

Forensic Nurse

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Sexual Assault Response Team

and

Forensic Nurse

Coordinator

New Jersey Statewide FNE Program Current Status

- Program NJSA 52:4B-44 (1996)
- NJ AG Sexual Assault Protocols 98, 04, 16
- 21 FNE Coordinators / SART
- Over exam 58 sites/56 acute care hospital
- No patient has to travel more than 15 miles for an exam

Forensic Nurse in NJ

- NJ licensed Registered Professional Nurse or Nurse Practitioner
- Complete 64 hour course in sexual assault forensic nursing that meets IAFN education guidelines
- Certified by the Board of Nursing as an
 - FN-CSA- Forensic Nurse –Certified Sexual Assault
 - 602 current FN-CSA in NJ



SART

PRIMARY TEAM MEMBERS

- Sexual Assault Examiner
- Investigating Officer
- Confidential Sexual Violence Advocate

Cultural Competence



Activation SART

- SART Team activation:
 - Be age 13 or older
 - Children under 13 are handled differently
 - Report the incident within 5 days
 - Patient request exam- informed consent



Purpose of the *Standards*

- Uniform treatment of sexual assault victims
- Victim-centered approach
 - Dignity
 - Compassion
 - Respect
 - Competency
- Non-judgmental
- Confidentiality



County Prosecutor's Offices

- County SART/FNE Program
- Local Administration
- Forensic Nurses are contracted for service
- County-wide SART Training
- Regular meetings County SART Advisory Board



Why does SART Exist?

- Victim-centered
- Minimize re-victimization
- Quality medical forensic care
- Timely and quality evidence collection
- Successful prosecution
- SART is required by law

**WE
PROMOTE**
Victim-centered response.

SART Coordinator

- **Sexual Assault Response Team**
- Team approach to meet the psychological, medical, traumatic and social needs of a victim of sexual assault
- SART training, education and in-services
- Liaison between hospitals, police, sexual violence programs, and forensic nurses
- Review all activations for quality assurance

When does the SART respond?

- Only at the request of the victim
- Criteria for a team response:
 1. the victim is 13 years of age or older
 2. assault occurred within past 5 days

Where does the SART respond?

- To the SART Participating Examination Facility chosen by the victim
- A SART Participating Examination Facility provides:
 - **designated space for medical forensic examination and separate waiting area**
 - **medical screening examination and prophylaxis for STI/ED free of charge**

SART Participating Examination Facility

- 58 sites in NJ
- Includes 56 Acute Care Hospital settings

No Victim Will Travel More Than 15 Miles
to an Exam Site

At the SART Participating Examination Facility . . .

Location specific:

- Inpatient or Emergency Department patient
(hospital setting)
Triage, Medical Screening Exam, medical
forensic examination
- Outpatient (hospital or non-hospital setting)
Seen by “appointment”
Referred for additional medical care if needed

Forensic Nurse Coordinator

- Supervises Forensic Nurses
- Training/Staff Meetings/Advisory Board Meetings
- Staff Education
- Call schedule

Who is on the team?

- Law Enforcement
- Confidential Sexual violence Advocate
- Forensic Nurses
- Our patient



Who's Who?

Law Enforcement

- Ensures safety and security of the public
- A sworn officer in the State of NJ who conducts investigations
- Able to make arrests for any offense in the NJ Criminal Code

Who's Who?

Confidential Sexual Violence Advocate

- Specialized 40 hour training
- Serves victim and their families
- Provides emotional support and information on advocacy services
- Advocates
- Client-counselor privilege

Role Forensic Nurse

- Assess and treat medical and psychological needs of the patient
- Obtain medical history, assault/abuse history and other pertinent health related issues.
- Provide detailed information on the medical/forensic examination, medication interactions based on initial medical interview and assess the patients ability to participate in the examination.
- Complete a comprehensive physical external and genital exam.
- Documents finding – SAFE report, diagrams, photography
- Collect and preserve specimens (forensic evidence) based upon history.
- Provide prophylaxis for Sexually Transmitted Infection & HIV.
- Utilize all referrals at our disposal.

SART Special Population

- Ombudsman
- Adult Protective Services
- DDD
- DCP&P
- Health Department
- Military
- Prison (PREA)

Pediatric activation

- Under age 13
- Acute assault/abuse
- Evaluation of inclusive criteria to determine services needed. Evaluate: County activation protocols
 - When was the last contact
 - What nature of contact
 - Is there injury/discomfort/pain/bleeding
- Consultation with Regional Diagnostic Center Physician
- Referral DCP&P & LE & Prosecutor office

Principles - Pediatric

- Provide immediate access to examination, pediatric trained forensic nurse examiners and quality care.
- Secure the physical and emotional safety of child
- Recognize each child has unique capacities and strengths to heal
- Patients are treated according to their chronologic, psychological and developmental stage.
- Offer comforts, encouragement, and support
- Provide information about exam and referrals
- Involve child in decision making
- Ensure appropriate confidentiality



Sexual **A**ssault **F**orensic **E**vidence (**SAFE**) PAPERWORK

SAFE report

Patient Information				
Name: <input type="text"/>		Address: <input type="text"/>		
Date of Birth: <input type="text"/> / <input type="text"/> / <input type="text"/>		Age: <input type="text"/>	Gender: <input type="checkbox"/> Male	<input type="checkbox"/> Female
Home Phone: <input type="text"/>		Cell Phone: <input type="text"/>		
Other Contact Information: <input type="text"/>				
Race (Check all that apply):	<input type="checkbox"/> White	<input type="checkbox"/> Black	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Asian/ Pacific Islander
	<input type="checkbox"/> American Indian	<input type="checkbox"/> Other, List: <input type="text"/>		
Parent/Guardian Information (if applicable)				
Name: <input type="text"/>		Address: <input type="text"/>		
Phone Number: <input type="text"/>		Relationship to Patient: <input type="text"/>		
Examination Information				
Case #: <input type="text"/>	Date: <input type="text"/> / <input type="text"/> / <input type="text"/>		Interview Start Time: <input type="text"/> <input type="text"/>	

Consent

State of New Jersey Forensic Medical Examination Report

Section I: Authorization for Physical Examination

I, _____, freely consent to allow
(Name of Patient/Parent or Guardian)

_____, and the designated assistants to conduct a physical
(Name of Examining Medical Professional)

examination of _____ for purposes of
(Name of Patient)

identifying findings, providing treatment, and collecting specimens related to a reported sexual assault. This procedure has been fully explained to me, and I understand that this examination may include clinical observation for the presence of injury and the collection of specimens for laboratory analysis. Information gathered may be used for professional consultation, peer review, and as evidence in a court of law.

I consent to examination _____
(Initial here)

State of New Jersey Forensic Medical Examination Report

Section II: Consent for Photography

As a part of the forensic medical examination process, photographic images may be taken to document findings related to this case. These images are a part of the forensic medical record and are stored in a manner designed to protect the patient's privacy. While information about any findings is provided in written reports to investigating agencies, the actual images are not included with the reports.

These images may be reviewed by health care professionals for purposes of case evaluation, consultation, and peer review. In the event that legal proceedings arise as a result of the incident, these images may be requested by the prosecuting and defense attorneys involved in this case.

I consent to photography _____
(Initial here)

Section III: Release or Retention of Documents and Evidence

At the conclusion of the examination, I authorize the examiner to release the following:

Forensic Medical Report _____ Clothing _____ Photographs _____ Specimens _____
(Initial next to each Item that is applicable)

to the following agency(ies): _____

I hereby release and hold harmless the examiner, the examination facility and its agents from any liability, and claims of injury whatsoever which may in any manner result from my authorized release of such items and information.

I consent to release of items and information as indicated _____
(Initial here)

I **do not** authorize release of documents, photographs, and items collected. I understand these items will be retained for a **minimum of five (5) years from the date of exam or if I am a minor, a minimum of five (5) years after I reach the age of 18** pending my decision to report the incident to law enforcement. After the expiration of the five (5) year period, the County Prosecutor or the Director of the Division of Criminal Justice may authorize the continued retention or destruction of the items collected.

I understand I can choose to be notified or not be notified at or near the expiration of the five (5) year minimum retention period, and/or at any other time.

I request all items and information be retained _____
(Initial here)

I request to be notified prior to destruction of specimens: Yes No (circle one)

Method of notification: _____

Signature of Patient	Signature of Parent / Guardian (where applicable)
Date	Signature of Witness
Case#	Examiner:

Description of Person(s) Involved in This Incident

Number of Persons:

1.

☐ Male

☐ Female

General Description and Relationship:

☐ Significant Other

☐ Relative

☐ Acquaintance/Friend

☐ Stranger

☐ No Recall

2.

☐ Male

☐ Female

General Description and Relationship:

☐ Significant Other

☐ Relative

☐ Acquaintance/Friend

☐ Stranger

☐ No Recall

3.

☐ Male

☐ Female

General Description and Relationship:

☐ Significant Other

☐ Relative

☐ Acquaintance/Friend

☐ Stranger

☐ No Recall

Contacts/ Oral contact

Physical Contact Between Person(s) and Patient

Was patient physically restrained in any way?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
If yes, method of restraint	<input type="checkbox"/> Hands	<input type="checkbox"/> Body	<input type="checkbox"/> Bindings	<input type="checkbox"/> Other

Indicate All Acts Described by Patient

(If more than 1 person is involved, use number from above to indicate which acts were performed.)

Oral contact	Yes	No	Attempted	Unsure
Licking/Kissing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sucking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Person's genitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Genital contact/ Penetration

Genital Contact	Yes	No	Attempted	Unsure
By Finger(s)				
By Penis				
By Foreign Object				
If yes, describe object:				
Penetration – Into Vagina	Yes	No	Attempted	Unsure
By Fingers(s)				
By Penis				
By Foreign Object				
If yes, describe object:				
Penetration – Into Anus	Yes	No	Attempted	Unsure
By Fingers(s)				
By Penis				
By Foreign Object				

Health History

Health History			
Height: <input type="text"/>		Weight: <input type="text"/>	
Menstrual History:	LMP: <input type="text"/>	Age at Onset: <input type="text"/>	
Current Pregnancy:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, weeks of gestation: <input type="text"/>
Has patient engaged in consensual sexual activity within the past 5 days?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, date: <input type="text"/> / <input type="text"/> / <input type="text"/>	Was a condom used?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Method of birth control currently in use: <input type="text"/>			
Pregnancy Test	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Not Applicable
Reporting Individual (if not FNE):			
Patient Medical History: <input type="text"/>			
History of Disabilities: <input type="text"/>			
History of Genitourinary Procedures: <input type="text"/>			
Current Medications: <input type="text"/>			
Medication Allergies/ Allergies: <input type="text"/>			

LOC/Pain

Post Incident History		
Has the patient experienced any physical pain since the incident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, document location, onset, and numerical equivalent of pain: <input type="text"/>		
<div><div>No Pain</div><div>Moderate Pain</div><div>Worst Pain</div><div><div>0</div><div>1</div><div>2</div><div>3</div><div>4</div><div>5</div><div>6</div><div>7</div><div>8</div><div>9</div><div>10</div></div></div>		
Did the patient report a loss of memory or consciousness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, describe: <input type="text"/>		

Dried Secretions/ Bite Injury

Dried Secretions

Specimens collected:

☐ Yes

☐ No

If areas of dried secretion(s) are identified either by history or visualization, moisten a swab with a drop of water, rub the area using a circular motion, then rub a second dry swab over the area again. Document any findings on the supplemental body diagram.

Bite Injuries

Specimens collected:

☐ Yes

☐ No

If biting is reported or suspected, photograph the site with and without scale, collect a dried secretion(s) specimen as indicated above and document location of bite(s) on the supplemental body diagram.

Forensic Toxicology

Suspected Drug Facilitated Sexual Assault

If the history of the incident as reported by the patient is indicative of, or suspicious for, possible drug facilitated sexual assault, then informed consent should be obtained and specimens collected.

Urine Specimen Collected: ☐ Yes ☐ No

Blood Specimen Collected: ☐ Yes ☐ No

Phlebotomist (if not FNE) :

Phlebotomy site:

This concludes the forensic medical examination. Advise the patient, in some cases, collection of additional specimens may be necessary.

Date Exam Completed: / /

Time Exam Completed:

Evidence Receipt Form

FORENSIC MEDICAL EXAMINATION EVIDENCE RECEIPT FORM

Examiner should initial next to each specimen collected from the patient. Any specimens collected which are not listed should be indicated in the area headed "Other Items".

ITEMS	Initials	SPECIMENS	Initials
Debris		Oral Swabs	
		External Genital Swabs	
		Vaginal Swabs	
Underwear		Cervical Swabs	
CLOTHING		Anal Swabs	
		Rectal Swabs	
		Buccal Swabs	
		OTHER ITEMS (list each item separately)	



**STATE OF NEW JERSEY
FORENSIC TOXICOLOGY**

(Print in ink)

MEDICAL PERSONNEL

SUBJECT NAME: _____ ☐ M ☐ F

EXAM NUMBER: _____ COLLECTION DATE: _____

EXAMINER NAME: _____

COLLECTION LOCATION: _____

KIT SEALED BY (print): _____

(sign): _____

(date): _____

STORE THIS EVIDENCE KIT IN A SECURE REFRIGERATOR. DO NOT FREEZE.

KIT CONTAINS: ☐ blood ☐ urine ☐ paperwork

CHAIN OF CUSTODY OF SEALED EVIDENCE KIT

PRINT NAME

SIGN NAME

AGENCY

DATE

No. NJBU100

STATE OF NEW JERSEY



FORENSIC TOXICOLOGY

DO NOT SEAL AND DO NOT SEAL WITH SEALER FROM SET

Case No. _____ Evidence/Property
TEAR HERE

SEALING BY: _____
Date: _____

FOLD HERE
EVIDENCE/PROPERTY

Agency _____ Case No. _____
Item No. _____ Offense _____
Suspect _____
Victim _____
Date and Time of Recovery _____
Recovered By _____
Description and/or Location _____

CHAIN OF CUSTODY

FROM	TO	DATE

TO USE:
1) Remove Release Liner from Flap.
2) Fold Where Indicated. BAG IS NOW SEALED.
3) Tear Where Indicated and Retain Evidence Receipt.
CAUTION: ATTEMPTS TO REOPEN WILL DISTORT SEALED AREA.

CONDITION OF BAG WHEN OPENED: ☐ SEALED
☐ OTHER _____
OPENED BY _____ DATE _____

SIRCHIE Products • Vehicles • Training
100 Hunter Place, Youngsville, N.C. 27596 U.S.A.
Phone: (919) 554-2244, (800) 356-7311
Fax: (919) 554-2266, (800) 899-8181
www.sirchie.com

TO REMOVE CONTENTS: CUT ALONG BOTTOM

Venture
STERILE GAZES
GAUZE SPONGES
COMPRENSIBLE DE GAUZE, 10 SPONGES, STERILE
COMPRENSIBLE DE GAUZE, 10 SPONGES, STERILE
DISTRIBUTED BY: Venture Medical, LLC, Division of Sirchie, Inc.
EXP. DATE: 12/15/2011 - 06/14/12

Povidone-Iodine Prep Pad
Antiseptic Wipes
For External Use Only
WIPES 17777-148-01

EVIDENCE
INITIAL HERE
WARNING: POLICE SEAL
DO NOT REMOVE

Case No. _____ Evidence/Property
TEAR HERE

SEALED BY: _____
Date: _____

FOLD HERE
EVIDENCE/PROPERTY

Agency _____ Case No. _____
Item No. _____ Offense _____
Suspect _____
Victim _____
Date and Time of Recovery _____
Recovered By _____
Description and/or Location _____

CHAIN OF CUSTODY

FROM	TO	DATE

TO USE:
1) Remove Release Liner from Flap.
2) Fold Where Indicated. BAG IS NOW SEALED.
3) Tear Where Indicated and Retain Evidence Receipt.
CAUTION: ATTEMPTS TO REOPEN WILL DISTORT SEALED AREA.
Condition of Bag when Opened: ☐ Sealed
☐ Other _____
OPENED BY: _____ DATE _____

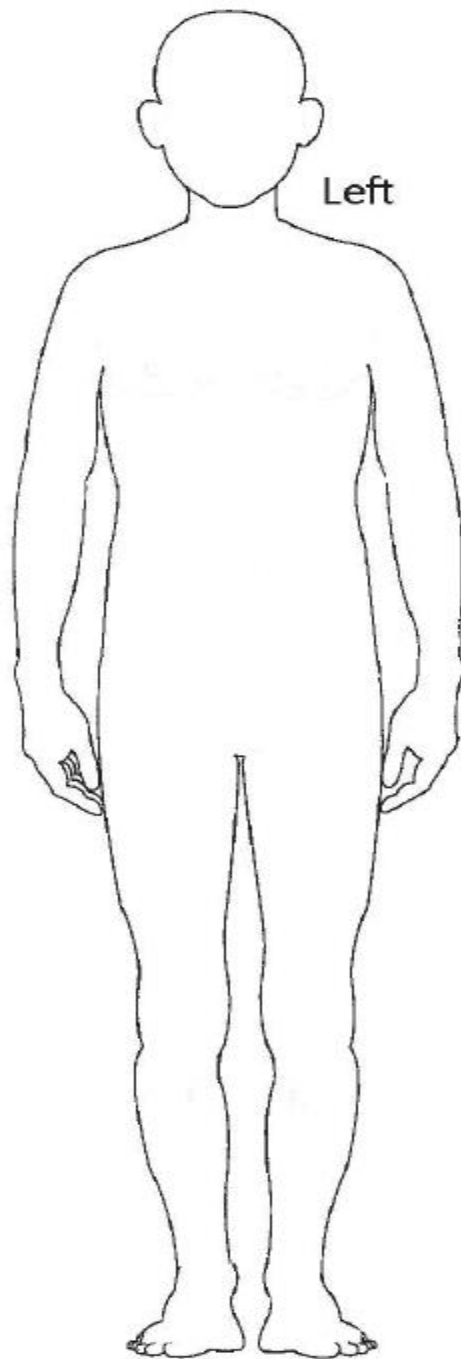
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Adult: External Skin Surfaces

AB	Abrasion	CU	Cut	PI	Patterned Injury
+AL	Alternate light reactive	DE	Debris	PE	Petechiae
AV	Avulsion	DS	Dried Secretion	PU	Puncture
BI	Bite	ER	Erythema	SH	Sample by History
BL	Blood	FB	Foreign Body	SI	Suction Injury
BR	Bruise	HA	Hair	SW	Swelling
BU	Burn	LA	Laceration	TE	Tenderness

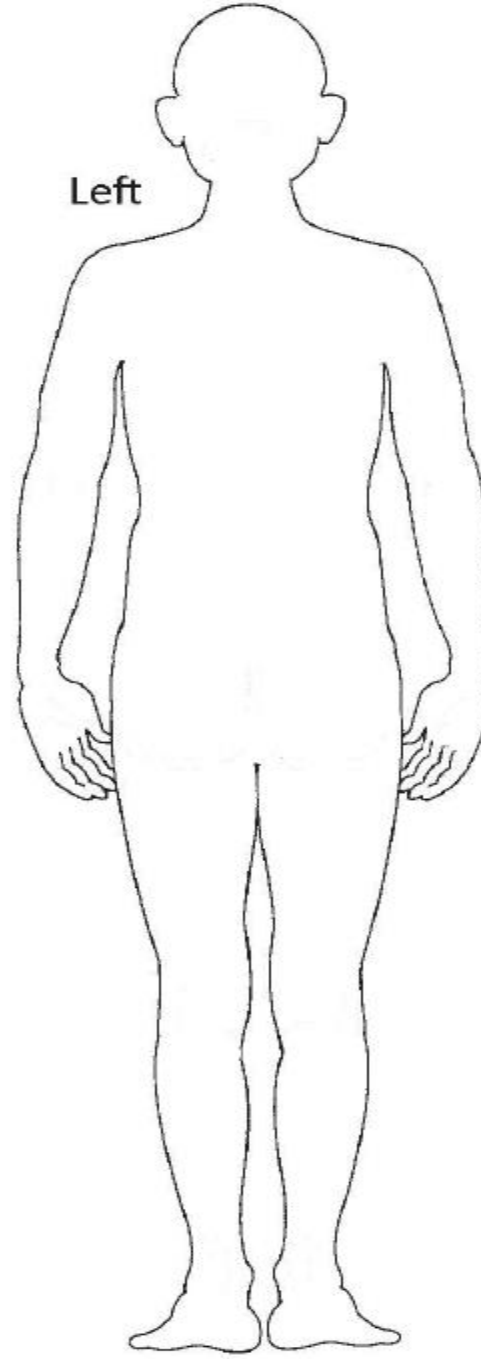
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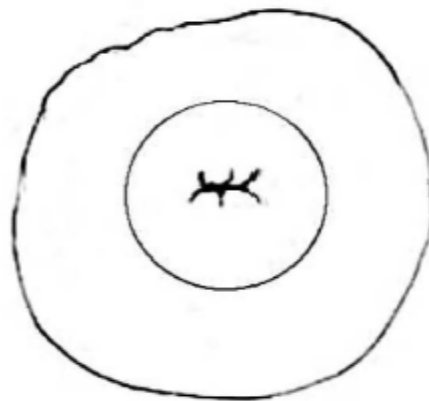
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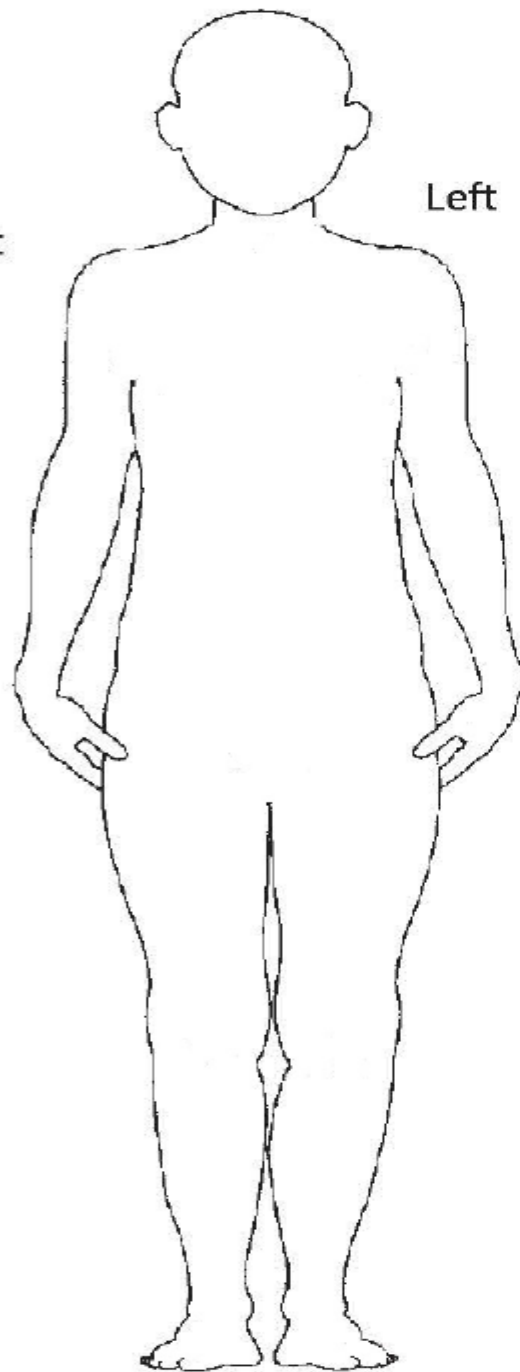
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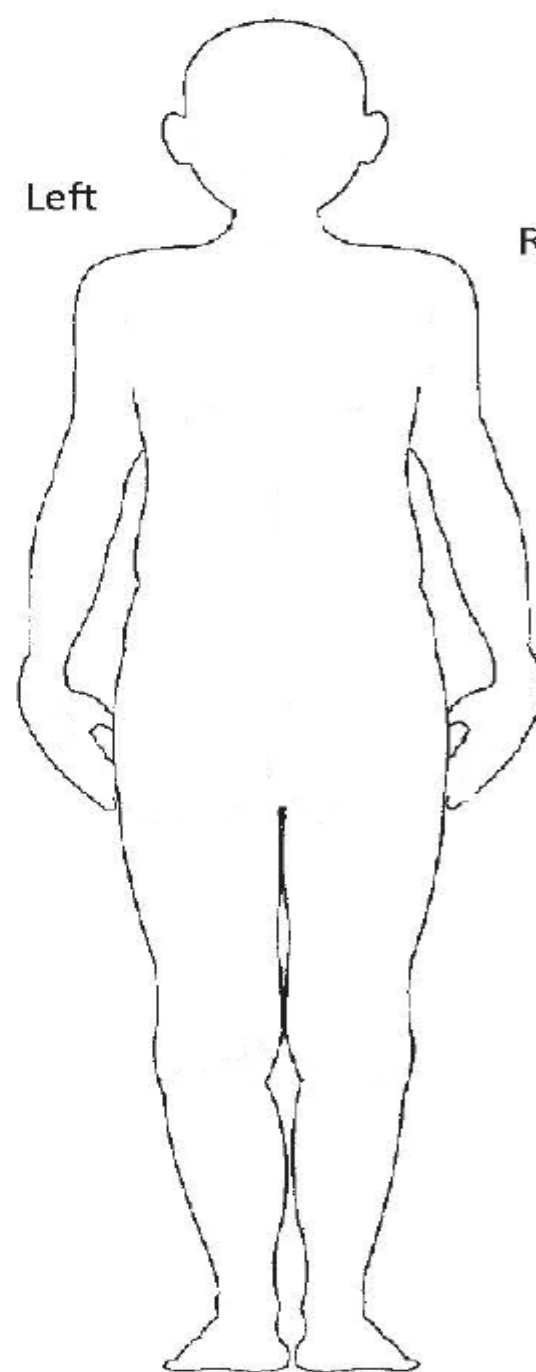
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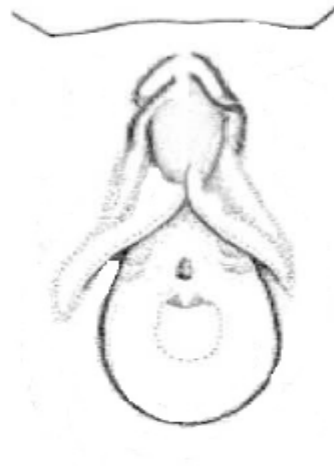


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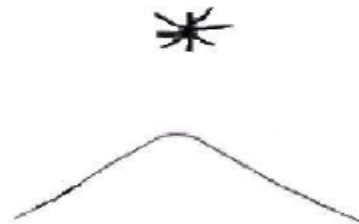
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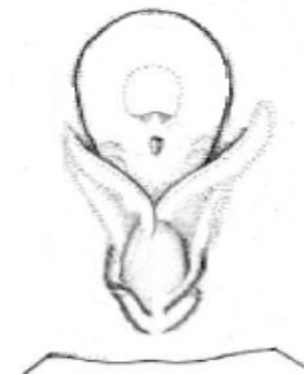
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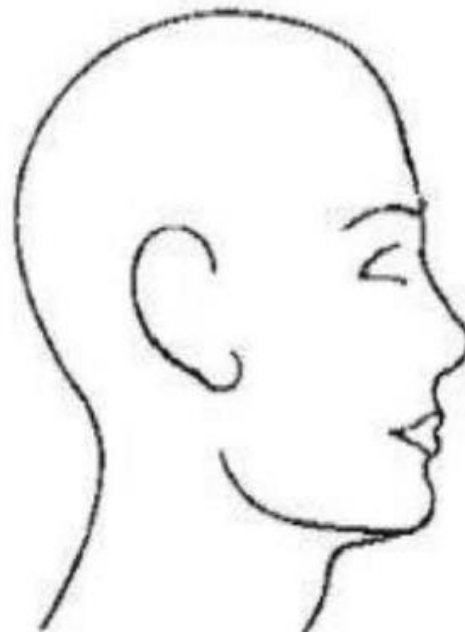
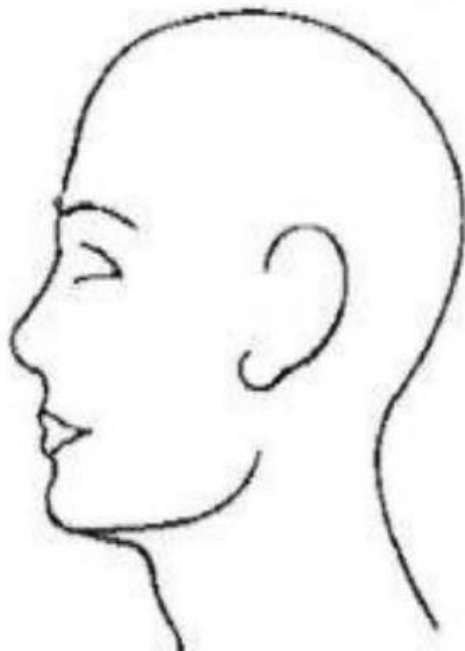
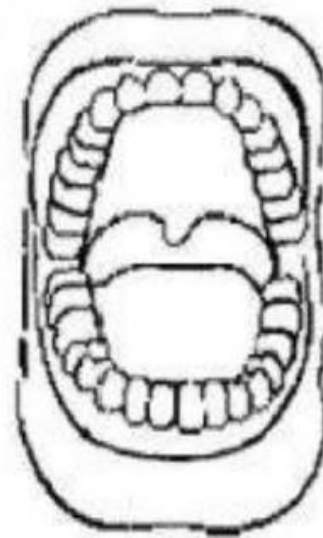


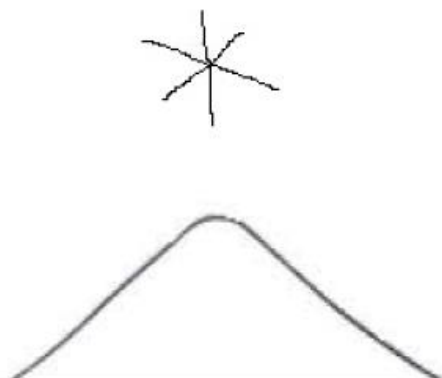
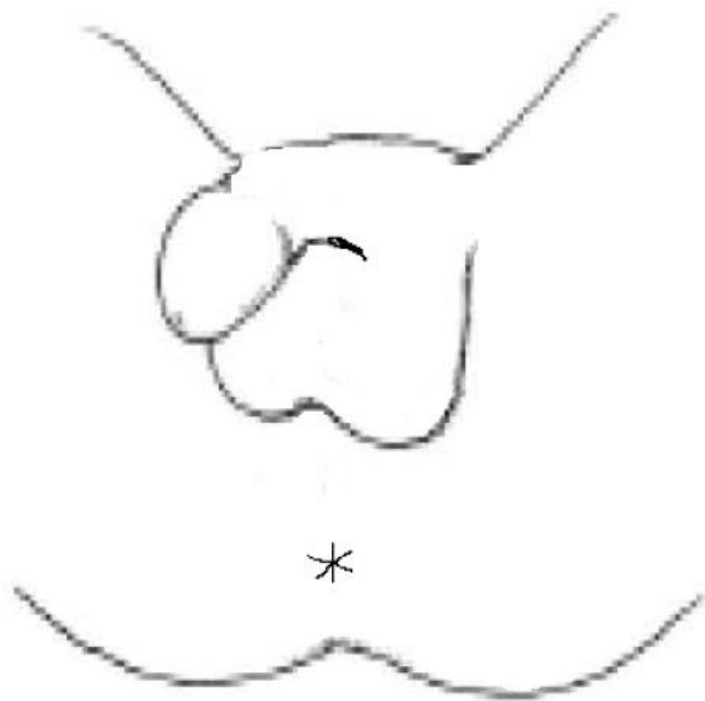
Anus



Prone





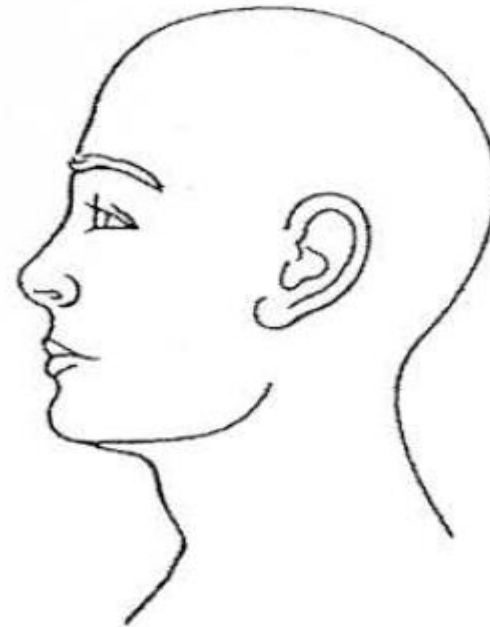
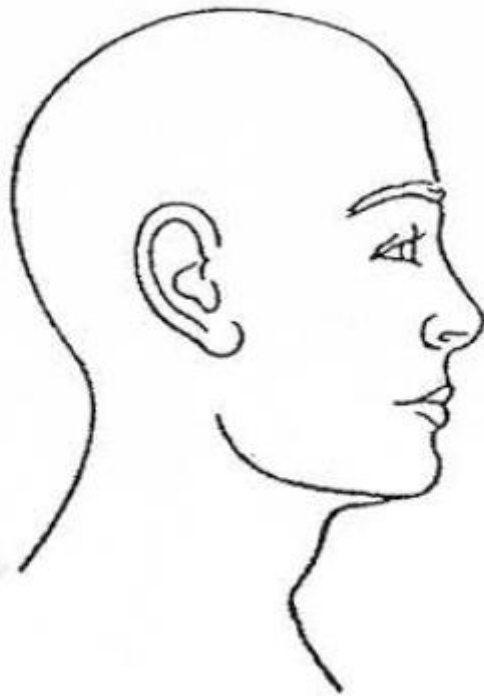


STRANGULATION DOCUMENTATION FORM

When a victim states that she/he was choked and/or strangled, the following symptoms should be assessed and any findings documented and photographed. Look for strangulation injuries behind the ears, on the front and back of neck, chest and shoulder areas, eyelids (above and under), jaw and upper chin. Ask "How did the person hold/control/choke/strangle you?" Use the checklist and diagrams to document pertinent information.

Method(s) of strangulation reported:

- ☐ One arm ☐ L ☐ Rt ☐ Unk
- ☐ One hand ☐ L ☐ Rt ☐ Unk
- ☐ Two hands
- ☐ Ligature (describe) _____
- ☐ Approached from front
- ☐ Approached from behind
- ☐ Other (describe) _____

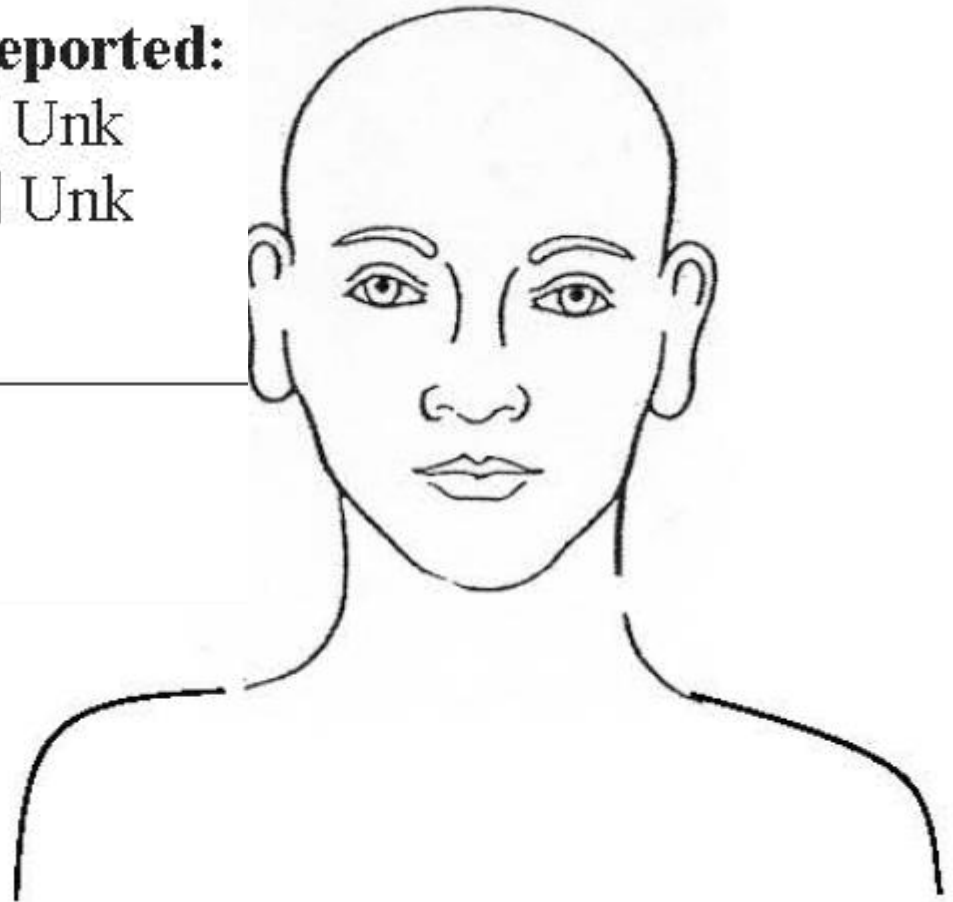


Photographs taken: ☐ Yes ☐ No

Notes: _____

Method(s) of strangulation reported:

- ☐ One arm ☐ L ☐ Rt ☐ Unk
- ☐ One hand ☐ L ☐ Rt ☐ Unk
- ☐ Two hands
- ☐ Ligature (describe) _____
- ☐ Approached from front
- ☐ Approached from behind
- ☐ Other (describe)



Assessment:

- ☐ Neck swelling
- ☐ Neck pain
- ☐ Linear Abrasion(s)- (e.g. Fingernail scratches")
- ☐ Diffuse Abrasion(s)- (e.g. "Rope burns")
- ☐ Bruising
- ☐ Petechial hemorrhages

Location _____

- ☐ Scleral hemorrhage
- ☐ Headache
- ☐ Dizziness
- ☐ Loss of consciousness
- ☐ Loss of memory
- ☐ Sore throat
- ☐ Voice changes (e.g. raspy or hoarse)

Describe _____

- ☐ Difficulty swallowing
- ☐ Drooling
- ☐ Coughing
- ☐ Breathing changes
- ☐ Nausea and/or vomiting
- ☐ Incontinence (urination and/or defecation)

Questions?

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Thank you