, largely thanks to support of St Mary's and GMP. The forensic nurse completed training in Seattle, USA, and within the Health Trust in examination and evidential procedures. The intervention was launched in March 2001.

- GMP were satisfied that the forensic nurse represented an improvement to service provision that was cost-effective. Greater Manchester Crown Prosecution Service (CPS) did not notice any negative impact on their work. The forensic nurse attended court for the first time in November 2002. Training issues highlighted by the forensic nurse attending and giving evidence in court have led to the development of improved court training for the whole forensic team at St Mary's.

- The project manager and CPS representatives noted improved access for complainants to prompt examinations as a result of the pilot. Forensic nursing is now well integrated into St Mary's overall service and is supported by the staff team. Police officers interviewed saw benefits in improved daytime provision, and also noted the high quality service and professionalism of the forensic nurse. The pilot has had a positive impact on the development of forensic expertise at St Mary's, evidenced by the introduction of an

improved forensic medical report form and court training for the whole forensic team, as well as a national conference on forensic nursing held by St Mary's in January 2003. A national protocol is needed to resolve the issue of disclosure in relation to photographs/video evidence obtained using a colposcope.

Research findings

- Three-quarters of service users undergo a forensic medical examination (mainly police referrals). The forensic nurse has performed a quarter of all examinations conducted at St Mary's during the evaluation; all others were performed by 13 forensic doctors on a rota system. The forensic nurse's examinees were reflective of the Centre's overall caseload – mainly young, female police referrals.

- There was a progressive rise in the number of forensic examinations conducted at St Mary's between 1987 and 2002. However, prior to the pilot the proportion conducted during weekday daytimes was in decline. During the pilot a fifth of all examinations were conducted during weekday daytimes. Over half of the forensic nurse's cases were seen during weekday daytimes. The number of weekday daytime examinations increased by a third during the pilot.

- The forensic nurse performed a quarter of weekday daytime examinations within three hours of the police report being made, half within six hours – slightly higher than the proportions achieved by the forensic doctors. Almost half of the examinations conducted at all other times were within three hours of the police report, three-quarters within six hours, and there was little difference between the forensic nurse and doctors. The range of factors contributing to delayed examinations included delayed reports to the police, assault types where there was minimal possibility of forensic evidence collection and multiple cases needing to attend for an examination at the same time.

- All service users who underwent an examination at St Mary's were examined by a female (n=992 females and n=80 males). One male service user requested a male examiner but did not go ahead with the examination. The vast majority of questionnaire respondents said they preferred a female examiner, mainly because they did not wish to be touched by a man, or felt safer or less embarrassed with a woman. The three male respondents also said they preferred a female examiner.

- The majority of questionnaire respondents received explanations from the examiner about the process of the examination, with slightly more of those examined by a forensic doctor having it explained throughout. Almost all respondents felt they could stop the procedure, with no difference evident between those examined by the forensic nurse and the doctors. Service user feedback underlined the importance of restoring a sense of control to victims/survivors during the examination, and very slightly more of those examined by the forensic nurse said they felt in control. Both examiner types were rated extremely highly across a range of attitudes, such as respect, belief, support and sympathy. It is, nevertheless, important to recognise that the examination can be experienced as a form of 'second assault' despite sensitive professional practice by examiners. No service user said they would have preferred to be examined by a forensic doctor than a forensic nurse. Service users registered almost 100 per cent satisfaction ratings for both examiner types, with none of those examined by the forensic nurse being dissatisfied.

- Although there was a notable rise in referrals to St Mary's between 1987 and 2002, self-referrals represent a decreasing proportion overall, and far fewer have a forensic examination than police referrals. A slightly higher proportion of self-referrals examined by the forensic nurse went on to report to the police compared to those examined by the doctors, but there was no significant increase in 'self then police' referrals overall compared to previous years. No significant differences were identified between the forensic nurse and the doctors in terms of documentation of findings in forensic medical

reports. There was little difference between the two examiner types in relation to attrition – slightly more of the forensic nurse's cases were detected, slightly more of the forensic doctors' cases proceeded to court, although more of the forensic nurse cases were pending trial. There was a slightly lower conviction rate among the forensic nurse cases but this was not statistically significant.

- Cost analysis of the intervention is complex, since the annual salary of the forensic nurse and the retainer fees for the team of forensic doctors must be taken into account. The cost per examination by a doctor was lower than for the forensic nurse, as they are paid an hourly rate rather than a full-time salary. However, the cost of on-call examinations conducted out of hours by the forensic nurse was considerably lower than that for the forensic doctors. Examinations performed by the forensic nurse during the pilot represented an overall saving of £16,738.16. Nonetheless, the value of the intervention cannot be assessed solely in terms of cost-effectiveness, as there is currently no alternative to providing adequate daytime provision of forensic medical examinations.

Policy implications

- The forensic nursing service alleviates the gap in prompt provision of weekday daytime examinations by a female examiner. The forensic nurse has become highly skilled in examination techniques and issues surrounding rape and sexual assault. Senior GMP officers would like to see the service expanded to include more forensic nurses and operate on a 24-hour basis. The service at St Mary's could be expanded either through two part-time forensic nurses covering the post, or by training a pool of hospital nurses to enhance the Centre's on-call rota and provide cover for the forensic nurse during periods of leave or absence.

- No limitations to the intervention were identified other than the outstanding issue of protocols on disclosure in relation to the colposcope. Detailed training (ideally accredited), examination protocols and supervision are essential for promoting acceptance of the forensic nurse examiner role elsewhere. The pilot at St Mary's highlights the importance of the forensic nurse being based within a wider forensic team.

1. Introduction

This report is based on the evaluation of the forensic nurse intervention implemented at the St Mary's Sexual Assault Referral Centre (from here referred to as St Mary's) funded under the Crime Reduction Programme (CRP) Violence Against Women Initiative, and is the first pilot and evaluation of forensic nursing in the UK.

Chapter 1 outlines the background to the intervention, its aims and expected outputs and outcome measures. Chapter 2 comprises the evaluation methodology and data sources, and limitations. Chapter 3 contains the process evaluation, exploring issues of implementation, inter-agency collaboration and consolidation for the intervention, and Chapter 4 presents the research findings from the evaluation, including analysis of cost-effectiveness and criminal justice outcomes. Chapter 5 reflects on policy implications and Chapter 6 presents the conclusions of the evaluation.

Background and context

St Mary's Centre was established in 1986 as a unique collaborative venture between Greater Manchester Police (GMP) Authority and the Central Manchester Health Authority.[1] The Centre provides a comprehensive forensic, counselling and medical aftercare service to adult[2] victims of rape and sexual assault in Greater Manchester. Core services include:

- forensic medical examinations;
- one-to-one counselling;
- screening for sexually transmitted infections and HIV counselling;
- prescription of post-coital contraception and pregnancy testing; and
- 24-hour telephone information and support.

The majority of referrals are from GMP, although the Centre operates an open referral system whereby victims/survivors are able to access the full range of services without reporting to the police. The current staff team consists of:

- Project manager;
- Clinical Director;
- 14 forensic examiners (including two forensic nurse examiners);
- 5 Crisis Workers;
- 3 counsellors;
- Support Worker;
- Administrator; and
- Research and development officer.

At the local level, the origins of the forensic nursing pilot lie in historic problems around provision of a prompt and effective daytime forensic medical examination service for victims of rape and sexual assault attending St Mary's (see discussion in this chapter). At the wider level, interest in the potential of forensic nursing has developed nationally as a result of three interlinked concerns:

- Waiting times for victims needing a forensic examination.
- Problems in the recruitment and retention of forensic medical examiners across different force areas where there is no sexual assault referral centre (SARC) or specialist service.
- Limited recruitment and retention of female forensic examiners.

[1] Now known as the Central Manchester and Manchester Children's Hospitals NHS Trust.
[2] As later data will demonstrate a number of adolescents are also attendees at St Mary's.

The issues surrounding recruitment in this field, particularly with respect to female examiners, who are estimated to constitute only 18 per cent of all forensic medical examiners, have been recognised as a national concern and are well documented (see HMCPSI/HMIC, 2002; Audit Commission, 1998). The role of a nurse in delivering forensic examinations is, in turn, linked to moves towards increased specialisation and professionalisation of the broader nursing field, which have been promoted by key nursing and government bodies alike during recent years (Royal College of Nursing, 2000; Department of Health, 1999).

Piloting forensic nursing at St Mary's was enabled by the commitment and support of the Centre management and Clinical Director, who welcomed the opportunity to develop this aspect of forensic expertise within their organisation. The forensic nurse examiner herself also played a key role in the development of forensic nursing at St Mary's. Prior to the onset of the project, she applied for and obtained a Winston Churchill scholarship to attend a forensic nurse examiner course in Seattle, USA, which she successfully completed. To our knowledge St Mary's is the first project to develop a forensic nursing service in the UK, whereas forensic nurse examiners have become the predominant form of provision in North America (see Kelly, forthcoming).

Interest in the potential of forensic nursing in relation to sexual offences has continued to grow throughout the conduct of the present evaluation, and a range of professional groups associated with the field have eagerly awaited the findings. For example, they were identified by the Metropolitan Police in their Project Sapphire Strategy Action Plan (2003). At the national policy level, the recent Metropolitan Police Authority's Rape Scrutiny Report (2002), the HMCPSI review (2002) and the resultant Home Office Plan of Action (2002) have signalled changes to the overall policy context with regard to forensic medical examinations, and have emphasised the need for reassessment of existing provision.

Description and aims of the intervention

The forensic nursing intervention at St Mary's involved training a nurse, who was also a current member of the staff team, to perform forensic medical examinations. She was expected to:

- conduct examinations;
- collect and document findings;
- prepare statements for court when requested by police/CPS; and
- give evidence in court, where necessary, on her findings.

From the outset it was envisaged that the forensic nurse examiner would remain under the Clinical Director's supervision for the entire duration of the pilot project.

The aims of the intervention were:

- to fill the gap in current service provision by providing a rapid response to victims of rape and sexual assault requiring a daytime forensic medical examination;
- to improve analysis and documentation of internal injuries through training in, and more routine use of, a colposcope;[3] and
- to inform policy and practice in other parts of the UK about forensic nurse examinations.

Although St Mary's operates as a 24/7 service, the introduction of a forensic nurse examiner was primarily designed to address issues around weekday daytime availability (defined as Monday to Friday, 9am to 5pm) for forensic medical examinations. Prior to the intervention, all forensic services were provided by a team of 13 female doctors under the supervision of the Centre's Clinical Director. Most of these doctors are general practitioners, which severely restricted their ability to undertake additional work during office hours. Whilst the Clinical

[3] A colposcope is an external instrument used to magnify, light and look at internal structures that also enables recording of any findings through still and/or video photography.

Director was available to perform some daytime examinations, her regular involvement in court work as an expert witness meant that she too was often occupied. This has historically led to gaps in service provision, resulting in increased waiting times for victims attending the Centre between 9am to 5pm, Monday to Friday. The immediate consequences of these delays have been:

- an unsatisfactory service response to victims, who may, as a result, be less inclined to pursue complaints; and
- a negative impact on the collection of vital forensic evidence, which deteriorates over time.

Before the implementation of the service, accurate empirical data demonstrating the precise level of daytime need were not accessible from GMP as they did not have a centralised mechanism for recording this information, although it was calculated that at least 63 daytime examinations had been performed by the Clinical Director in the period 1999-2000 prior to the application to the CRP. There was, furthermore, a firm consensus among St Mary's practitioners and GMP based on mutual day-to-day experiences that a serious gap in the service needed to be addressed. As St Mary's former Police Liaison Officer commented:

> *Our view on that is, really, if it works it will be a tremendous step forward, because we've always had this problem at St Mary's about daytime services. And I think there is a real need to crack that particular nut… We're never going to find many doctors that are willing to turn out during the day. They've got to have a day job. So if we can bring forensic nurses in, then I think that will be all to the good, just on that logistical side of thing.* (Police Liaison Officer, January 2001)

Another element within the forensic nursing intervention was the hope that improved documentation of genital injuries by the nurse examiner would be possible both through her having been trained in colposcopy and routinely using it, and that this would ensure the best possible evidence for any subsequent legal case.

Outputs and outcome measures

This report assesses the success of the forensic nursing intervention according to the following set of formally agreed outputs and outcome measures. These were negotiated at an early stage between St Mary's and the CRP, and as such represent the framework for the development of the evaluation.

Outputs:

- Successful training of a forensic nurse examiner at St Mary's.
- Production of a forensic nurse examiner protocol document.
- Production of a comprehensive training package for forensic nurse examiners.

Outcome measures:

- Increase in numbers of weekday daytime examinations conducted.
- Numbers of weekday daytime examinations conducted by a forensic nurse examiner.
- Time waited for a forensic medical examination – comparing pre- and post-intervention weekday daytime waiting periods.
- Service user assessments of the forensic nurse examiner.
- Cost of examinations conducted by a forensic nurse examiner compared to forensic doctors.
- Numbers of examinations for self-referrals resulting in pursuit of case by complainant – comparing pre- and post-intervention figures.
- Numbers of examinations conducted by a forensic nurse examiner resulting in prosecution/conviction – comparing pre- and post-intervention figures.

2. Evaluation methodology

This evaluation was undertaken concurrently with two other evaluations funded under the Crime Reduction Programme Violence Against Women Initiative (Kelly *et al.,* forthcoming; Lovett *et al*., 2004). The design and methodology used to evaluate the forensic nursing intervention and also issues arising which affected projected sample sizes are outlined here.

Evaluation design and methods

The data for the evaluation of the forensic nursing intervention cover a period of 27 months, from 1 October 2000 to 31 December 2002, and comprise the following elements (a full description can be found in the Appendix).

- Prospective case tracking[4] using a specially designed research database.
- Analysis of the historic data in St Mary's own database for comparison with the work undertaken prior to the pilot.
- Questionnaires to service users sent in the first, fifth and twelfth months after initial contact.
- Face-to-face qualitative interviews with service users (all those completing questionnaires were invited to take part, and those who agreed form a small sub sample group).
- Phased interviews with St Mary's staff and key players at the beginning of the project, at a mid-point and towards the completion of the pilot.[5]
- An audit of a sample of forensic medical reports.

During the extension period of the evaluation (from October 2002) two additional elements of data collection were agreed and introduced.

- A small database was designed to enable the forensic nurse to record details relating to each forensic examination she conducted. This allowed the nurse to track her own work, as well as giving the evaluators access to an accurate record of forensic findings.
- A single-page feedback *pro forma* to be given to service users following examination. The intention was to increase feedback beyond the opt-in questionnaires and/or interviews.

All data relating to each individual service user were coded with a unique reference number to enable cross-referencing between the different data sources. Table 2.1 summarises the total data collection achieved in all of these fields.

[4] The prospective element of the study involves tracking progress through the Criminal Justice System of referrals to the service. This is distinct from the retrospective design of most previous UK research on reported rape.
[5] Where these are quoted in the text the date of the interview is also included.

Table 2.1: Total actual and projected data collection for the forensic nurse pilot 1 October 2000 to 31 December 2002

Data source	Actual	Projected
Prospective case-tracking data	1,442[1]	1,000
St Mary's Centre historic database	6,438	All referrals
Service user questionnaires:	66	100
$ Questionnaire 1	23	30
$ Questionnaire 2	20	20
$ Questionnaire 3		
Qualitative interviews with service users	12	20
Total of phased interviews with staff and key informants	34	25
$ Project manager	1	
$ Clinical Director	1	
$ Forensic nurse	1	
$ Forensic doctors	3	
$ Support Worker	1	
$ Crisis Workers	5	
$ Counsellors	2	
$ Senior nursing staff	1	
$ Police officers	12	
$ CPS prosecutors	2	
$ Victim Support	4	
$ Greater Manchester Police Authority	1	
Forensic medical reports	100	100
Forensic nurse database[2]	249	249
Forensic feedback *pro formas*	27	50

Notes [1] This includes 1,176 individuals aged 16 years and over and 266 aged under 16.
[2] The cases entered on the forensic nurse database are included on the case-tracking database.

All of the data have been analysed and are drawn on in this report. In the presentation and discussion of findings below (see Chapter 4) the case-tracking data set, which comprises all referrals to the service during the 27 months of the evaluation, forms the main sample group. Pre- and post-intervention comparisons are drawn between the St Mary's historic and case-tracking data sets. Findings from the service user questionnaires and additional data sources are reported on where they differ from findings from the case-tracking database, or where they provide more in-depth insights into the particular aspect of the process under discussion.

Further comparisons have been drawn between the forensic nurse and the forensic doctors during the period of the evaluation. The questionnaire to St Mary's service users contained an extensive section on the forensic medical examination, including questions about their experience of the process and treatment by the medical examiner. Prior to the arrival in post of the forensic nurse examiner, examinations at St Mary's were routinely carried out by

forensic doctors and by the Clinical Director. All completed questionnaires returned to the evaluators in the first two quarters of the evaluation, therefore, related to cases examined by a female doctor. For those returned after February 2001 a proportion of respondents were examined by the forensic nurse. These data provided direct feedback from service users about the forensic nursing service. Through the unique identifier assigned to each questionnaire, it was possible to track exactly which replies fell into this category by linking back to baseline data being collected for case tracking.

The section of the questionnaire on the forensic medical examination has been analysed for the whole sample, and by those who were examined by a doctor compared with those examined by the forensic nurse. Where quantitative comparisons between the two examiner types are made statistical tests (Chi square) have been run using the SPSS statistical package, and none were found to be significant. Responses to open-ended questions were typed into text files related to each question. These were then grouped thematically and coded for frequency of responses. Although, in some instances the analysis produced quite small numbers, particularly where more complex investigation was conducted on specific sub-sample sets, the results have been accompanied by qualification, where relevant.

Limitations

Table 2.1 also compares the actual data collected with that projected in the original application to the CRP. In some areas the projected data totals were exceeded: the number of cases in the case-tracking database; and the interviews with staff and key informants. In other cases the data targets were not reached, especially with respect to the involvement of service users through questionnaires and interviews. Here, challenges arising during the process of data collection that affected these sample sizes are reported.

The collection of data was linked in part to proceedings within the other linked evaluations under the CRP Violence Against Women Initiative, as many of the data collection tools were the same where the elements of the different evaluations overlapped (Kelly *et al.,* forthcoming; Lovett *et al*., 2004). There were a series of delays and lengthy negotiations between the evaluators, the project Steering Groups and the St Mary's staff team about aspects of the evaluation. Many of the compromises involved negotiating a tension between the practice principle of choice and control for service users that has predominated at St Mary's since its inception,[6] and the desire of the evaluators to maximise participation and data collection. Whilst some form of agreement was always reached, the sometimes extended negotiations, and uneven implementation, have affected the level of returns for some elements of the evaluation.

Early in the evaluation it became clear that the St Mary's historic database was ill-suited to analysis, having been designed in the late 1980s on a now outdated and no longer available software package. It also became evident that data inputting, especially in the earliest years, was inaccurate. As part of the evaluation, data entry has been checked and corrected for the years 1988-1992. During the evaluation the database became unstable, and after protracted negotiations a new database was designed and the original data imported. This process took over six months longer than anticipated, also delaying the checking and updating, and meant that it was only possible to conduct data analysis after February 2003.

It took several months for the content of the service user questionnaire to be agreed with the staff team at St Mary's and, primarily, the hospital management and ethics committees, who requested that a series of amendments be made to limit the potential for disclosure. Although the questionnaires began to be sent out to service users in late 2000, further disruption was caused when the local CPS in London[7] referred the questionnaires to the CPS National Policy Directorate for guidance on a further disclosure issue relating to the section of the

[6] The introduction of proactive follow-up as part of the *Understanding Attrition* project, also funded by the CRP (see separate site report), has resulted in a shift of perspective, but this was not the case until late 2002.

[7] This related to the linked national evaluation of SARCs (see separate report XXXX), which uses the same data collection tools, and the fact that two of the Comparison areas (where there is no SARC) were in London.

questionnaire on reporting to the police. As a result, a second version of the initial questionnaire had to be developed so that a distinction could be made between cases that were ongoing and those that were not. None of the issues raised at either point related to the questions on the forensic medical examination specifically, but they nevertheless affected the recruitment of research participants and the distribution of questionnaires for a period of months.

The overall participation of service users in the evaluation was considerably lower than hoped for, and this, in turn, affected the numbers of questionnaires completed by respondents examined by the forensic nurse. A total of 716 service users (50% of the entire service user group) were invited to take part in the evaluation, of which 363 (49%) consented to receive further information or to take part. Those aged under 16 formed a notable proportion of all service users (18%, n=266) and were not invited to take part due to ethical issues and the question of parental consent. Self-referrals were also excluded until late in the evaluation (22% of all referrals, n=313).[8] These two factors, particularly, accounted for low numbers of service users invited to participate in the evaluation. An additional number were not invited due to other reasons of vulnerability (mental health, learning disability, lack of safe contact address and language barriers), because the staff member omitted to ask them (8% of all referrals, n=122), or because there was no Crisis Worker available to ask them (2% of all referrals, n=25). Overall, there was a nine per cent (66 out of 716) response rate among those invited to take part, although this is equal to 19 per cent of those sent the questionnaire pack (66 out of 343). However, compared to other studies on rape and sexual assault, these participation rates do not appear unusually low. Lees and Gregory's (1999) study on attrition in Islington included testimony from 26 complainants, while Harris and Grace's (1999) study on attrition included four complainant interviews. Other researchers (see, for example, Jordan, 2001) have noted the difficulties of recruiting participants into studies following recent rape.

Despite these problems, our research participants were broadly reflective of the overall socio-demographic profile of St Mary's service users. The characteristics of those who chose to take part were analysed and compared to the case-tracking sample as a whole. The 66 questionnaire respondents were mainly female, White and aged under 35, though there were three male participants and four from Black or other minority ethnic backgrounds. These trends were replicated in the case-tracking sample, although the average age of respondents was slightly older at 29 years. All respondents had an examination, and 13 were examined by the forensic nurse. The optional interviews conducted with service users did not involve any cases examined by the forensic nurse.

In an attempt to broaden the level of service user feedback on the forensic medical examination and the forensic examiner (whether nurse or doctor), the evaluation team devised a single-page pro forma containing a series of key questions on the examination extracted from the questionnaire. This was to be offered to all service users by Crisis Workers following the examination. It took several months, whilst Crisis Workers and forensic staff at St Mary's were consulted, for the *pro forma* to be agreed and introduced. The evaluators had suggested that all service users be encouraged to complete a form to maximise return rates, and that Crisis Workers be on hand to provide reference numbers to enable the evaluators to link completed *pro formas* to other forms of data being collected. However, Crisis Workers raised concerns that instructing service users to complete the forms whilst still at the Centre, and having any involvement in their completion, might affect the nature of the response given. At a Steering Group meeting in July 2002 it was eventually agreed that service users attending for an examination should be directed to the forms – made available in the waiting area – by their forensic doctor/nurse, and that a collection box should be provided for completed responses in order to promote a greater sense of confidentiality. A total of 27 completed responses were received (18 examined by a doctor, eight by the forensic nurse and one where the examiner type was unclear).

[8] Sixty-seven self-referrals were latterly invited to take part.

As this evaluation report assesses the impact of the forensic nursing intervention, comparisons between the forensic nurse and the doctors have been drawn. Although grouping the responses from service users according to examiner type means the sample groups can be quite small, particularly where more detailed analysis was conducted, it is important to gauge how the forensic nurse performed, as well as to measure whether there were any differences in how their practice was perceived by examinees. The fact that there is only one forensic nurse compared to a team of 13 forensic doctors also affects the sample sizes, meaning there are fewer in the forensic nurse group.

It should also be recognised that the pilot itself was limited to the employment of one forensic nurse examiner in one location. This may mean that some of the findings are influenced by the personality, expertise and commitment of this one individual, whose performance was measured against that of a team of 13 forensic examiners. Extension of the service elsewhere or employment of a larger pool of forensic nurse examiners at St Mary's may shed light on the extent to which this is the case.

A further limitation of the evaluation is that due to the length of time it takes for cases to come to court, and a period of absence due to ill health by the forensic nurse examiner at the end of the pilot, it was not possible to extensively assess the impact of her evidence-giving in court. After 19 months in post only 30 of her cases had proceeded to court, and in all but two of these her written statement was accepted pre-trial.

3. Process evaluation

In this chapter we report on the implementation of the pilot, any delays or unanticipated issues encountered, and the views of staff and key players on its contribution to the services St Mary's endeavours to provide.

Implementation

Despite the fact that negotiating and agreeing protocols across the project with the Health Trust and police took longer than anticipated, there were limited problems in relation to the implementation and running of the pilot. The process was aided by the fact that the intervention had the whole-hearted support of the Centre's Clinical Director and the police. Its potential benefits, in terms of victim care, evidence-gathering and cost effectiveness, were obvious to the key players. The fact that the forensic nurse examiner was formerly a long-term member of the St Mary's staff team also, undoubtedly, contributed to the relative ease with which the project was implemented.

A Steering Group comprising representatives from GMP, the CPS and Police Authority, as well as St Mary's forensic and management team, met at quarterly intervals during the evaluation, and addressed any issues as they arose. Members of the evaluation team also attended most of these meetings.

The forensic nurse examiner came to the post as a qualified nurse, with a wide experience in gynaecology, as well as six years' service at St Mary's as a trained counsellor and Crisis Worker. Having already completed 40 hours accredited training in sexual assault nurse examining at the Harborview Medical Center in Seattle, USA,[9] at the start of the evaluation the forensic nurse underwent intensive training within the Health Trust over a three-month period in all aspects of the procedures involved. This consisted of work in a number of clinics where internal examinations are performed, and covered the clinical areas of blood taking, genito-urinary medicine, resuscitation and termination, as well as close study with specialist Scene of Crime Officers (SOCOs) with regard to forensic and evidential issues. She was also trained in the use of the colposcope for forensic examinations during this period. In addition, between October 2000 and February 2001 she observed 12 and performed 15 forensic medical examinations under the direct supervision of the Clinical Director of St Mary's.

The forensic nurse began conducting examinations in late February 2001. Initially her examinations were performed under the supervision of the Clinical Director, or with another senior doctor. However, from March 2001, when the service went 'live', she performed examinations single-handedly, seeking second opinions from her colleagues as necessary. The role of the forensic nurse examiner was envisaged as being limited to the documentation of forensic medical findings, as well as the taking and preserving of forensic samples, whilst the Clinical Director continues to be responsible for interpreting the findings and providing expert opinion on them in court.

> *We feel very strongly that the opinion for the court should be done by a very experienced forensic doctor; that was the system that obtained in the unit in Seattle[10] that [the forensic nurse] went to, to do her training, and it must be the system in this country, that a very experienced senior forensic doctor should give the expert opinion to the court on the significance of findings or absence of findings.*
>
> (St Mary's Clinical Director, July 2002)

[9] During the period of training in the USA the forensic nurse observed a number of examinations additional to those required by her own arrangement.

[10] This is not the practice in other US and Canadian jurisdictions, where forensic nurses have become skilled providers of expert forensic evidence in court (Kelly, forthcoming).

Inter-agency issues

There were few problematic inter-agency issues in relation to this project. GMP welcomed the service from the beginning.

> *It's the office hours that have caused us problems, and the very early hours of the morning like I've talked about, the sort of five, six o'clock in the morning. So the benefits of having [the forensic nurse], are that – you know, she's filled that gap in the rota, if you like. I mean there's cost benefits as well, we have – it's unfortunate that these things do come down to cost, but it's a fact of life nowadays … having a forensic nurse is cheaper than having a doctor.* (Police Liaison Officer, July 2002)

As the intervention progressed, these expectations appeared to be fulfilled, and the police were confident that the forensic nurse examiner service represented a clear improvement that was also cost-effective. Interviewed again in April 2003 the Police Liaison Officer summed up the view of GMP:

> *I think overall the idea was to increase the service to the clients, which was the primary objective, but also service provision from St Mary's to us at GMP. It certainly achieved that as well. So, overall, I think it's certainly a step in the right direction, and my views are that it's a very positive step in the right direction.*

The CPS had no objections to the introduction of forensic nursing, but remained reticent to comment on its impact in the legal arena until more cases examined by the forensic nurse had come to court.

> *We have not seen any cases yet involving the nurse so it's difficult to comment. Hopefully the nurse will be sufficiently expert in what she does that evidence-gathering is reliable – this is the acid test for us – her ability to be a credible witness at court, and she must apply the same high standards as the forensic doctors. If she does this then we will be satisfied with the service.* (CPS 1, March 2002)

Interviewed at the end of the evaluation, the second CPS representative noted that the fact that examinations were being conducted by a forensic nurse had had no negative impact on their work.

> *As a member of the CPS, I don't think in all honesty that I could say that it's had a real impact on what we do, insofar as we would have had this evidence one way or the other. I know that [the forensic nurse's] evidence has never been challenged. I can say from a prosecution point of view, instead of getting our statements directly from a doctor, we now get our statements from a forensic nurse, and then we get an opinion from a doctor. There has never been any significant challenge to that format of giving evidence. It's certainly been looked at by senior counsel, who doesn't think that there would be any mileage in challenging that format.* (CPS 2, April 2003)

During the evaluation the forensic nurse examiner prepared written statements for 30 cases that proceeded to court. In 28 of these cases the medical evidence supplied by the forensic nurse examiner and supported by the opinion of the Clinical Director were accepted prior to the trial. In the remaining two cases the forensic nurse was required to appear in court in November 2002. In one of these an inconsistency in the presentation of findings by the forensic nurse created some evidential difficulties for the prosecution. Although the forensic nurse had been given advice and instruction around court issues prior to this, she had been unable to attend the mock court training that had been planned to prepare her for appearing in court. Discussions of how to prevent any similar difficulties in the future revealed that the court training for the forensic nurse had not been sufficiently detailed, and needed additional elements. They also revealed the varied experience and expertise in giving evidence among the forensic doctors. In response to this Greater Manchester CPS and St Mary's

subsequently devised and ran a court training weekend, which was attended by the forensic nurse and 11 forensic doctors. The training included work on:

- practical issues connected to the court system;
- pre-court preparation, such as statement and report writing; and
- skills development in relation to effective evidence giving.

Consolidation and integration of the intervention

The forensic nursing intervention successfully achieved one of its key objectives in providing an efficient remedy to the gap in daytime service provision, and this was noted in interviews with all relevant key professionals. The impact of this improved provision on the level of victim care was identified, firstly, by the project manager.

> *Well the impact for the clients is that they've got access to daytime examinations, so that's a massive impact, because where, before the intervention, they may have had to wait twelve hours for an examination, they can now access a daytime examination.*
> (St Mary's manager, February 2003)

Comments from one of the two CPS lawyers interviewed also pointed to the beneficial effects of prompt access to the service.

> *I'm very aware that with the forensic nurse examiner they [complainants] have access to her more quickly I suspect than they would do a doctor. So that's very useful. And she is always on site, which I think is also useful. One of the most important factors that has come out of this is that demands on other people's time have been alleviated to a certain extent. And I'm sure that's what the doctors would say, that it is the time factor. So the biggest benefit I would say is time.*
> (CPS 2, March 2003)

Despite some initial concerns expressed by the forensic doctors, the forensic nurse examiner service now appears to be well integrated into the service provided by the Centre as a whole.

> *I think initially there was a lot of hesitancy really about the whole project, but I guess that always happens when a nurse takes over a doctor's role. But they seem to be more accepting now, and certainly [the forensic nurse] provides cover on the rota, so without her input on the rota, cover for out-of-hours examinations would be very difficult. And I've not noticed any hostility towards the forensic nurse or the project as a whole, from the doctors*. (St Mary's manager, February 2003)

This was reiterated by one of the senior forensic doctors, who commented that whereas at the beginning there was a sense on the part of some of the doctors that forensic nursing could be viewed as a threat, it has since come to be seen not only as an integral feature, but as an enhancement to the forensic service the Centre is able to provide. Indeed, the forensic nurse enjoys the full support of the staff team at St Mary's, including the Support Worker and Crisis Workers, with whom she works closely when receiving an examinee.

Reflections by other members of the St Mary's team further supported this conclusion.

> *I think on a practical level it has improved the service in that people can be seen quicker during the day, because most of us work during the day, so we're not available and it's a bit grim when you're asking someone to stay in the same clothes and not bath for several hours. I think addressing that issue only improves the service* (St Mary's forensic doctor 2, July 2002).

They were offered a forensic medical within a couple of hours of being raped, and for the clients that I've seen, that was brilliant for them, because my guess is, if we didn't have a forensic nurse examiner, they would be waiting many, many hours.
(St Mary's counsellor 1, January 2001)

We haven't had the same problem with waiting, so if the police have wanted to access an examination or a self-referral wanted to access an examination, because the nurse is there, it can be done sooner rather than later. So I would be hugely surprised if the difference in waiting time wasn't highly significant.
(St Mary's counsellor 2, January 2001)

The twelve police officers from GMP who were interviewed were also asked about the impact of the forensic nursing service. All who had knowledge of, or had used the service, welcomed its introduction, agreeing that having consistent daytime cover had greatly improved the service both to them and to victim/survivors. Although the priority seen by these officers was to provide a speedier daytime service to victims, some also saw other benefits, including enhanced evidence gathering and professionalism. The majority of officers also commented on the quality of the service they received from the forensic nurse.

I think it's an excellent idea. It provides a service during the day, which is something that previously hasn't been available. It reduces waiting times. Overall I think the actual principles behind it are excellent, because you can have a lot more of these people that are trained up to do this, and therefore we are reducing waiting times, we're also not, like I say, dependent on doctors who are already in a GP's surgery doing a clinic or whatever, you know. (Forensic crime scene manager, May 2003)

Oh I think it just speeds things up, and that. Because the doctors have got surgeries, you know, and they're not always available during the day, whereas [the forensic nurse] she's there during the day. So, yeah, I find the forensic nurse very good, she's very nice, she's very approachable, she'll help you where she can, and she knows exactly what it is she's looking for, and she'll go out of her way, you know, to assist you. So, yes, she's good. (police officer DC, F1, July 2002)

[The forensic nurse] has been on a couple of my cases, and I've also had the doctors as well. I think she's as good as the doctors, and I have found that if she's unsure of something she calls out a doctor to give a second opinion. So she's very, very thorough. But she's very experienced. I mean if she can do it as good as a doctor, then I don't see the problem, you know, my main aim is that all evidence is recovered and whether it is [the forensic nurse] or [a forensic doctor] who does it, it doesn't matter to me as long as they do the same job. (police officer DC, F7, March 2003)

I think it's very good, I think it's a good idea. I think that, you know, anything where the expertise is greater is a plus. (police officer DC, M25, March 2003)

She's [forensic nurse] just very good. She's very approachable and puts them all at ease. She's super. (police officer PC, F5, July 2002)

One officer did question the two-tier approach of the current model of providing evidence to the court and her comments echoed those from two other officers, which highlighted the possibility that more explanation of the model may be needed for some investigating officers.

If we're going to have to get the expert opinion off the doctor on top of the nurse's notes then I don't think it's the best idea, you know. If the forensic nurse is going to be able to give a statement, and go as the expert witness to court, then fine, but as I say I've only had experience of it once, and a doctor had to give a statement on her notes, and she was going to be the expert witness at court, but not having dealt with the victim directly. It was kind of second-hand information. I'm sure that if they're

[forensic nurse] as medically qualified or able as the doctors, there can't be a problem, but it's whether they have that sort of training. I honestly don't know enough about it. (police officer DC, F10, March 2003)

Well I don't really know – what does a forensic nurse do? I've only ever had a doctor. I've never had a forensic nurse. (police officer DC, F24, March 2003)

I've actually never had occasion to use the forensic nurse, but I mean in theory I think it's a good idea. I think the reason that St Mary's works, isn't it, is because they can go to court and they are experts in that field, but I think you have to have experience to become an expert, don't you. I honestly don't know the experience that the forensic nurse has, I don't know. (police officer DC, F16, March 2003)

All St Mary's staff also noted positive responses from the police officers about the forensic nurse service.

And from the police that have actually come to the centre, and escorted somebody down, and they are introduced to [forensic nurse] – the feedback is very, very good, that I get. (St Mary's Crisis Worker, January 2001)

In terms of police on the ground when they're coming through for the examination, there's only been positive praise of the situation.

(St Mary's counsellor 2, February 2002)

The police have taken it on board fully, they're a lot happier, because they can get access to daytime examinations, so that when they get a report of rape or sexual assault they can access this a whole lot quicker. So their investigation process can continue, whereas before if there was a delay in examination, then the whole investigative process was delayed. So the police are highly delighted with it.

(St Mary's manager, February 2003)

The introduction of the forensic nursing intervention has also impacted positively on the continued development of forensic expertise at the Centre. The rigorous nature of the training the forensic nurse underwent, together with the need to clearly document her job description and protocols for conducting examinations in order to validate her position within the wider health context, contributed in part to the decision to review the wider recording practices of the St Mary's forensic team. In 2003, the forensic medical examination form developed by the Centre was refined to ensure even tighter documentation of findings.

There have also been unanticipated outcomes of the pilot. The thoughtful and lengthy process of ensuring adequate training for the forensic nurse, to ensure that her skills and expertise would be recognised in legal proceedings, highlighted gaps in both the training and supervision of the forensic doctors.

I think, you know, as we've said, [the forensic nurse] did have a great deal of supervision, more supervision than the doctors generally, have had, and we've already agreed that that's something we need to address with the training of doctors in the future, that they get better training than they've sometimes had in the past.

(St Mary's Clinical Director, July 2002)

[The forensic nurse] training has been of a very high standard and has in fact included much more than the forensic doctors have been provided with in the past, and it's gone very well and she is now very well trained. It's certainly going to be necessary for there to be provision for new forensic doctors to get the training of the quality and depth that [the forensic nurse] has had.

(St Mary's Clinical Director, March 2003)

It is also true that the forensic nurse, as a full-time member of staff, was available during normal working hours to undertake training. This is much more difficult for the forensic doctors who have to fit training into an already busy timetable. Doctors also receive no remuneration for their time whilst doing training.

> *I'm full-time here, so I'm able to go along to different clinics and observe, and take part. You know the doctors have got other jobs and they can't do that. I'm going on some training for preparation for being a witness in court. Well they never get that. And they do manage to vocalise that as well, you know, they do manage to say 'well we didn't have that'. But it's difficult, because they've all got other jobs.*
>
> (St Mary's forensic nurse, March 2003)

The Centre has, in fact, identified the need for a rolling programme of training and will now be providing yearly training around court and other key issues for all forensic staff at the Centre, including the forensic nurse.

Fulfilling one of the aims of the pilot, a national conference, *Sexual Assault Examinations: the SANE (Sexual Assault Nurse Examiner) Option*, was organised by St Mary's in January 2003. The preparation for the conference created an impetus to consolidate the pilot, through a range of protocols and other documentation. The widely-attended conference – 150 delegates, primarily from the police, rape and sexual assault services and health (including nursing) sectors – meant that St Mary's was able to promote not only the idea of forensic nursing, but also its growing expertise.

One outstanding issue the evaluation team identified, and sought to promote discussion around at Steering Group meetings, was the extent to which the colposcope is used for still or video recording of internal findings. Evidence from the USA, where forensic nursing is more established, suggests that not only does the colposcope significantly increase the identification of internal injuries,[11] taking still photographs of such findings is considered routine practice (Kelly, forthcoming). Despite the fact that the nurse examiner used a colposcope as a diagnostic tool in every case where an internal examination was conducted[12] – with the exception of two instances where the instrument was not working – consent to photograph or video findings was still sought from each individual prior to examination.[13] The reasoning behind this is that the Centre cannot guarantee that such evidence will be limited to doctors, and there is a possibility that a videoed internal examination could be shown in court. During the evaluation permission to video internal injuries was only granted in seven cases, and for still photography in 25. Where the colposcope was used (203 cases), the forensic nurse identified the presence of internal injuries in around a fifth of examinations (19%, n=39).

From Steering Group discussions it was clear that the single most important barrier to making evidential records using the colposcope is the absence of a clear national protocol on the disclosure of video or still photographs of intimate body parts.The Clinical Director at St Mary's confirmed that examinees are generally happy to agree to the use of a video or still photography record of injuries if that record will be seen only by other medical personnel.

> *The complainant who comes to us is just about able to manage to let us examine her, or him, she can't go the last bit to agree that it's possible that this could be on the wall in the court. And that has happened, you see.*
>
> (St Mary's Clinical Director, March 2003)

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[11] See, for example, a review of research on forensic findings (Ledray, 1999) and of colposcopic findings (Ledray, 2001).

[12] Service users are advised that all aspects of the examination should be conducted with their consent, and that they may choose to stop at any point. A few do not consent to internal/genital examinations, whilst permitting the review and documentation of external injuries.

[13] The forensic medical examination form includes a section *Consent to Examination and Report* where the service user signs to consent to any number of or all of the following: full medical examination; collection of forensic specimens/clothing; taking of photographs for record purposes; use of the colposcope and making a video recording of genital examination; and report to the police. The service user may withhold consent to any of these five possibilities.

Although there has been a series of discussions between St Mary's forensic examiners, Greater Manchester CPS and the Department for Constitutional Affairs,[14] no national protocol has been developed, yet there are local working protocols in different parts of the country. This relatively simple process needs to be taken forward, creating a protocol which includes: informed consent by the complainant; non-disclosure of such evidential records to non-medical personnel; and, where there is disagreement about findings between prosecution and defence medical experts, the appointment by the court of an independent medical expert. St Mary's staff support a model whereby use of video and still photography with a colposcope becomes a 'routine' part of the examination, but that consent for disclosure of such evidence (to other medical personnel only) is gained as part of the witness statement-taking process. Currently complainants sign a form to consent to evidence-gathering at the time of the examination. It is suggested that a paragraph is added which enables complainants to withdraw consent at a later date.

We are aware that St Mary's is reconsidering its practice in relation to examinees under the age of 16 in light of the *Guidance on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse* issued by the Association of Police Surgeons (AFP)[15] (2002). Here more routine use of video/photography with people under the age of 18 is encouraged as good practice, the rationale being that if there is any legal query relating to medical evidence, a photographic record greatly decreases any necessity of re-examination, thus lessening the potential for retraumatisation. Examinees aged from 16 to 18 are treated as adults by St Mary's in relation to consent to the range of aspects associated with the forensic medical examination.

St Mary's are still in discussion with the CPS to resolve these issues, with a view to establishing clear protocols in relation to both child and adult examinations. Representatives of Greater Manchester CPS are, themselves, currently seeking guidance at the national level.

A final issue in implementation was highlighted by the forensic nurse's absence due to ill health, which resulted in her performing no examinations from early November 2002 to the end of data collection, and beyond this. During this period daytime service reverted to the model before the pilot, and raises questions about cover for holidays, sick and maternity leave where only one member of staff has the requisite skills.

[14] Formerly the Lord Chancellor's Office.
[15] This body is now called the Association of Forensic Physicians.

4. Research findings

The findings reported on here are based on analysis of the full range of data sources described in Chapter 1.

Number of examinations conducted

Analysis of all St Mary's cases entered on the case-tracking database shows that three-quarters of those attending the Centre during the evaluation underwent a forensic medical examination (74%, n=1,072 of 1,442). The majority (83%, n=308) of those who did not were self-referrals, many of whom were not reporting a recent assault. An additional 62 service users, predominantly police referrals, attended for an examination but ultimately declined to proceed with one.

Analysis of the examiner type in all 1,072 cases where an examination was conducted reveals that the forensic nurse was responsible for performing around a quarter of all examinations (23%, n=249). All others (77%, n=822) were carried out by a female doctor. As St Mary's has a team of 13 forensic doctors who operate a rotating on-call system, the proportion of 77 per cent must thus be seen as the sum of their collective efforts, whereas the forensic nurse is singly responsible for almost a quarter of all examinations.[16] The forensic nurse was in attendance for a further twelve service users who, following discussion with the nurse and Crisis Worker about their options decided not to proceed with an examination.[17]

The vast majority (89%, n=222) of examinees seen by the forensic nurse were police referrals to the service, and the remaining 11 per cent (n=27) were self-referrals. As with the service generally, the majority were female (96%, n=239), with a small number of males (4%, n=10). The forensic nurse examined a slightly higher proportion of female service users than the doctors (96%, n=239 versus 91%, n=753), and a slightly lower proportion of male service users (4%, n=10 versus 9%, n=70). In terms of the age range of her examinees, they fall into these age brackets: under 16 years old (16%, n=39); from 16 to 24 (43%, n=107); from 25 to 34 (21%, n=53); 35 and over (20%, n=50). These proportions reflect those of St Mary's service users overall, and echo findings from the British Crime Survey, in that the 16 to 24 age group have the highest reporting rate for rape (Myhill and Allen, 2002).

Weekday daytime provision

Between 1987 and 2002 there has been a progressive increase in the numbers of forensic examinations conducted at St Mary's – from 186 to 473 (154%), but an overall decrease in the proportion conducted during weekday daytimes before the introduction of the forensic nursing service, particularly between 1994 and 2000 (see Table 4.1). This shows that the concerns raised by St Mary's and GMP about the limited availability of forensic examiners during these times – one of the key arguments underpinning the pilot — were well founded. The maximum number of weekday daytime examinations performed before the introduction of the forensic nurse examiner service was 68 in 1999 compared to 80 in 2001 and 154 in 2002 when the pilot was operational. We can conclude, therefore, that the pilot succeeded, not only in providing a more professional response to those reporting rape, but also in increasing the number of examinations undertaken during office hours.

[16] This would undoubtedly have been a quarter had there not been a period of several months when the forensic nurse was on extended sick leave.

[17] This is not an experience exclusive to the forensic nurse; it has also occurred in some cases examined by female doctors. Indeed, of the 62 service users who attended St Mary's for a medical but declined to undertake one, 49 were to be seen by a female doctor, 12 by the forensic nurse and one by a male doctor. The choice-centred approach that St Mary's seeks to promote with its service users means that some will inevitably exercise their choice not to undergo an examination.

Table 4.1: Timing of forensic medical examinations 1987 to 2002 where dates/times known

Year	Weekday daytime examinations (9.00am-5.00pm)	% change from prior year	Examinations at all other times	Total	% change from prior year
1987[1]	56		130	**186**	
1988	46	-18%	153	**199**	**7%**
1989	35	-24%	172	**207**	**4%**
1990	47	34%	200	**247**	**19%**
1991	38	-19%	164	**202**	**-18%**
1992	37	-3%	188	**225**	**11%**
1993	47	27%	199	**246**	**9%**
1994	67	43%	253	**320**	**30%**
1995	63	-6%	257	**320**	**0%**
1996	63	0%	326	**389**	**22%**
1997	66	5%	345	**411**	**6%**
1998	56	-15%	332	**388**	**-6%**
1999	68	21%	353	**421**	**9%**
2000[2]	47	-31%	395	**442**	**5%**
2001	80	70%	383	**463**	**5%**
2002	154	93%	319	**473**	**2%**
Total	**970**		**4,169**	**5,139**	

Source: St Mary's historic database and case-tracking database.

[1] Although St Mary's opened in 1986, figures are from 1987 as this was the first full year in which data were collected. Twenty-six cases where the date/time of the examination was unknown have been excluded from this analysis.

[2] Totals for the year 2000 derived from adding data from St Mary's Centre database up to 30 September 2000 (start date of the CRP-funded projects and evaluations) and referrals from 1 October – 31 December entered on case-tracking database (period of evaluation).

During the 27 months covered by the evaluation, just over a fifth (22%, n=236) of all examinations have been conducted on weekdays during the daytime: an average of 105 weekday daytime examinations per year (see Table 4.2), and one-third more than the pre-pilot maximum of 68 in 1999. Of the 249 examinations the forensic nurse has performed, well over half (60%, n=150) have been conducted on weekdays during the daytime, the remainder being on-call. She has thus performed almost two-thirds (64%, n=150) of all weekday daytime examinations since the evaluation began: 22 of the weekday daytime examinations conducted by the doctors cover the period when the forensic nurse was still training, most of the rest relate to periods of annual leave and the couple of months of sick leave.

Table 4.2: Timing of forensic medical examinations during evaluation (1 October 2000 to 31 December 2002)

Examiner type	Weekday daytime examinations (9.00am-5.00pm)	Examinations at all other times	Date/time not known	Total
Forensic nurse	150 (60%)	99 (40%)	0 (0%)	249 (100%)
Female doctor	86 (10%)	712 (87%)	25 (3%)	823 (100%)
Total	**236 (22%)**	**811 (76%)**	**25 (2%)**	**1,072 (100%)**

Source: Case-tracking database.

Speed of response

One of the key issues for women and men reporting rape are the delays that occur, especially with respect to forensic examinations. This was one of the issues SARCs were established to address, and the forensic nursing intervention aimed to correct a particular shortfall during the daytime on weekdays due to the limited availability of the forensic doctors in the team during these times.

In the case of police referrals, it is the role of the police officers dealing with a case to contact St Mary's and ensure that a forensic examiner is available before taking a complainant to the Centre. The attendance time should, therefore, correlate closely with the time when the forensic examination takes place. The speed of response has been calculated here on the basis of the time lapse between when a report was made to the police[18] and the start time of the examination where both sets of dates and times were available. It should be noted that travelling time to St Mary's can vary significantly from ten to 15 minutes from the closest police stations in Central Manchester, to more than an hour from areas of Greater Manchester, such as Bolton, Oldham and Rochdale, furthest away from the hospital, though this is unlikely to delay attendance beyond one or two hours.

In analysis of the speed of response at St Mary's, the time lapse from report to the police to examination in cases seen by the forensic nurse and the forensic doctors, both during weekday daytimes and at all other times were compared. Although not all cases seen by the forensic doctors relate to the pre-intervention period, they have been used as a baseline here as they are, nonetheless, representative of how the service functions without the daytime provision afforded by the forensic nurse examiner service. The analysis conducted shows that the forensic nurse performed a quarter of all weekday examinations (24%, n=27 of 111 where dates/times known) within three hours of the assault being reported to the police. This compares favourably with the fifth of cases (17%, n=13 of 75 where dates/times known) examined by the forensic doctors within three hours. For weekday daytime examinations conducted within six hours of the police report, the proportions rose to almost half (46%, n=51) of the forensic nurse cases, which was slightly higher than for the forensic doctors (41%, n=31).

For weekday daytime examinations conducted by the forensic nurse, the average (mean) time lapse between the police report being made and forensic medical examination being conducted was 10.5 hours, with over half (57%) falling below the mean. For the forensic doctors the mean time lapse was noticeably higher at 16.9 hours, with three-quarters (75%) falling below the mean. Excluding the extremes, defined as those cases with a time lapse exceeding 48 hours, from this analysis (1 of the forensic nurse cases and 5 of the doctors') causes the mean to fall to 9.8 hours for the forensic nurse and 10.5 for the forensic doctors.

For cases examined at all other times (weekday evenings and weekends) almost half overall were conducted within three hours of the assault being reported to the police, with a negligible difference between those examined by the forensic nurse and the forensic doctors (46%, n=40 of 87 where dates/times known compared with 47%, n=299 of 633 where dates/times known). For examinations conducted within six hours of the police report the proportions rose to around three-quarters, again with only a minor difference between those examined by the forensic nurse and the forensic doctors (72%, n=63 compared with 77%, n=485).

For examinations conducted by the forensic nurse at all times outside weekday daytimes, the mean time lapse between the police report being made and forensic medical examination being conducted was 6.7 hours, with almost three-quarters (72%) falling below the mean. For the forensic doctors the mean time lapse was marginally higher at 6.9 hours, again with around three-quarters (77%) falling below this level. There were no cases examined by the forensic nurse in this group with a time lapse exceeding 48 hours. However, excluding the extremes from those examined by the doctors (6 cases) causes the mean to fall to 5.8.

[18] This is based on the time the Force Wide Incident Number (FWIN) for each report made was created.

The service user questionnaire data supplement this basic information. Just over half (55%, n=36) of St Mary's questionnaire respondents experienced a delay between the time of reporting the assault and attendance of the Centre. For these respondents attendance of St Mary's varied from one hour (22%, n=8) to, for one respondent, 24 hours, after reporting. For the majority (62%, n=23), however, the intervening time is three hours or less – this will include the time it takes police officers to establish what has happened, making the arrangements with St Mary's and transporting the victim to the Centre.

There is a notable group of cases conducted both during weekday daytimes and at all other times (16%, n=144 of a total of 906 examinations conducted) where the time between the report to police and the forensic medical examination exceeded 12 hours. Unsurprisingly, almost half of these cases (44%, n=67) were examined on weekdays during the daytime; since if a degree of delay has already been experienced it would appear sensible to schedule such examinations at a time comfortable for complainants.

Whilst a variety of factors may have contributed to this delayed arrival at St Mary's, such as prior attendance of Accident and Emergency, complainants needing to identify the crime scene or formal statements being taken, it is not possible to quantify the impact of any of these variables as they are not recorded consistently. However, analysis within the case-tracking database shows there is some link with delayed reporting of the assault, with a quarter of these cases (25%, n=27 of 107 where assault, report and examination dates/times known) involving reports made to the police in excess of 24 hours after the assault. In ten of these cases the assault was reported over three days later. Another factor that may influence the speed of response is the type of assault experienced. In cases of indecent assault or attempted rape not involving penetration, for example, the possibilities of obtaining forensic evidence may be limited. If a case of this type presents at the same time as one involving recent rape, the latter is likely to be prioritised to maximise the chances of collecting the relevant samples. Almost a third (21%, n=45) of cases in this group were not rapes.

Discussions with the forensic team at St Mary's suggest a further reason for delay may be that if a victim reports during the early hours of the morning and needs a medical examination, the police may defer attendance until the forensic nurse begins her shift at 9am. This is especially likely where the on-call female doctor has examined several cases during the night. As there is only one examination suite at the Centre, there is further potential for delay where several reports occur on the same day around the same time. Indeed, in around a fifth (22%, n=32) of cases in this group one or more examinations were held during the hours immediately preceding their arrival. As on average an examination takes two hours, and the examination suite must be thoroughly cleansed between each examination to prevent cross-contamination of evidence, there is potential for several hours delay under these circumstances.

The sex of the forensic examiner

A number of research studies and consultations (see Kelly, 2002) have noted that most survivors of rape and sexual assault express a preference to be medically examined by a woman. Again, this represents one of the motivations for the establishment of St Mary's and its protocols. All those who underwent an examination during the evaluation (n=1,072) were examined by a woman, whether a female doctor or the forensic nurse. This applied equally to female and male service users (female n=992; male n=80). Only one additional male, who did not proceed with an examination, exercised his right to request a male doctor. [19]

We explored this issue further in the service user questionnaires, asking explicitly if the sex of the forensic examiner made a difference. Almost all (89%, n=56) said that it did, with the most common reason given that at that point they did not wish to be near to, or touched by a

[19] At St Mary's a female examiner is the default position, although a male can be found for anyone expressing this preference.

man (43%, n=22). Some expressed their preference in more positive terms, such as feeling safer, more at ease or less embarrassed with a woman.

> *I could not have a male touch me.* (St Mary's Q1, 1001)
>
> *I was already angry about a man looking and touching my body, I didn't need another.* (St Mary's Q1, 1023)
>
> *I wouldn't have wanted a male doctor looking or touching me after what happened.* (St Mary's Q1, 1030)
>
> *Not just being female – which makes you feel safer – but the caring understanding that I received.* (St Mary's Q1, 1018)
>
> *I felt safe and secure.* (St Mary's Q1, 1006)
>
> *It made me feel comfortable with myself after what happened.* (St Mary's Q1, 1015)
>
> *I felt more comfortable and at ease knowing it was a woman especially after what had happened to me.* (St Mary's Q1, 1038)

Although there were only a small number of male questionnaire respondents (n=3), all said they preferred a female examiner, with two focusing on feeling more comfortable with a female and one that he did not want to be touched by a male. The same preference for a female forensic examiner was evident in the 27 service user feedback *pro formas*. These data suggest that the default position for forensic examiners in sexual assault cases should be that they are women. Whilst only a small proportion of this sample would have refused examination by a man, this becomes more significant when seeking to address attrition at a national level. In addition, the vast majority of women and men felt more at ease, and cared for, with a female examiner, suggesting that this makes the examination less stressful, and, in turn, will not be a factor which feeds into subsequent decisions to withdraw.

Service user assessments of the forensic examiner

Here service users' experiences of the forensic examiner expressed in the questionnaires, forensic feedback *pro formas* and interviews are reported. Key areas discussed include: whether examinees felt they had choice and control in the examination process; whether they received sympathetic and supportive treatment from the examiner; how they experienced the examination; and their overall satisfaction with the examiner's response to them.

Choice and control

A recurring criticism of forensic examinations elsewhere has been that the behaviour of examiners is too detached, and that they fail to explain the process. Practice at St Mary's has sought to address this, both through the Crisis Worker role (explaining the process before anyone takes the decision to go ahead), and by encouraging doctors to explain the process overall, as well as step by step. The questionnaire to service users asked a series of questions about how the examination was conducted. Almost all respondents (96%, n=63) answered the question about the level of explanation they were given: for 81 per cent the process was explained at more than one point (70%, n=44 throughout; 11%, n=7 at several points); and for the remainder (19%, n=12) it was outlined at the beginning.

A slight difference was discernible here between those examined by a forensic doctor and those by the forensic nurse, with the former group more likely to have had the process explained throughout. The service user feedback *pro formas* support the conclusion that both doctors and the forensic nurse are most likely to explain the process throughout the forensic examination (78%, n=21).

The philosophy behind this approach involves recognising both the intrusive, albeit necessary for evidential purposes, nature of internal examinations and that restoring a sense of control to survivors can begin very early post-assault. Whether this reflects the perceptions of service users explicitly in the questionnaire were explored, by asking if they felt they could stop the medical, and whether this was important to them. Almost all (92%, n=58) felt they could stop the medical, and 'feeling in control' was the main reason given for why this was important to them (70%, n=25 of 36 who answered the question). There was no difference here between those examined by the forensic nurse and by a forensic doctor.

This theme recurred in response to a question about how respondents felt during the examination – here two-thirds (65%, n=41) said they felt in control. Albeit the numbers are very low, slightly more of those examined by a forensic nurse reported this compared to those examined by a forensic doctor (82%, n=9 versus 62%, n=32). An even higher proportion (82%, n=22) of those completing service user feedback *pro formas* reported feeling in control. As the numbers here are even smaller,comparisons between examiner type cannot be taken as conclusive, however a slightly lower proportion of those examined by the forensic nurse reported feeling in control (75%, n=6; 83%, n=15, 1 examiner type unknown). Some comments from the questionnaires illustrate how important a sense of being in control was.

> *I knew if I felt uncomfortable I could take a break and compose myself.* (St Mary's Q1, 1064)

> *A lot, confident to take it step by step.* (St Mary's Q1, 1010)

> *I know I could tell her to stop and she would if I got scared or the examination started to hurt.* (St Mary's Q1, 1044)

> *It made me feel more relaxed knowing I could stop if I wanted.* (St Mary's Q1, 1058)

Sympathetic/supportive treatment

Three-quarters of questionnaire respondents (76%, n=48) also reported that they were able to tell the forensic examiner how they were feeling, and although the sample size is small, slightly more of those examined by the forensic nurse reported this than those examined by a forensic doctor (82%, n=9 versus 75%, n=39). Service users were also asked to rate the forensic examiner according to a range of variables, including respect, belief, support and sympathy, in both the questionnaire and the *pro forma.* There were very high satisfaction levels across all these measures with the medical examiners. In the questionnaire data the forensic nurse received a 100 per cent satisfaction rating across all but one variable (non-judgemental), where she scored 92 per cent. The forensic doctors received ratings that varied from 92 per cent to 98 per cent. None of these small differences between examiner type were statistically significant.

For almost half of questionnaire respondents (43%, n=26) and two-thirds of those completing *pro formas* (63%, n=17) the forensic nurse and forensic doctor were thought to have said something helpful during the examination. Being told 'not to worry/being reassuring' and 'explaining the process' were the most helpful things (35%, n=9 and 27%, n=7 respectively).

> *I was very scared in case it might hurt but she was very good and all the way through she told me what she was going to do next.* (St Mary's Q1, 1020)

> *She was explaining what she was doing whilst she carried out the exam, which made me feel more comfortable.* (St Mary's Q1, 1026)

Only a small number (5%, n=3) reported that something unhelpful had been said. In all such cases a forensic doctor had conducted the examination. Unhelpful things said included: 'no signs of trauma/injury'; 'length of time for results' and 'judgmental/unsympathetic comments'. One of only two interviewees who did not have a positive experience of the forensic examiner

(of a total of 12 all examined by a forensic doctor), illustrates the importance of conducting the examination in a supportive and sympathetic environment.

> *But when I got to St Mary's, it was the first point at which I encountered somebody that didn't seem to believe me, and that was the doctor that did the forensic examination … The doctor tried to sort of tell me that I'd maybe drank too much. I mean I only had about one because I was driving and also I'm also clear in the quantities I'd drank so I wasn't … I was really angry with her, really angry. And I'd up till then had been numb, really … I felt her response to it was that she didn't believe me … As far as the examination, she was very respectful in terms of, you know, making sure I was covered up and explaining things and, you know, medically speaking she's very respectful. But obviously we'd just had this conversation five minutes before in which I felt she didn't believe me, and it's very hard being examined by someone that, you know, has just implied they didn't believe you … The thing that lasts as far as experience is whether you were believed or not.*
>
> (St Mary's service user, Interview 9)

Only one respondent reported something confusing being said, which was also by a forensic doctor.

Over three-quarters of respondents were concerned about physical injury as a result of the assault (78%, n=47). The majority of these concerns centred around sexually transmitted infections (STDs) (58%, n=26), followed by actual physical injuries (33%, n=15) and HIV (22%, n=10). More than three-quarters felt more reassured by the forensic examiner. Comments from two respondents illustrate how medical examiners can provide accurate information in a supportive manner.

> *[She said] the STDs are treatable and the morning-after pill would ensure I wasn't pregnant.* (St Mary's Q1, 1050)
>
> *She assured me that any infection I may have would be treated immediately.*
>
> (St Mary's Q1, 1057)

How service users experienced the examination

Previous research (see, for example, Jordan, 2002; Temkin, 1996) has reported that, for some complainants, the forensic medical has been experienced as not just intrusive and painful, but almost a form of 'second assault'. This was addressed in the questionnaire and *pro forma* by asking how respondents would describe the experience. Unsurprisingly, there was a wide range of responses, with differences apparent here between those examined by a forensic nurse or a doctor, although again the numbers are small and the comparison is between one forensic nurse and a team of 13 forensic doctors. The most cited response was 'uncomfortable' by just over a quarter (26%, n=14), although all but one of these service users was examined by a forensic doctor, closely followed by 'necessary' (24% n=13), which was much more likely amongst those examined by the forensic nurse (63%, n=5 versus 17%, n=8). A further fifth described the experience as 'embarrassing'.

> *A necessary thing – made easier by the doctor and Crisis Worker.*
>
> (St Mary's Q1, 1018)
>
> *Very uncomfortable and embarrassing but the examiner helped by explaining what she was doing.* (St Mary's Q1, 1026)
>
> *Difficult and uncomfortable.* (St Mary's Q1, 1015)

A small number of respondents described the examination as 'clinical/cold' (7%, n=4), all of whom were examined by a forensic doctor. These findings suggest that the forensic nurse is skilled not only at putting service users at ease, but also in the technical aspects of internal

examinations. The latter must, in part, be attributed to the greater number of examinations and the detailed training she has undertaken.

One interesting finding is that while experiencing the forensic examination as similar to an assault may be inevitable for some survivors, it is not necessarily the outcome of poor practice, as has sometimes been assumed in previous research (Temkin, 1996; Koss and Harvey, 1991). In this sample virtually everyone expressed satisfaction with the attitude and behaviour of the examiner, but despite this a number referred to resonances with the sexual assault. This also highlights the importance of having a range of measures to assess practice, and understand the reality of internal examinations, following rape.

Response to the forensic nurse examiner

The forensic feedback *pro formas* were used to explore whether being examined by a nurse or doctor made a difference to service users. The forensic nurse conducted the examination in 30 per cent of cases (n=8) where a *pro forma* was completed. Although this is a very small number of responses, it reflects the overall proportion of examinations she conducted compared with the forensic doctors (a quarter were performed by the forensic nurse, three-quarters by the doctors). In response to a question asking whether being examined by a nurse or a doctor made a difference to them, just over two-thirds of service users said it did not (68%, n=17). Of the eight who did express a preference, five explained why: two said their examiner was 'very nice' (one each examined by a forensic doctor and a forensic nurse); one that the 'nurse was very good and very professional'; and two that they 'felt better' being examined by a forensic doctor. There are, therefore, no services users examined by the forensic nurse who would have preferred to be examined by a doctor.

Overall satisfaction with the forensic examiner

Questionnaire respondents were asked to indicate their overall satisfaction levels with the forensic examiner. Those who answered the question (n=62) demonstrated very high levels of satisfaction, with the majority of those examined by both the forensic nurse and the forensic doctors being 'very satisfied' (forensic nurse 91%, n=10; forensic doctor 77%, n=39) and almost all others 'satisfied' (forensic nurse 9%, n=1; forensic doctors 22%, n=11). Only one respondent (examined by a forensic doctor) reported being dissatisfied. Given the intrusive nature of a forensic examination following a sexual assault, the almost 100 per cent satisfaction ratings (when taking into account those who were 'satisfied' and 'very satisfied') are an indicator of the care and sensitivity in current practice at St Mary's.

Only six respondents made suggestions about how forensic medical examinations could be improved, including: giving 'more reassurance'; 'improving procedure'; providing 'better surroundings' and being 'less judgmental/disrespectful'. All but one of these comments were made by respondents examined by a forensic doctor.

Forensic nursing intervention and attrition

It was hoped that the forensic nurse pilot would have an impact on attrition in two ways: firstly, through an increase in self-referrals who decide to report to the police and, secondly, through enhanced forensic evidence gathering. The final part of this chapter presents comparative detection, prosecution and conviction rates among cases examined by the forensic nurse and the forensic doctors.

Self-referrals reporting to the police

The majority of St Mary's service users have already reported to the police, but there have always been a significant proportion of self-referrals. Using data from St Mary's historic database and the case-tracking database designed specifically for this evaluation, Table 4.3 illustrates the breakdown of service users by referral source since the Centre opened up to

and including the period of the evaluation. Since 1987 the total number of referrals to St Mary's has increased year-on-year, and has more than doubled between 1987 and 2002. The majority of this increase has come from police referrals. Although there have always been a significant number of self-referrals, these have only increased marginally in 2002 compared to 1987, and actually represent a decreasing proportion of all service users during the period.

Table 4.3: Total referrals to St Mary's Centre 1987 to 2002

Year	Police	% change from prior year	Self	% change from prior year	Self then police	% change from prior year	Total	% change from prior year
1987[1]	167		133		0		**300**	
1988	199	19%	140	5%	5		**344**	**15%**
1989	242	22%	155	11%	9	80%	**406**	**18%**
1990	260	7%	132	-15%	7	-22%	**399**	**-2%**
1991	246	-5%	151	14%	2	-71%	**399**	**0%**
1992	244	-1%	148	-2%	0	-100%	**392**	**-2%**
1993	308	26%	151	2%	0		**459**	**17%**
1994	317	3%	135	-11%	0		**452**	**-2%**
1995	305	-4%	168	24%	0		**473**	**5%**
1996	365	20%	175	4%	0		**540**	**14%**
1997	410	12%	182	4%	1		**593**	**10%**
1998	388	-5%	167	-8%	0	-100%	**555**	**-6%**
1999	413	6%	197	18%	9		**619**	**12%**
2000[2]	425	3%	196	-1%	2	-78%	**623**	**1%**
2001	462	9%	165	-16%	7	250%	**634**	**2%**
2002	480	4%	173	5%	4	-43%	**657**	**4%**
Total	**5,231**		**2,568**		**46**		**7,845**	

Source: St Mary's historic database and case-tracking database.

[1] Although St Mary's opened in 1986, figures are from 1987 as this was the first full year in which data were collected. Twenty-two cases where the referral source was unknown have been excluded from this analysis.

[2] Totals for the year 2000 derived from adding data from St Mary's Centre database up to 30 September 2000 (start date of the CRP-funded projects and evaluations) and referrals from 1 October – 31 December entered on case-tracking database (period of evaluation).

A service user defined as a police referral will have reported being assaulted to the police, and will have been taken by them to the Centre for a forensic medical examination. Once at St Mary's, the Crisis Worker and forensic examiner will inform him/her of his/her options in relation to the medical and police processes, as well as outlining support services offered by the Centre. Any examination then takes place with the service user's consent. However, not all choose to do so, and some also decline any further police involvement in the case at this point. Self-referrals will normally have attended the Centre without prior police involvement, although a small number may have reported their assault to the police in the past. Upon contacting St Mary's, self-referrals are informed of their options regarding support. In cases of recent assault, St Mary's also offers the possibility of undergoing a forensic examination and storing any samples taken securely at the Centre until such time as the service user decides that they should be handed over to the police, or, upon their request, destroyed.

Drawing on the data in Table 4.3, a small proportion of self-referrals (2%, n=46) opt to make a report to the police after, or even whilst, attending the Centre. This group are defined as 'self then police' referrals. It must be noted, however, that the referral type is recorded at the point of initial attendance, meaning there may be more self-referrals who went on to report to the police following contact with St Mary's whose referral type has not been updated to 'self then police' in the Centre records. To test the extent to which data of this nature may be missing, an audit of all self-referrals from 1999 was conducted. This revealed that nine self-referrals out of a total of 206 reported to the police following contact with the service (4% during the year). The number of self-referrals who may have had contact with the police in relation to their assault at any stage prior to contacting the service is also not reflected in the above

table. According to Table 4.3, police involvement in the case, whether prior to or after attending the Centre, thus occurs in around two-thirds of all referrals (67%, n=5,277), although the actual figure may be slightly higher.

Again using data from the St Mary's Centre database and the case-tracking database, Table 4.4 presents a breakdown of all referrals resulting in a forensic medical examination. The increase in referrals evident in Table 4.3 is also reflected in the increase in forensic examinations performed at St Mary's, both overall (from 186 in 1987 to 496 in 2002) and as a proportion of all cases seen (from 62% in 1987 to 75% in 2002).

Table 4.4: Total referrals leading to a forensic medical examination 1987-2002

Year	Police	% change from prior year	Self	% change from prior year	Self then police	% change from prior year	Total	% change from prior year
1987[1]	144		42		0		**186**	
1988	160	11%	34	-19%	5		**199**	**7%**
1989	193	21%	8	-76%	6	20%	**207**	**4%**
1990	233	21%	9	13%	6	0%	**248**	**20%**
1991	190	-18%	10	11%	2	-67%	**202**	**-19%**
1992	220	16%	5	-50%	0	-100%	**225**	**11%**
1993	241	10%	5	0%	0		**246**	**9%**
1994	293	22%	26	420%	0		**319**	**30%**
1995	284	-3%	36	38%	0		**320**	**0%**
1996	353	24%	36	0%	0		**389**	**22%**
1997	386	9%	24	-33%	1		**411**	**6%**
1998	371	-4%	17	-29%	0	-100%	**388**	**-6%**
1999	402	8%	15	-12%	4		**421**	**9%**
2000[2]	415	3%	23	53%	2	-50%	**440**	**5%**
2001	429	3%	29	26%	7	250%	**465**	**6%**
2002	458	7%	34	17%	4	-43%	**496**	**7%**
Total	**4,772**		**353**		**37**		**5,162**	

Source: St Mary's historic database and case-tracking database.

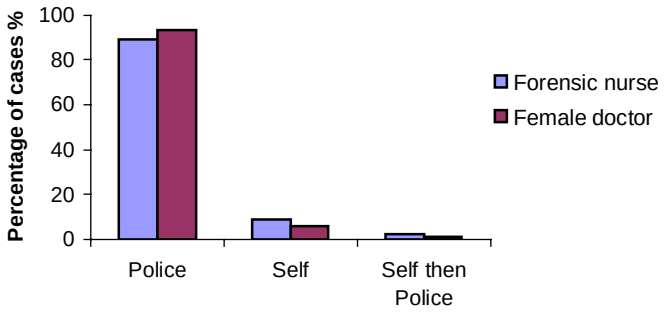
[1] Although St Mary's opened in 1986, figures are from 1987 as this was the first full year in which data were collected. Four cases where the referral source was unknown have been excluded from this analysis.

[2] Totals for the year 2000 derived from adding data from St Mary's Centre database up to 30 September 2000 (start date of the CRP-funded projects and evaluations) and referrals from 1 October – 31 December entered on case-tracking database (period of evaluation).

Comparing the total figures in Tables 4.3 and 4.4 shows that the majority (91%, n=4,772) of police referrals undergo an examination, whereas a much smaller proportion (15%, n=390) of self-referrals do. Although self-referrals are offered the option of undergoing a forensic examination, the lower level of police reporting among this group and the fact that not all have been assaulted recently, at least from a criminal justice perspective, mean that a forensic examination may not be appropriate.

The levels of police and self-referrals examined during the evaluation confirm these overall trends. However, as Figure 4.1 below demonstrates, the forensic nurse has seen around one-third more self-referrals within her overall caseload than the doctors (11% n=27, compared to 7%, n=55).

Figure 4.1: Referral type by forensic medical examiner



n=1,072 cases who had a forensic medical examination (forensic nurse 249, female doctors 823).

Source: Case-tracking database

With respect to 'self then police' referrals to the service an interesting trend has also emerged. Historically, only a small proportion of these per year go on to report to the police. However, five (19%) of the 27 self-referrals the forensic nurse has examined have gone on to report to the police, compared to eight (15%) out of 49 examined by the doctors. Nevertheless, comparisons with the St Mary's Centre database suggest that the overall level of self-referrals going on to report to the police in the period covered by the evaluation is not significantly higher than in previous years.

The fact that a slightly lower proportion of cases examined by the forensic nurse than the doctors reported to the police overall (91%, n=227 compared with 94%, n=776) is the outcome of her examining a higher proportion of self-referrals.

Forensic and medical evidence

As part of the linked evaluation of the *Understanding Attrition* project at St Mary's (report forthcoming) an audit of forensic medical reports was undertaken on 100 cases. These were selected to reflect examinations conducted by the forensic nurse and doctor, and where the cases did and did not proceed to court. In the context of this report the central question was whether on any of the measures there were differences between the reports of the nurse compared to the doctors. All the variables were analysed and no significant differences emerged. This is most probably due, firstly, to the fact that all reports are compiled using a *pro forma* designed by St Mary's[20] and, secondly, that the forensic nurse and forensic doctors have all been trained by the same Clinical Director.

The forensic nurse has also prepared statements for the police in 51 cases to date. On the basis of positive developments in respect of legal cases where their medical evidence has been agreed, the Clinical Director has recently commented that she believes the forensic nurse's documentation of the examination performed and samples taken, together with her own presentation of medical opinion, constitutes the most robust form of evidence, as it combines careful and thorough evidence collection and recording with expert opinion. This suggests the potential to transform this aspect of professional responses to reported rape through the conjoined development of forensic expertise among doctors and nurses. The former Police Liaison Officer expands on the possibilities in this regard.

> *I think, thinking forward…if the concept of the forensic nurse as the evidence-gatherer is established, then what we can possibly do is further develop the doctor's role as expert interpreter. Because at the moment the way it's structured…the doctors perform a dual role, they are both gatherer of the evidence and interpreters*

[20] The precise content changed four times during the evaluation, to tighten the recording of findings, most commonly by changing open-ended questions into tick box lists.

of their own findings. And that actually works very well. That doesn't create a problem. But I think we could actually up the level of evidence, or the standard of evidence we're given, by having someone who was an expert at gathering those exhibits and…someone who has got a very, very high level, a technical level, of gathering evidence – and then having someone independent who has an enhanced level of interpretation (Police Liaison Officer, April 2003).

Case outcomes

Table 4.5 records the legal outcomes, where known, of cases reported to the police during the evaluation period by examiner type.

Table 4.5: Legal outcome of cases examined by forensic nurse and female doctors during evaluation

Police outcome	Forensic nurse	Female doctor
No crime	21% (41)	26% (171)
Undetected	36% (69)	32% (210)
Detected no proceedings	13% (25)	14% (95)
Detected	30% (57)	28% (185)
Total[1]	**100% (n=192)**	**100% (n=661)**
Prosecutions		
Proceeded to court	53% (30)	61% (112)
Pending court	33% (19)	20% (37)
Did not proceed to court	14% (8)	19% (36)
Total*	**100% (n=57)**	**100% (n=185)**
Convictions		
Acquittal	57% (17)	45% (50)
Conviction	43% (13)	55% (62)
Total*	**100% (n=30)**	**100% (n=112)**

Source: Case-tracking database.

[1] 154 cases where the outcome of the police investigation was unknown have been excluded from this analysis (forensic nurse n=37; forensic doctors n=117).

The outcomes of the police investigation, comparing cases examined by the forensic nurse and forensic doctors, follow a relatively similar pattern, although a slightly higher proportion of cases in the forensic nurse group were detected (30%, n=57 compared with 28%, n=185). In relation to prosecutions there were, again, negligible differences between the two groups. The fact that fewer of the forensic nurse cases proceeded to trial may simply be accounted for by the fact that more of her cases were pending trial, as the proportion of cases not proceeding to court was similar in both groups and, in fact, was slightly higher among those examined by the forensic doctors. In terms of conviction rates, these were moderately lower for the forensic nurse group (43%, n=13 compared with 55%, n=62). However, the very small number of cases examined by the forensic nurse proceeding to trial (n=30) means that this variation is not statistically significant and could be attributable to a range of random factors. The small numbers mean that it would not be appropriate or meaningful to conduct more in-depth analysis on any possible predictive factors.

Cost of examinations

Financial data collected by the St Mary's Centre manager suggest that the forensic nursing intervention can represent a significant saving to GMP in terms of the cost of certain categories of examinations, but that the picture is more complex when the difference between paying a full salary and on-call attendance fees is considered. At the same time, the fact that all forensic doctors are paid a variable retainer fee, dependent on their level of qualification, means that the overall costs for the forensic nurse compared to forensic doctors represent a significant saving (see Tables 4.6 and 4.7). Start-up costs are not included in this analysis, since they would have to account for not just training the forensic nurse, but also all previous training for nurses and doctors. The analysis, therefore, concentrates on the period of 20 months when the forensic nurse conducted examinations.

No charges are made for use of the examination facilities, as they are provided by the hospital and cover the operation of St Mary's Centre as a whole. Examinations performed by the forensic nurse during the daytime (9am-5pm) are, therefore, linked solely to her salary, whereas those performed by forensic doctors incur a set fee of £68.10 for the first half hour and £17.20 for each subsequent half hour (on average an examination lasts two hours, making a total cost of £119.70). Weeknight, weekend and Bank Holiday examinations incur a higher fee. Any examinations conducted by the forensic nurse out of office hours are subject to an on-call fee and hourly rate, which can vary according to whether this is on a weeknight, weekend or Bank Holiday. These, however, are considerably lower than a doctor's overall fees.

Table 4.6: Cost of examinations performed by forensic nurse 1 March 2001 – 31 October 2002

Time of examination	Number of examinations	Cost per unit	Total cost
Weekday daytime	149[1]	£297.43	£44,316.67[2]
Weeknight	35	On-call fee £6.18 + £23.34 = £29.52	£1,033.20
Weekend	64	On-call fee £18.44 + £35.02 = £53.46	£3,421.44
Bank Holiday	0	On-call fee £18.44 + £46.68 = £65.12	£0.00
Statements prepared	51	£120.00	£6,120.00
Total	**248**		**£54,891.31**

Source: Case-tracking database; costings from St Mary's Centre and GMP.

[1] Examinations performed in the period 1 March 2001 – 31 October 2002.
[2] Forensic nurse salary, including on-costs, 20 months (1 March 2001 – 31 October 2002) covering period from when started performing examinations to when on long-term sick leave.

Table 4.7: Cost of same examinations if performed by forensic doctor

Time of examination	Number of examinations	Cost per unit[1]	Total cost
Weekday daytime	149	£119.70	£17,835.30
Weeknight	35	£179.83	£6,294.05
Weekend	64	£179.83	£11,509.12
Bank Holiday	0	£179.83	£0.00
Statements prepared	51	£61.00	£3,111.00
Retainer fees[2]	Not applicable	7 @ £577.00 1 @ £1,109.00 5 @ £2,916.00 x 20 months	£32,880.00
Total	**248**		**£71,629.47**

Source: Case-tracking database; costings from St Mary's Centre and GMP.

[1] Calculated on basis of average examination length two hours.
[2] Based on whether have no, part or full Diploma of Medical Jurisprudence.

The major cost of the forensic nurse has been her full-time salary: during the pilot she has performed 149 weekday daytime examinations (one of these was in February 2001 and thus not included in the above tables), and received an annual salary of £26,590. If performed by a forensic doctor, those same examinations would have cost £17,835.30, excluding retainer fees. It should also be noted that the forensic nurse has assisted in filling gaps in the rota outside weekday daytime hours. The cost of these additional examinations being performed by a doctor would have been £17,803.17, compared to the actual amount of £4,454.64 paid to the forensic nurse. The doctors receive an additional fee of £450.00 per day for a court appearance, though, typically, they attend for a half-day at half the fee. This has not been included in the above analysis as it is a cost borne by the court service rather than GMP. The forensic nurse receives no fee as court attendance is considered part of her salaried duties. Taking account of the full range of costs associated with each examiner type, the forensic nursing intervention has represented an overall saving of £16,738.16.

The worth of the intervention cannot, however, be assessed solely in terms of unit costs, since there is currently no alternative for ensuring the timely provision of forensic examinations during office hours. The question of how forensic nursing might develop in the future is discussed at the end of the report.

5. Policy implications

The policy implications of this intervention are clear in that the forensic nurse alleviates an obvious gap in prompt daytime provision of a forensic medical examiner. The forensic nurse is a female examiner (as are all members of the team at St Mary's), and is now extensively trained and highly skilled in examination techniques, having performed 249 examinations since the intervention was launched. Moreover, because she has been trained as an integral component of the St Mary's team, and has developed technical expertise specifically in relation to rape and sexual assault, she is acutely aware of, and equipped to deal with, the issues for victims in this context.

Echoing their general welcoming of the forensic nursing service, almost all the police officers interviewed who either knew of or had used the forensic nurse wanted the service to continue and, in some cases, to expand. The most senior officers interviewed provided clear reasons for their support.

> *I would like to see it expanded. The bottom line is that the service provision has been enhanced because of plugging the gap in the rota if you like. My view is that there's been no reduction in the service provided to the clients and possibly there's been an enhancement of the service as well, so my view is, you know, if anything, it should be expanded in the future, and we should have more forensic nurses.*
>
> (Police Liaison Officer, April 2003)

> *I would have liked to have seen it run on a more 24-hour basis, and not just one person, more of them, and more available.*
>
> (Forensic crime scene manager, May 2003)

There are a number of different ways in which the forensic nursing service could be expanded at St Mary's. The first suggestion emerges directly from the problems caused by the loss of the forensic nurse whilst she was on extended sick leave. This highlighted the necessity of cover in times of absence. The Clinical Director proposes that two part-time forensic nurses may be a better way to ensure consistent service.

> *We've learnt a lot in recent months and if we were starting again, we wouldn't start from here; we'd certainly have two part-timers rather than one full-time nurse I think. So that in case of sickness there would be cover. That was a mega problem we had when unfortunately, [the forensic nurse] had to go off sick. If we'd had two people, it would have been easier to be covered, if we'd had two part-timers that would have been better.* (St Mary's Clinical Director, March 2003)

The flexibility afforded by this model could boost recruitment potential among nurses who might prefer to job-share or need to negotiate childcare commitments. Additionally, part-time nurses already working in other departments within the Trust wishing to increase to a full-time schedule could combine their current working hours with the part-time forensic nurse post.

Although the model St Mary's drew on from the USA is based around specialist nurses who perform rape/sexual assault examinations exclusively, the Clinical Director at St Mary's made a strong case for forensic examiners (whether nurse or doctor) to be involved in other areas of medicine.

> *It's true with doctors as well, that you need to have your feet in some other aspect of medicine or nursing. Rather than just doing rape cases all the time. I think possibly doing rape cases all the time might make some people burn out, you know, it is a difficult and stressful area… Also, when you're assessing injuries and genital findings, seeing people with other complaints, what we refer to as 'ordinary patients', can be helpful in enhancing your skills, that you're seeing those different aspects of things.* (St Mary's Clinical Director, March 2003)

Part-time forensic nurses would also be in a position to develop or continue with their nursing expertise in a similar way to forensic doctors in general practice.

The second suggestion for future development involves training a small pool of hospital nurses[21] who could be an addition to the 'out of hours' on-call service, staffed currently by forensic doctors and the forensic nurse, and provide cover for holidays and absence of the full-time forensic nurse. As the forensic nurse herself noted:

> *One of the difficulties, and the doctors will tell you this, is retaining people. We've got thirteen doctors on the rota, but rarely thirteen doctors working that rota, and right from the word go I've been included on that rota. I'd like another two [forensically-trained nurses] to work with the team of doctors. I'd really like to see a couple more nurses taken on to do on-call.* (St Mary's forensic nurse, July 2002)

Wider policy issues

Other than the mention made above regarding use of the colposcope, there are no evident limitations to the operation of this intervention. However, the researchers recommend that the facilities of detailed training and supervision continue to underpin the service over the longer term. The need for forensic nurse examiners to be accepted as competent 'experts' in the legal arena necessitates extensive training, examination protocols and supervision exemplified by the forensic nursing intervention at St Mary's. Accreditation of training within the framework of a nursing or, indeed, forensic examiner professional body offers a further possibility for promoting recognition and acceptance of the nurse examiner role in both the health and criminal justice spheres.

The forensic nurse examiner pilot also highlighted training and supervision issues in relation to the wider forensic team at St Mary's. The detailed clinical training the forensic nurse undertook, and the recognition during the pilot that training on court preparation needed to be enhanced, raised questions about future skills development for the forensic doctors. It was partly the enhanced training of SANEs in the USA that resulted in nurses becoming preferred to doctors as examiners for sexual assault. There are complex issues at stake here which need to be addressed at the national level by the Association of Forensic Physicians and government.

Interviews with police officers in the Comparison areas involved in the national evaluation of SARCs (see Lovett, J., Regan L. and Kelly, L. (2004)) support the conclusion that the introduction of a forensic nurse examiner service could considerably improve the system for both victims and police officers. Many of the interviewed officers complain of the delays between initial reporting and undertaking the forensic examination. Daytime delays are extensive in these areas and for some, are accentuated by the need to transport victims long distances to an examination suite simply to ensure access to an available doctor. They also cannot guarantee access to a female examiner, despite recommendations from the early 1980s to this effect (see Home Office Circular 25/1983). Similar concerns were also voiced by one of the St Mary's key informants interviewed in relation to areas outside Greater Manchester.

> *We have huge problems getting female doctors, not in GMP necessarily, 'cause we do have lots of female doctors in GMP, but nationally there is a shortage of female doctors that are trained, but the difference with this is you're actually training somebody specifically for one task, i.e. sexual offences. The training is much more detailed and in depth, we're not just relying on grabbing a female doctor who perhaps is a police surgeon and more used to getting the blood alcohols and the like! And*

[21] In fact this is the model most commonly found in the US and Canada. In the US forensic nurses tend to undertake all aspects of practice, including giving evidence and opinion in court; in Canada models similar to that under discussion at St Mary's can be found.

> *every time you reduce the waiting time, you increase the opportunity for gaining the evidence.* (Forensic crime scene manager, May 2003)

Whilst there are peripatetic models of nurse examiners in the US,[22] the successful incorporation of the forensic nurse within the wider forensic team at St Mary's also suggests that the existence of a base from which to work is of central importance. In the case of St Mary's, this has enabled the nurse examiner to have constant access to guidance, mentoring and advice whenever necessary. Again, this illustrates the successful collaborative working between forensic doctors and the nurse examiner.

[22] This model involves the forensic nurse travelling with a mobile unit to where she is needed to conduct an examination (see Kelly, forthcoming).

6. Conclusions

On the basis of the findings discussed in Chapters 2 and 3 of this report, each of the key outputs and outcome measures for the evaluation is revisited individually below.

Outputs

- *Successful training of a forensic nurse examiner at St Mary's*.

The nurse examiner has successfully completed training in all aspects of the procedures involved, and observed the required number of forensic examinations before beginning to perform them. She has also more recently completed in-depth training in relation to the preparation of statements for the police and on court procedures and evidence giving.

- *Production of a forensic nurse examiner protocol document.*

A detailed job description for the post has been produced by the Centre, as well as a step-by-step protocol document outlining how the forensic nurse should conduct herself during a medical examination. This covers procedures for examinations involving police referrals and self-referrals, confidentiality, evidence collection and dispensing of post-coital contraception. The document also contains a protocol, based on current practice at the Centre and elsewhere, regarding use of a colposcope. This contains elements the Centre is currently seeking to formalise with Greater Manchester CPS.

- *Production of a comprehensive training package for forensic nurse examiners.*

On the basis of the extensive training the nurse examiner has undertaken, a draft training package, which also contains guidelines on certification and accreditation, has been produced. This is currently under consideration by the Workforce Confederation within the Health Trust. Once finalised, universities will be invited to tender for provision of the package, which will be implemented with input from St Mary's. The course is envisaged as assessment-based, with a 42-hour taught component and a period of observation at St Mary's Centre. It will be accessible to qualified nurses with a relevant background in genital anatomy (through obstetrics, gynaecology, sexual health or maternity) or experience of accident and emergency nursing. All candidates must have an identified supervisor and be based at, or closely linked with, a host SARC. Currently, the greatest potential for developing forensic nursing in the UK exists in hospital-based SARCs, but the variations of forensic nurse models in North America are worthy of consideration in areas where there is no SARC.

Outcome measures

- *Numbers of weekday daytime examinations conducted by a forensic nurse examiner.*

Since the start of the intervention, the forensic nurse has performed 249 examinations, of which 149 have been conducted during the daytime. These represent nearly two-thirds of all daytime examinations conducted by the Centre's forensic team in the period. The intervention demonstrates the potential for forensic nurse examiners to become extremely skilled practitioners, given the number of examinations they perform. This is similar to the mainstreaming of sexual assault nurse examiners (SANEs) in the USA. The fact that the nurse examiner has carried out a quarter of all examinations conducted at St Mary's during the 27 months of the evaluation is evidence of the considerable expertise she has amassed in this field. As part of this specialist expertise, use of the colposcope is also mainstreamed practice among SANEs in the USA, although this is not yet the case here.

- *Increase in numbers of weekday daytime examinations conducted.*

Providing weekday daytime cover was one of the key aims of the forensic nursing intervention. Since the evaluation began a total of 236 weekday daytime examinations have been performed at St Mary's. The average number of weekday daytime examinations per

year during the pilot is significantly higher compared to previous years, with around one-third more examinations being conducted at these times.This suggests that the existence of the service not only permits a prompter response to cases presenting during these times but also encourages higher use of the Centre in the daytime for forensic examinations.

- *Time waited for a forensic medical examination - comparing pre- and post- intervention daytime waiting periods.*

Analysis of overall waiting times at St Mary's shows that around a quarter of examinations performed by the forensic nurse are conducted within three hours of the assault being reported to the police, rising to around half within six hours. This represents an improvement on the daytime provision afforded by the forensic doctors, both pre-intervention and in periods during the pilot when the forensic nurse was absent, where a fifth of examinations were conducted within three hours and well under half within six. The mean time waited to see the forensic nurse was substantially lower than for the doctors. Delayed reporting of the assault to the police and multiple cases needing to attend St Mary's for an examination at the same time can be factors in varying waiting times.

- *Cost of examinations conducted by a forensic nurse examiner.*

Since the start of the evaluation, the forensic nurse examiner has provided an efficient and cost-effective weekday daytime service to victims of rape and sexual assault, where there were no alternatives. When calculated only in terms of the unit cost per examination, the forensic nurse appears more expensive than examinations conducted through an on-call system using forensic doctors. However, the high additional retainer fees for forensic doctors reverse this picture, making the service cost-effective in comparison. Such fees are necessary for the retention of forensic doctors, and given the need for a rota, are paid to a relatively large number regardless of the number of examinations they actually undertake. Significant savings were also evident in the cost of out-of-hours examinations performed by the nurse examiner compared to the potential cost of forensic doctors. It should be noted here that GMP appear wholly satisfied with the fulfilment of the key objectives of the intervention, and have contracted to continue the service through recurrent funding of the salary of the forensic nurse.

- *Service user assessments of the forensic nurse examiner.*

On all the measures used in the evaluation involving service user feedback, the forensic nurse scored as, or even higher, than the forensic doctors. No evidence emerged at any point of a lack of faith in her abilities from the perspective of complainants. There was no indication of a preference among examinees for one examiner type over the other, indeed all received extremely high satisfaction ratings. There was, however, an overwhelming preference for forensic examinations to be conducted by women.

- *Numbers of examinations for self-referrals resulting in pursuit of case by complainant – comparing pre- and post-intervention figures.*

During the intervention the nurse examiner has examined 27 self-referrals, and a fifth of these have gone on to report to the police. Though one-third more self-referrals examined by the forensic nurse than those examined by a doctor went on to report to the police, this did not represent a significant rise compared to previous years. There is undoubtedly potential for further development here, although it is likely to be strongest where staff are full- or part-time (rather than on-call), since this would enhance face-to-face interactions between the police and the forensic examiner.

- *Numbers of examinations conducted by a forensic nurse examiner resulting in prosecution/conviction – comparing pre- and post-intervention figures.*

There are no major differences in detection and prosecution rates between cases examined by the forensic nurse and the forensic doctors. As the number of cases examined by the forensic nurse going to trial is very small, the slightly lower conviction rate among her cases

compared to those examined by forensic doctors in not statistically significant. A higher proportion of her cases are also pending trial and this could affect the results of the analysis.

The forensic nurse's evidence has been accepted in statement form on a number of occasions, but evidence given by her in court has not yet been challenged in any way, mainly due to the fact that she has only attended on two occasions. On her first appearance she was only asked to go through her statement and, following problems derived from her illness, she did not attend further court cases after her second appearance as she went on a period of leave.

Although the intervention has demonstrated a highly successful model of collaborative working between forensic doctors and the nurse examiner, which extends to the issue of evidential credibility, an obvious next step for the long term lies in the development of the forensic nurse's role from documenter to interpreter of her own evidence, as is common practice in North America. There is, however, a tension here with the preferred model at St Mary's, where they wish to retain expertise amongst doctors in terms of medical opinion.

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Appendix: Research tools and data sources

The evaluation of the forensic nursing pilot at St Mary's was undertaken concurrently with two other CRP-funded evaluations and draws on many of the same research tools (Kelly *et al.,* forthcoming; Lovett *et al*., 2004). In order to make these relevant across all three evaluation projects a range of topics were covered in addition to the question of forensic examinations, such as reporting to the police and the progress of cases through the Criminal Justice System. The full content of all the research tools relevant to the evaluation of the forensic nursing pilot are outlined here.

Case-tracking database

The case-tracking database was created specifically for this project using Access software to include details on all cases referring to St Mary's. Every individual entered on the database has a record consisting of a header and a series of linked forms. The header contains: the unique reference number; referral type; and details of participation in the evaluation. The linked forms and fields within them focus on:

- *details of the assault* – date and time it occurred, location, type and additional details;
- *details of the victim – age, sex, ethnic origin, disability, relationship profile and employment status;*
- *details of the perpetrator(s) – age, sex, ethnic origin, disability, employment status, relationship to the victim, length of acquaintance and whether a weapon was used;*
- *forensic examination – date and time of, examiner type, whether injuries were sustained, whether drugs/alcohol were involved and which samples were taken;*
- *service use – type of service accessed at each site;*
- *police report – date and time reported, who reported, whether a statement was taken, whether a suspect was identified, arrested and held in custody, CPS advice, reasons for cases not proceeding and additional details; and*
- *legal process* – final police classification, whether the case went to court, plea, trial outcome and sentence.

Details on victims' socio-demographic profile, forensic examinations and service use were provided by St Mary's. There was a significant degree of reliance on the police for data relating to the Criminal Justice System, such as details of the police report, perpetrator(s) and legal outcomes. This information was obtained by distributing two *pro formas* to investigating police officers, one within a month of the initial police report and the second up to a year later. In a number of cases multiple follow-ups were needed both to recover outstanding *pro formas* and to obtain complete information on cases that had not been completed at the time of returning the second *pro forma*.

St Mary's historic database

St Mary's has its own database containing details of all cases which have been referred to the Centre since it opened in late 1986. The original database ran on a FoxPro system, which is now obsolete. In 2003 this was replaced with a new Access database, designed by an external consultant, and all original data were imported. The new database contains a similar range of fields to those in the case-tracking database which are organised around the following four main areas:

- *Attendance and personal details* – SARC number, referral type, attendance date and time, age, sex, ethnic origin, disability, relationship profile, employment status and area of residence.

- *Assault details* – date and time it occurred, type of assault, area it occurred in, type of location, number of assailants, relationship between assailant and victim and use of weapon and force.
- *Police details* – date of report, Crime number, Force Wide Incident Number, type of offence recorded, statement details, crime classification and court and sentencing details.
- *Forensic details* – examination date and time, nature of incident and details on the presence of alcohol, drugs and injuries.

Forensic nurse database

A separate small database was designed for the forensic nurse examiner to record all cases she examined during the evaluation. This was intended primarily as a means for her to track her own caseload. It contained fields on key details of examinees, examination dates and times, findings, including injuries and use of the colposcope, as well as the forensic nurse's involvement in criminal justice proceedings, such as preparing a statement for the police and attending court. There were also free text fields where the forensic nurse examiner could record more extensive details about individual examinations and her progress in post. All cases entered in the forensic nurse database were already included on the case-tracking database. Any additional information on individual cases was downloaded and added to the relevant case-tracking record.

Service user questionnaires

All those included on the case-tracking database were potential participants in this element of the research. Three phased questionnaires were distributed to those service users who agreed to take part at the first, fifth and twelfth month after their initial contact with St Mary's. The questionnaires were designed to be applicable to those who had reported to the police and those who had not, and were referenced using the unique reference number to enable linking them to cases entered on the case-tracking database. The areas covered in each of the questionnaires were:

Questionnaire 1

- *About you* – age, ethnic origin, disability, relationship profile, employment status.
- *After the assault* – did you tell anyone about the assault before reporting to the police and what was their response.
- *Reporting to the police* – did you report to the police, reasons for reporting, how long after assault was the report made, how was the report made, your state of mind when reporting, how would you rate the response of first police officer you spoke to, satisfaction with the police at this stage, any suggestions for improving the initial police response.
- *Crisis Worker* – how you understood their role, sex of the Crisis Worker, did this make a difference, how would you rate their response, satisfaction with Crisis Worker, how much information did they give you about the next stage of the process.
- *Forensic medical examination* – did you have one, did you have to wait to see examiner, feelings before the examination, sex of the examiner, did this make a difference, was the process of the examination explained, how you experienced the examination, how would you rate the response of the examiner, satisfaction with examiner, any suggestions for improving examinations.
- *After the forensic medical examination* – contact with Crisis Worker after the examination, how would you rate their response.
- *Making a statement to the police* – did you make one, when did you make one, where did you make one, were you given a choice about the timing and location of the statement-taking, feelings before making a statement, sex of the officers present, did this

make a difference, how you experienced making a statement, how would you rate the response of the officers taking the statement, were you given information about the next stage of the process, have you had any contact with the police since the statement, any suggestions for improving the statement taking process.

- *Use of services* – which services have you used so far, how would you rate the response of St Mary's, any suggestions for improving the service, were there any services you needed that were not provided.
- *Your decisions and the future* – are you intending to pursue the criminal case, if not, why, how are you coping at the moment, what are you finding difficult.
- *About the questionnaire* – are there any additional questions we should have included, how have you found completing the questionnaire, any additional comments.

Questionnaire 2

- *About you* – how are you coping at the moment, what are you finding difficult, are there any areas where you need support.
- *Take-up of services* – have you been in contact with St Mary's since completing the initial questionnaire, has this been helpful, which services have you accessed, how would you rate the response of the service provider, were you referred to any other services by St Mary's, how would you rate their response, have you received any support from family or friends, who has provided the best support so far.
- *Contact with police* – have the police been in contact since completing the initial questionnaire, what about, how would you rate their response, how well have you been kept informed about their case, is there anything more the police could have done.
- *Criminal case* – do you know the current status of the case, if yes, what is it, what are your views on the outcome.
- *About the questionnaire* – are there any additional questions we should have included, how have you found completing the questionnaire, any additional comments.

Questionnaire 3

- *About you* – how are you coping at the moment, what have you find most difficult over the past year, are there any areas where you need support now.
- *Take-up of services* – have you been in contact with St Mary's since completing the second questionnaire, has this been helpful, have you been in contact with any other services since completing the second questionnaire, what was their response, how would you describe your overall experience of support services over the past year, could anything have been done differently to support you more.
- *Contact with police* – have the police been in contact since completing the second questionnaire, what about, how would you rate their overall response since you reported the assault, could the police have done anything differently to support you more.
- *Criminal case* – has your case been heard in court, if no, what is the current status, if yes, what was the outcome, did you meet the prosecution barrister, did you give evidence, what was your experience of giving evidence, what are your views on the outcome, how would you describe the overall experience of going to court, is there anything that might have made the experience of going to court easier.
- *About the questionnaire* – are there any additional questions we should have included, what has it been like taking part in this research, any additional comments.

Service user interviews

All service users participating in the questionnaire element of the research were also invited to take part in a semi-structured interview, either face to face or over the telephone. This was to gain more detailed qualitative information on their experiences of service use and the criminal justice process. For face-to-face interviews participants were given a choice of locations, including St Mary's and their own home. A letter explaining what taking part in the interview would involve and a return form were distributed with the second of the three service user questionnaires. Interview transcripts were anonymised and referenced using the unique reference number so they could be linked to completed questionnaires and the case-tracking database. All interviews covered the following broad themes:

- Decision-making about reporting to the police.
- Experience of initial contact with the police.
- Experience of contact with St Mary's.
- Response of Crisis Worker.
- Experience of forensic medical examination.
- Experience of giving a statement to the police.
- Follow-up contact/support from St Mary's, police and elsewhere.
- Decision-making about the legal process.
- Current status of the case.
- How they are feeling/coping?
- Comments on the process so far.
- What victims of rape/sexual assault need. How did their experience compare with this?
- How the process could be improved.

Forensic medical reports

At St Mary's copies of all forensic medical reports are stored centrally. All cases where a forensic examination was conducted during the evaluation period were grouped according to examiner type (female doctor or forensic nurse) and then according to final police classification (no crime, undetected, detected no proceedings and detected). Random sampling was then conducted within these groups and a roughly equal number of reports selected from each. All forensic medical reports received were anonymised, removing the names of both the service user and the forensic examiner, and referenced with the unique identifier to enable cross-referencing with the case-tracking database and other data sources.

Interviews with staff and key informants

Phased semi-structured interviews were conducted with St Mary's staff (management, counsellors, Crisis Workers, Case Tracker and Support Worker and forensic medical examiners). Senior staff, the Support Worker, forensic nurse examiner and counsellors were interviewed on three occasions during the evaluation. The Crisis Workers were interviewed once. All of the pool of 12 forensic doctors (excluding the Clinical Director) were invited to participate in an interview, although only three chose to do so. Additional interviews were conducted with multi-agency partners and key players in the Greater Manchester area (police officers, Crown Prosecutors, Steering Group members and Victim Support). In most cases these were single individuals representing their agency on the Steering Group. The exceptions were police officers and Victim Support workers. The GMP Police Liaison Officer selected a representative group of investigative officers for interview. One individual, usually the Branch Co-ordinator, from each Victim Support area was interviewed.

For St Mary's staff the interview questions covered the following themes:

- Role in and length of involvement with SARC.
- Contribution of SARCs.
- Any noticeable changes while they have been in post in the type of rape/sexual assault cases they see.
- System for providing forensic examinations.
- Reasons why rape/sexual assault is under-reported.
- Reasons why complaints are withdrawn.
- Reasons why cases are lost later in the criminal justice process.
- Progress and impact of CRP-funded interventions.
- Inter-agency links.

The views of police and other key informants were sought on the following areas:

- Outline of role.
- Connection with SARC.
- Contribution of SARC and services provided.
- Service offered by police to rape/sexual assault victims in area.
- System for providing forensic examinations.
- Reasons why rape/sexual assault is under-reported.
- Reasons why complaints are withdrawn.
- Reasons why cases are lost later in the criminal justice process.
- Progress and impact of CRP-funded interventions.
- Inter-agency links.

Forensic feedback *pro formas*

This one-page *pro forma* was developed and used towards the end of the evaluation in an attempt to increase service user feedback on the experience of the forensic examination. The aim was for it to be relatively short to encourage completion and was based on a series of key questions extracted from the section of the service user questionnaire on the examination. Questions included:

- Date and time of examination.
- Were you examined by a forensic doctor or nurse?
- Did whether the examiner was a doctor or a nurse make a difference to you?
- Did the fact that the person who examined you was female make a difference to you?
- Was the process of the medical explained to you?
- Whilst the medical was happening how did you feel?
- Did the medical examiner say anything that you found particularly helpful, unhelpful or confusing?
- Please rate the medical examiner's attitude/behaviour towards you in terms of respect, belief, support, help, sympathy and judgement.

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Home Office
Research, Development and Statistics Directorate
Communication Development Unit
Room 264
50 Queen Anne's Gate
London SW1H 9AT

Tel: 020 7273 2084 (answerphone outside of office hours)
Fax: 020 7222 0211
Email: publications.rds@homeoffice.gsi.gov.uk

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