Template Memorandum of Understanding
Anonymous Reporting for Sexual Assault Victims

We have developed a set of templates to help communities implement a multidisciplinary protocol for victims to anonymously report their sexual assault to law enforcement. These documents are posted in Word format, so they can be easily modified for use in communities across the country. Questions are highlighted in yellow that will need to be addressed to adapt the materials. You will also need to revise the wording to reflect the unique structure of your multidisciplinary community protocol. In other words, these materials represent only the "starting point." They can be tailored based on the specific agencies, laws, resources, and other unique factors in your community environment. This material was developed by Sgt. Joanne Archambault (Ret. San Diego PD) and Kimberly Lonsway, Ph.D., with the approval of the Office on Violence Against Women.

Philosophy / Purpose

The purpose of anonymous reporting is to allow victims of sexual assault to take the process of reporting to law enforcement "one step at a time." By providing victims with the opportunity to gather information, solidify their support system, and establish rapport with first responders, we hope to create an environment that encourages reporting, even for those victims who initially feel unable, unwilling, or unsure about doing so.

Victims are often overwhelmed by the prospect of a reporting decision that is viewed as "all or nothing" and "now or never." This barrier can be reduced when victims experience firsthand the competence and compassion of professionals providing services during the reporting process.

Achieving this goal requires a multidisciplinary, community-wide protocol for collecting and storing evidence from a medical forensic examination, for victims who have not yet talked with law enforcement. It also necessitates procedures for recording, storing, and retrieving anonymous reports within law enforcement agencies.

Anonymous Report: Definition

An anonymous reporting procedure offers victims or other third parties an opportunity to provide information about a sexual assault to law enforcement without identifying the victim (and/or the suspect). The information is recorded by law enforcement, in a manner that is generally similar to a standard reporting procedure. It may be recorded as an informational report or a crime report, depending on whether the information gathered at the time is sufficient to establish the elements of a sexual assault offense and departmental policy. However, the report is assigned an anonymous identifier to be used instead of the victim's name.

- With **direct anonymous reporting**, the victim provides information about the sexual assault directly (but anonymously) to law enforcement.

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- A **third party anonymous report** is made by a third party, such as a Sexual Assault Forensic Examiner (SAFE), Sexual Assault Nurse Examiner (SANE), or other health care provider – or even a friend, family member, or other professional. Again, it does not include the victim's name (i.e., anonymous).

Note on Language: For the purposes of this document, the term "victim" will be used for consistency and grammatical simplicity. However, it is understood that the term "client" is typically used by victim advocates, and "patient" is the preferred term for health care personnel. Use of the term "victim" is not meant to imply that victim advocates or forensic examiners are factfinders who make determinations regarding the legitimacy of sexual assault

Law Enforcement Agencies:
Roles and Responsibilities

Introduction / Philosophy

Anonymous reports are valuable to law enforcement for a number of reasons.

- First, they provide information about sexual assaults committed in the community that law enforcement would not otherwise know about. This gives law enforcement a more accurate picture of crime patterns in the community, which can be useful for investigative purposes as well as effective public education.

- Second, the procedure offers victims the opportunity to "try out" the reporting process and experience a competent and compassionate response from law enforcement personnel.

When developing a protocol for anonymous reporting, the goal is to create an environment that encourages victims to take the "next step" by providing their name in a standard report.

Direct anonymous reporting

Some victims of sexual assault first access the community response system by contacting law enforcement, including communications personnel (911 call takers). Because they have contacted law enforcement directly, it is less likely that these victims would opt for an anonymous reporting procedure. However, some victims are extremely reluctant to participate in the standard reporting process and quickly consider withdrawing their cooperation. When victims express such a concern or the intention to withdraw, they can be offered the opportunity to provide information about their sexual assault through an anonymous reporting procedure (either direct anonymous reporting or third party anonymous reporting).

When an anonymous report is made directly to law enforcement, the responding officer or investigator will record whatever information is provided. This information may be very limited or more detailed. The information provided to law enforcement will be documented in a written report and assigned some kind of tracking number (even if it is not a formal case number). This tracking number will then be provided to the victim along with follow-up contact information.

Even if the officer or investigator knows the victim personally, the written report for law enforcement will not include the victim's name or other identifying information. If a medical forensic examination was conducted, records that include the victim's name will be retained by the SAFE program or other health care facility where the exam was conducted.

While law enforcement has the ability to initiate an investigation based on the information provided in an anonymous report, this MOU documents a good faith agreement not to do so, except perhaps in certain circumstances (e.g., in cases with a serial stranger rapist, when the sexual assault is committed by an intimate partner, or when the victim is severely injured).

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Questions to answer: The answers should then be incorporated into the MOU

Once an anonymous report is received by a law enforcement agency, who will be assigned to respond? Will it be a patrol officer, or a detective?

What are the expectations regarding this law enforcement response? High priority should be placed on establishing rapport with the victim, answering questions and addressing concerns, and then documenting whatever information the victim provides in a written report.

How will a tracking number be generated for anonymous reports, without the victim's name?

What form will be used to record the information in a direct anonymous report (i.e., a report made directly by the victim)? Will it be the standard reporting form used by the law enforcement agency? Or will another form be developed specifically for this purpose?

Resource: IACP Supplemental Reporting Form and Guidelines

One recommendation for best practice is to use the Supplemental Reporting Form and corresponding guidelines developed by the International Association of Chiefs of Police (IACP).

These tools are based upon national best practices regarding sexual assault investigations and were developed in collaboration with local, state, and federal law enforcement, prosecutors, advocates, medical, and forensic professionals. The goal is to support officers and departments in preparing sexual assault cases for successful prosecution through detailed case documentation and thorough investigations. (Note: These guidelines are not intended for use when the victim is a minor.)

All materials are available at the website for the IACP at:
http://www.theiacp.org/PublicationsGuides/ContentbyTopic/tabid/216/Default.aspx?id=1143&v=1.

What will be used for the victim's name on the report? (e.g., "Jane Doe," anonymous identifier)

What will be used for assault location on the report form? Possibilities include the address of the law enforcement agency receiving the report or the 100-block location of the sexual assault.

What will be used for the crime code, if the elements of the offense are met? Will the report be scored and/or cleared for the purpose of reporting to the FBI's Uniform Crime Reports (UCR)?

If anonymous reports are recorded as informational reports rather than standard crime reports, how will they be tracked and how long will they be retained in Records? Best practice is to retain anonymous reports longer than the one year that is typical for most informational reports.

How will the anonymous report be retrieved, if the victim converts to a standard report? How will it be linked with any other information (e.g., report from a medical forensic examination)?

To what extent will the information included in an anonymous report be reviewed for crime analysis, to possibly identify a series of sexual assaults being committed in the community?

Resource: Reporting Methods for Sexual Assault

A document is posted on the website for EVAW International, to clarify the different concepts and terms that describe various methods for reporting a sexual assault to law enforcement. These terms include: blind reports, anonymous reports, third-party reports, informational reports, "Jane Doe" reports, etc. It is available at: http://www.evawintl.org/images/uploads/DefiningTerms-OLTImodule.pdf. This document is an excerpt from the larger training module on *Reporting Methods for Sexual Assault,* which is available in the On-Line Training Institute (OLTI) at: http://www.evawintl.org/evaw_courseware/. The goal of this document is not to suggest that all communities must use the same terminology. Rather, the goal is to differentiate the various reporting methods, so community professionals can make sure that they are all using the same terms to mean the same things (i.e., "on the same page").

Third party reports: Health care professionals

In some situations, information about a sexual assault can be provided to law enforcement anonymously by a SAFE or other health care professional. This person may have conducted a medical forensic examination with a victim, or provided more general health care services.

Third party reports can be made by a SAFE or other health care provider using a standard form, which could be developed in conjunction with local law enforcement agencies specifically for this purpose. Alternatively, a standard report form could be used, and the SAFE or other health care provider could write the phrase "declined by patient" in the spaces for the patient's name, address, and telephone number. This phrase may also be used in place of the suspect's name. A non-identifying address can also be used for the location of the assault (e.g., the address for the police department, or the 100-block of the assault location). The report form can be sent to the law enforcement agency with presumed jurisdiction over the assault. However, third party reports may also be provided on the phone, either instead of – or in addition to – a written report.

Depending on the wishes of the victim, third party reports might include the victim's name and other identifying information – or they might be anonymous third party reports. The report can include as much or as little information about the sexual assault as the victim wants to provide. If a medical forensic examination was conducted, the SAFE or other health care provider will retain a more detailed report documenting the findings at their program office or facility.

Resource: Mandated Reporting Laws and Payment for Forensic Examinations

Many professionals have questions about whether or not they are required by law to report a patient's disclosure of sexual assault to law enforcement. Answers can be found on the web page for the Sexual Assault Prevention and Response Office (SAPRO) of the U.S. Department of Defense, which has posted a summary of state laws compiled by the American Prosecutors Research Institute, National Center for the Prosecution of Violence Against Women. By clicking on a state, a document appears that summarizes any relevant laws pertaining to mandated reporting, payment for forensic examinations, and other reporting statutes that may impact rape victims (e.g., injuries). However, the materials were last updated in January of 2007, so they may not reflect recent changes in state statutes to comply with the 2005 Violence Against Women Act provisions governing sexual assault medical forensic examinations. The map is available at: http://www.sapr.mil/HomePage.aspx?Topic=ResourcesReports&PageName=ReportingLaws.htm.

Best Practice Recommendation: Health care providers should NOT report patient disclosures of sexual assault if not required by law

It is not recommended that health care providers report patient disclosures of sexual assault to law enforcement – if they include the victim's name and other identifying information -- if there is no legal requirement to do so. Some SAFE programs and other health care facilities have a written policy, or an unwritten rule, that they will do this. However, this practice clearly violates the spirit of the VAWA 2005 provisions, which were designed to increase access to medical forensic examinations for victims who are unsure, unwilling, or unable to report to law enforcement.

More importantly, this practice of reporting a patient's disclosure of sexual assault to law enforcement constitutes a violation of HIPAA if: (1) the report is not required or expressly authorized by state law, OR (2) the patient has not consented to this report being made. In other words, there are three general situations that can take place:

(1) If the law requires health care providers to report sexual assault disclosures to law enforcement, the patient does not have to consent to it. (However, the patient will still need to be notified of the fact that the report will be made, unless this notification will place them at further risk of harm).

(2) Whether or not there is a law mandating such reporting, health care providers can report sexual assault disclosures to law enforcement when the patient requests it or consents to it in writing.

(3) However, if there is no law mandating or expressly authorizing such a report – and the patient has not consented to it – health care providers will violate HIPAA if they report a sexual assault disclosure to law enforcement.

These three scenarios assume that the report to law enforcement includes the victim's name and/or other identifying information. On the other hand, SAFE programs or health care providers could design a protocol indicating that they will provide information about all sexual assault disclosures to law enforcement – <u>without the victim's name or other identifying information.</u> This type of protocol can meet the previously stated goals of anonymous reporting, while protecting the confidentiality of the victim. However, the protocol must be carefully designed with collaboration between law enforcement, health care providers, victim advocates, and other community professionals involved in sexual assault response. The protocol must also be supported with written documentation of a good faith agreement that law enforcement agencies will not investigate these reports, except in certain circumstances as previously described.

Best Practice: Do Not Require Victims to Talk with Law Enforcement

VAWA 2005 specifies that states and territories may not "require a victim of sexual assault to participate in the criminal justice system or cooperate with law enforcement in order to be provided with a forensic medical exam, reimbursed for charges incurred on account of such an exam, or both." However, there are different interpretations of what this means, and some communities are considering establishing a protocol that will essentially require a victim to talk with law enforcement -- if only to allow officers the chance to introduce themselves, offer their services, and confirm that the victim does not want to participate. This is probably more common in states that have mandated reporting requirements for sexual assault, although it may also be seen in communities that have a policy that all sexual assault disclosures to a health care provider will be reported to law enforcement – even if there is no legal requirement to do so. (Again, we want to emphasize that it is not best practice for health care providers to report to law enforcement when patients disclose that they have been sexually assaulted, if there is no legal requirement that they do so.)

On the one hand, it is easy to understand why officers might prefer this type of protocol, because it provides an opportunity to personally establish rapport with victims and make sure that the argument for reporting to law enforcement is presented fairly. There is sometimes a concern that victims will be "talked out of reporting" by forensic examiners, advocates, and even support people – and officers want an opportunity to present the victim with accurate information and to show that they are competent and compassionate professionals who can help victims to pursue justice. It is often frustrating for officers to feel "shut out" of the process, especially if their law enforcement agency pays for the costs of a forensic medical examination.

However, we believe that a common sense interpretation suggests that this is in fact "requiring victims to cooperate with law enforcement." Clearly, victims are not suspects, and they cannot be detained or forced to do anything they don't want to just because they have disclosed that they were sexually assaulted. Some people have even thought that perhaps they can "make" victims have a forensic exam, and this suggestion is so outrageous to anyone familiar with sexual assault dynamics that it shows – through an extreme example – the error in the logic of requiring victims to talk with law enforcement. It begs the question of what would happen in situations where victims have clearly stated that they do not want to talk to an officer. How exactly would community professionals make them do so? And equally important, why? It is difficult to imagine any outcome other than alienating victims completely from the reporting process.

In other words, the practice of calling law enforcement in situations where victims do not want to report their sexual assault to police does not violate VAWA. OVW has stated this clearly in their document on "Frequently Asked Questions" about the forensic compliance provisions of VAWA 2005. (This document is available at: http://www.ovw.usdoj.gov/ovw-fs.htm#fs-act/). OVW specifies that states with medical mandated reporting requirements "would be in compliance with the VAWA 2005 forensic examination requirement as long as the victim retains the ability to choose not to cooperate with law enforcement or the criminal justice system and receives a forensic examination free of charge or with full reimbursement." OVW does not specifically address the situation where a SAFE program or health care facility has a policy or practice of reporting all sexual assault disclosures to law enforcement, as long as the report does not include the victim's name or other identifying information. However, another problem arises if community professionals try to make victims talk with law enforcement. No explicit guidance is provided by OVW to clarify whether a requirement for victims to talk with law enforcement actually constitutes a requirement for them to "cooperate with law enforcement or the criminal justice system." We believe it does. At the very least, it clearly violates the spirit of the law.

Third party reports: Other individuals

In other situations, information about a sexual assault may be provided to law enforcement anonymously by another individual. This could include a family member or friend of the victim, or someone with a specific professional relationship (e.g., teacher, coach, counselor, clergy). Most law enforcement agencies have existing procedures for responding to such third party reports where identifying information is provided for the victim and/or suspect. The difference with direct anonymous reporting is that this identifying information will not be provided.

The procedure for recording these anonymous third party reports might not differ from the protocol for direct anonymous reporting (i.e., anonymous reports made by the victim). Clearly, law enforcement is limited in their ability to investigate a report when the victim does not want to participate. Nonetheless, it is important to use a standardized protocol for documenting and tracking these reports. This information will be important later if the victim decides to provide identifying information and participate in the process of an investigation.

Storing evidence

When a law enforcement agency receives an anonymous report (either directly or through a third party), there may be evidence submitted along with it. This evidence could be provided directly to the law enforcement agency by the victim or third party, such as a family member or friend. In these situations, the law enforcement agency will likely follow established procedures for collecting, documenting, storing, and tracking the evidence along with the anonymous report. The only differences in protocol might stem from variations in the procedure for anonymous reports versus standard reports that include the victim's name and other identifying information.

More typical, however, the evidence will be collected by a SAFE or other health care provider who conducts a medical forensic examination with the victim. In these situations, there are two common protocols for storing evidence.

- First, some communities have developed a protocol where the evidence associated with an anonymous report will be stored by the SAFE program or other health care facility where the medical forensic examination was conducted.

- In other communities, the law enforcement agency with presumed jurisdiction over the assault location stores the evidence.

It is recommended that health care providers work with their local prosecutors and law enforcement agents when writing protocols for storing and transferring evidence -- to ensure that they are consistent with local law and policy. These protocols should address issues such as chain of custody as well as avoiding cross-transfer and contamination.

Best Practice Recommendation: Forensic Evidence Stored by Law Enforcement

As indicated above, some communities have implemented a procedure where evidence collected during a medical forensic examination is stored by the SAFE program or other health care facility conducting the exam (e.g., hospital, health care clinic). In these communities, it is recommended that health care providers work with their local prosecutors and law enforcement agents when writing protocols for storing evidence -- to ensure that they are consistent with local law and policy. These protocols should address issues such as chain of custody as well as avoiding cross-transfer and contamination.

This procedure may be implemented in communities where law enforcement is resistant to developing an anonymous reporting procedure. However, we believe that this does not represent best practice. Instead, we recommend that evidence be stored by the law enforcement agency with presumed jurisdiction over the sexual assault, following standard procedures.

Rationale for recommending law enforcement storage

Evidence storage clearly falls within the role of law enforcement, so police departments have already developed policies and procedures for properly addressing issues such as evidence integrity, chain-of-custody, and destruction of hazardous materials. Law enforcement agencies have also developed the necessary record-keeping systems, so evidence can be properly identified, retrieved, and linked with other information in the case (e.g., police reports, victim interviews, witness statements). The integrity of these policies and procedures are continuously tested, when law enforcement personnel are cross-examined by defense attorneys in criminal cases. This provides a means of identifying any problems in the process. While problems certainly do arise, challenges based on the transfer and storage of evidence are rather rare in criminal litigation.

For health care providers to store evidence, a number of policies and procedures must be implemented to protect against possible challenges. Maintaining chain of custody is of paramount concern, so storage facilities must be properly secured. This applies to facilities for dry storage as well as refrigerated storage. Access to these storage facilities must also be strictly limited to a very small number of people with a legitimate need to place evidentiary materials in storage or remove them for transferring to law enforcement. Whenever a person accesses materials in storage, this must of course be meticulously documented to preserve chain of custody.

Yet chain of custody is not the only concern. Health care providers who store evidence must also take careful steps to protect against possible cross-transfer and contamination. Conditions for storage and security must meet accepted standards in the field of law enforcement or the integrity of the evidence may be successfully challenged later in court. This requires health care providers to stay up to date on any developing knowledge and technology, which may prove difficult because these responsibilities fall outside the typical boundaries of their professional role.

The impact of the Crawford decision

Because of the central role that SAFEs and other health care providers play in these cases, some people have asked about the potential impact of the Crawford decision. It is unlikely that anonymous evidence collection will be utilized in cases with victims who are not competent to make legal decisions such as whether or not to participate in criminal investigations (e.g., minors, persons with disabilities that render them mentally incompetent, etc.). In sexual assault cases involving competent adult victims,[1] it is unlikely that the prosecutor will proceed without the victim because defendants commonly claim that their victims consented to the sexual acts in question, and it is almost impossible to overcome this type of consent defense in cases where a victim is legally able to consent without the victim's testimony. The Crawford decision only applies in cases where the victim does not testify or where his/her testimony does not satisfy the requirements of the Confrontation Clause.[2]

There is a question, however, that forensic examiners who store evidence may blur their professional boundaries with law enforcement -- and this could impact their ability to testify about a victim's statements made during the examination where the victim does not testify at trial or where her/his testimony does not satisfy the requirements of the Confrontation Clause. More practically, the practice will likely fuel the perception that forensic examiners are serving as members of the prosecution team, which will provide the defense with support for their arguments that the forensic examiner is biased. It is recommended that medical professionals creating procedures for anonymous evidence collection meet with their local prosecutors to ensure that the procedures created address any potential Crawford issues.

Determining jurisdiction

Many victims have a hard time specifying exactly where their sexual assault took place. Therefore, it is important to keep in mind that the SAFE or health care provider can only be expected to do their best in determining the presumed jurisdiction for an anonymous report. If the victim later converts an anonymous report to a standard report, the law enforcement officer conducting the investigation will need to determine the proper jurisdiction. If the investigation reveals that another law enforcement agency actually has jurisdiction, the two agencies will need to work together to transfer the investigative responsibilities, information, and evidence in a way that will minimize any negative impact on the victim and the investigation of the case.

[1] *Competent adult* is used to represent those adults who are viewed by the legal system as capable of making decisions and giving legally recognized consent. Please refer to state law for definitions or interpretations of what constitutes a *competent adult* in a given state.

[2] A defendant's right to confront witnesses against him is set forth in the 6th Amendment of the US Constitution. See also: *Crawford v. Washington*, 541 U.S. 36, 124 S. Ct. 1354 (2004); *Giles v. California*, 128 U.S. ___, 128 S. Ct. 2678 (2008); Davis v, Washington, 126 S. Ct. 2266 (2006).

Best Practice Recommendation: Take Courtesy Reports for Other Agencies

Any discussion of anonymous reporting highlights the need for law enforcement agencies to take courtesy reports of sexual assault for other agencies. The issue may arise more frequently for anonymous reports, because victims may not provide enough information for law enforcement to determine the proper jurisdiction for their sexual assault. However, the need also exists for standard reports where the victim provides their name and sufficient information to determine that responsibility for the investigation actually rests with another law enforcement agency. For example, police departments near a college campus or popular tourist destination often receive reports of sexual assaults committed outside their jurisdiction – sometimes even from outside the state or country. Best practice is clearly for the law enforcement agency receiving the report to conduct a preliminary investigation, rather than turning victims away and telling them that they must report their sexual assault to the agency with jurisdiction. In many cases, this agency could be hours away – so sending the victim to report there is essentially the same as telling them not to report. A far better response is for the law enforcement agency receiving the disclosure to take a report, conduct a preliminary investigation, and then assist with the transfer of investigative responsibility to the other law enforcement agency.

Timelines for Storage

Community professionals must also determine how long the evidence will be stored for anonymous reports; this should be included in the multidisciplinary protocol. Best practice is to store the evidence for the length of time specified in the statute of limitations for sexual assault. Some states do not currently have a statute of limitations for sexual assault crimes. In these states, community protocols may need to specify a realistic timeline for evidence retention.

When the timeline for storage expires, the evidence will be destroyed. For law enforcement agencies storing the evidence, its destruction will follow established procedures. When evidence is stored by a SAFE program or other health care facility, procedures for evidence destruction will need to be developed; this is best done in coordination with law enforcement personnel.

Best Practice Recommendation: Store Evidence for Statute of Limitations

Often, community protocols do not currently require evidence to be stored for the statute of limitations, if there is no standard report to law enforcement that includes the victim's name. Yet best practice is clearly to store the evidence for this length of time, because the goal of an anonymous reporting protocol is to encourage the reporting and prosecution of sexual assault – when the victim is initially unwilling, unable, or unsure about participating in the process.

Many communities have implemented protocols requiring storage for shorter periods of time, ranging from days to years (e.g., 30 days, 60 days, 90 days, 1 year, 18 months, 2 years, etc.). While recognizing the reality of limited resources, communities are encouraged to store evidence as long as possible and continue to work toward extending the timeline.

Evidence Destruction

In addition, the determination must be made whether a community protocol will require notification of the victim when the evidence associated with their report will be destroyed.

- Some community protocols require that the victim be notified when their evidence will be destroyed; this will likely be done some period of time before the actual destruction of evidence (e.g., 30-90 days before the scheduled destruction).

- Other communities have developed a protocol where victims are notified of the timelines for evidence storage upfront, so they are not notified at the time the evidence is destroyed.

In either situation, it is critical that victims understand the timelines for evidence storage and any procedures for notification. This will need to be included in the materials for informed consent.

Follow-up responsibilities

Because victims do not provide a name or other identifying information in an anonymous report, it will not be the responsibility of law enforcement to follow up with them. For anonymous reports, the responsibility for follow-up contact likely rests with the Victim Advocacy Agency (VAA), the Sexual Assault Forensic Examiner (SAFE) program, and/or the health care facility that conducts medical forensic examinations.

Converting from an anonymous to a standard report

Victims must be informed that they can decide at any time to convert to a standard report, by providing their name and participating in a law enforcement investigation.

Once this protocol for anonymous reporting has been implemented, law enforcement officers will need to keep in mind that any victims contacting their agency might actually be converting an anonymous report to a standard report by providing their name and other information. In these situations, it will be important to ask victims if they had a medical forensic exam, so the information and evidence can be located and retrieved. The investigation will then generally proceed as in any other standard report.

Best Practice Recommendation: Collect Data on Anonymous Reports

After implementing a protocol, data collection is critically important – to document how often victims convert from an anonymous report to a standard report, and how long it takes them to reach that decision. Other information that would be helpful for monitoring policy implementation would include: any problems with evidence collection, documentation, transfer, storage, and retrieval; the extent and quality of the law enforcement investigation for reports that convert from anonymous to standard; case dispositions and prosecutorial outcomes for converted reports; and levels of victim satisfaction with the process and services provided by various responding professionals. For more information on data collection and tools that can be used to assist with this process is available at the website for EVAW International at: http://www.evawintl.org/forensiccompliance.aspx?subpage=3#DC.

Sexual Assault Forensic Examiner (SAFE) Programs or Other Health Care Facilities Providing Medical Forensic Examinations: Roles and Responsibilities

Philosophy / Purpose

Some victims of sexual assault decide to participate in a medical forensic examination, offered by the Sexual Assault Forensic Examination (SAFE) program or other health care provider. Victims are typically referred to the SAFE program or another health care provider who conducts medical forensic examinations – either by law enforcement personnel or Victim Advocacy Agency (VAA) advocates. When they arrive at the SAFE program office or other health care facility, victims vary widely with respect to their initial preferences regarding reporting to law enforcement. Some victims fully intend to report to law enforcement and actively participate in the process of an investigation and criminal prosecution. Some victims are absolutely unwilling to talk with law enforcement personnel. However, most victims range between these two extremes and express a range of questions and concerns about reporting to law enforcement.

Information about the standard reporting process

The SAFE or other health care provider will begin by explaining the process of a medical forensic examination and standard reporting to law enforcement. This will include a discussion of the benefits of prompt reporting and a summary of the victim's rights during the process. If victims are comfortable with this process, then previously established procedures for standard reporting to law enforcement will be followed.

Questions to answer: The answers should then be incorporated into this MOU.

How does the SAFE or other health care provider conducting a medical forensic examination request a law enforcement response – if law enforcement has not already been notified?

How will communications personnel (e.g., 911 call takers) prioritize these calls from a SAFE or health care provider, in comparison with other priority calls? Community protocols will need to specify these procedures, so communications personnel can properly follow them – and other professionals can realistically understand them.

How will law enforcement agencies respond to these calls? Will an officer or investigator physically respond to the SAFE program or other health care facility? If so, will they respond as soon as possible, or will they wait until after the medical forensic examination has been completed? This is obviously related to the prior question about how to prioritize these calls.

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Information about anonymous reporting

If victims express that they are unsure, unwilling, or unable to participate in the standard reporting process to law enforcement, the SAFE or other health care provider will discuss anonymous reporting. This information should address the following issues:

- Advantages of prompt reporting to law enforcement
- Basic procedures for standard reporting and anonymous reporting
- Direct anonymous reporting versus third party anonymous reporting
- Types of evidence stored with an anonymous versus standard report
- Where the evidence will be stored for each type of report
- Whether evidence is truly stored anonymously, or if it includes the victim's name and specific protections for the confidentiality of that information
- How long the evidence will be stored for each type of report, and whether victims will be notified as the deadline for evidence destruction approaches
- How long anonymous reports will be retained by law enforcement agencies
- How to change an anonymous report to a standard report
- How to have clothing returned (if possible)
- How and when victims will be contacted for follow-up
- Payment issues for medical and/or forensic components of the exam
- Crime Victim Compensation eligibility and procedures, particularly if anonymous reporting excludes the victim from eligibility for future financial reimbursement
- Where to call with questions

Communities offering anonymous reporting must develop an informational form for victims to describe their various options, and help them to weigh the advantages and disadvantages of each.

Best Practice Recommendation: Clarify Victim Rights to Evidence (if any)

Community protocols may need to clarify what rights (if any) victims have for returning clothing or other evidence associated with an anonymous report. This information must then be incorporated into the informational materials that are developed for victims.

In communities where the evidence is stored by law enforcement, it may be difficult for victims to have anything returned to them. Even if they can have some items returned (e.g., clothing), it is probably impossible to do so anonymously; ID will be required before evidence can be handed over.

When the evidence is stored by a SAFE program or other health care facility, it may be easier to return some items to victims if they request it. However, this is most likely to pertain only to items such as clothing or bedsheets. Serious concerns would arise if victims were offered the option of requesting other types of evidence (e.g., biological samples collected during the medical forensic examination). Perhaps most important, this would create an opportunity for suspects to intimidate victims into requesting to have evidence returned, in order to interfere with the investigation. Best practice is therefore to clarify that the biological evidence does not belong to the victim; no process exists for victims to request access to this evidence or have it returned to them.

Payment for the medical forensic examination

Victims must also receive clear and detailed information about how the costs of a medical forensic examination will be paid. In some communities, the victim will never see a bill or pay any costs associated with the exam. This is clearly best practice, because it increases access to an exam for all sexual assault victims, regardless of their ability to pay the costs upfront.

Other communities require the victim to pay for the exam and be reimbursed later. Still others submit a bill to the victim's private insurance. According to the Office on Violence Against Women (OVW), U.S. Department of Justice, both of these procedures can be compliant with the Violence Against Women Act (which was most recently reauthorized in 2005), as long as a number of conditions are met. First, victims must be fully reimbursed for any out-of-pocket costs for the medical forensic examination, regardless of their decision regarding whether or not to participate in the criminal justice process. Second, victims or their private insurance cannot be billed by any state or territory that uses STOP Grant funding to pay for forensic exams. This type of procedure can only be used by states or territories using other funds to cover these costs.

It is also critically important to clarify whether costs for medical testing or treatment will be covered in the same way as other aspects of the medical forensic examination. According to OVW, a medical forensic examination is defined as including the following components:

- examination of physical trauma
- determination of penetration or force
- patient interview; and
- collection and evaluation of evidence [28 C.F.R. § 90.2(b) (1)]

Thus the forensic components of the exam must be covered for states or territories to be deemed compliant with the 2005 Violence Against Women Act. Yet the legislation gives discretion to states regarding whether or not to pay for medical aspects of the exam (i.e., medical testing and treatment). The practice therefore varies both as a result of state laws and specific protocols within communities. As a result, victims of sexual assault may find that all, none, or some of the costs for medical testing and treatment procedures are covered. Clearly, victims must be provided with information that is accurate and current regarding what costs will be covered.

Best Practice: Evaluate Timeline for Exams on a Case-by-Case Basis

Many community protocols specify a certain timeline for how many hours after a sexual assault incident a medical forensic examination will be conducted. The timeline is commonly in the range of 72, 96, or 120 hours. While the longest of these (120 hours) can be used as a general guideline, best practice is for each sexual assault to be evaluated on a case by case basis. The question of whether or not to conduct an exam should be based on the facts of the case, the victim's history, the likelihood of recovering evidence, and the types of evidence that will be needed for successful prosecution. This issue is discussed in detail in a Promising Practices article from the e-newsletter for Sexual Assault Training & Investigations (SATI), Inc. The e-newsletter was dated May 19th, 2005, and it is available at: http://www.mysati.com/enews/May2005/practices_0505.htm. The article was also published in *Sexual Assault Report,* Volume 10, Number 3, January/February 2007, p 33-47.

Informed consent: Follow-up preferences

The informational form can be used to describe the options for follow-up, and document whether victims want to be contacted for various purposes and/or at different times. Victims can also record on the form their preferred method(s) of being reached (e.g., phone number, email). Possible arrangements for assigning follow-up contact to professionals will be discussed later.

Direct anonymous reporting

For victims who choose to file a direct anonymous report, the SAFE or other health care provider will need to contact law enforcement if they have not already been notified. This will require first asking the victim where the sexual assault occurred, and then contacting the law enforcement agency with jurisdiction over that location. However, it is important to keep in mind that the SAFE or health care provider can only be expected to do their best in determining the presumed jurisdiction for an anonymous report, based on the information received. Many victims have a hard time specifying exactly where their sexual assault took place. If the victim later converts an anonymous report to a standard report, the law enforcement officer conducting the investigation will need to determine the proper jurisdiction and transfer the case if necessary.

Depending on the policy of the law enforcement agency, an officer or investigator might respond directly to the SAFE program or other health care facility in order to meet with the victim. Other agencies may schedule another time for the victim to talk with the officer or investigator.

Best Practice Recommendation: Conduct Courtesy Exams for Other Jurisdictions

Any discussion of anonymous reporting highlights the need for SAFE programs or other health care providers to conduct courtesy exams for other jurisdictions. The issue may arise more frequently for anonymous reports, because victims may not provide enough information to determine the proper jurisdiction for their sexual assault. However, the need also exists for standard reports where the victim provides their name and sufficient information to determine that the location of the sexual assault is actually in another jurisdiction. For example, SAFE programs and other health care facilities near a college campus or popular tourist destination often receive reports of sexual assaults committed outside the community – sometimes even from outside the state or country. Best practice is clearly to conduct the medical forensic examination regardless of where it occurred, and then work with the law enforcement agency with presumed jurisdiction to determine the appropriate process for transferring evidence and information. Of course, this will require community professionals to think carefully about how to pay for these exams and establish a protocol for doing so before the need actually arises.

The victim will then have the opportunity to talk with a law enforcement officer without providing identifying information to be documented in the report (i.e., remaining anonymous). Even if the responding officer knows the victim personally, a protocol for anonymous reporting requires that the written report not include the victim's name or other identifying information.

This report will need to be assigned some kind of tracking number, to be provided to the victim and documented in the records kept by the SAFE program or health care facility. This tracking number could initially be generated by the law enforcement agency or by the SAFE or other health care provider conducting the medical forensic examination. The victim will also need to be provided with written information, including a phone number for the law enforcement agency, and the name and ID number for the officer who responded to the anonymous report.

Records that include the victim's name and identifying information will be kept by the SAFE program or other health care facility conducting the medical forensic examination.

Third party anonymous reporting: Health care providers

In states with laws mandating that health care providers report any disclosure of sexual assault, victims do not have the option of choosing whether or not a report will be filed with law enforcement. For those states without such a medical mandated reporting for sexual assault, the decision regarding whether or not to file a report with law enforcement should be left to the victim. The SAFE or other health care provider can provide information for victims about their reporting options; this information can also ideally be provided by a victim advocate as well.

Third party reports can be made by a SAFE or other health care provider using a standard form, which could be developed in conjunction with local law enforcement agencies specifically for this purpose. Alternatively, a standard report form could be used, and the SAFE or other health care provider could write the phrase "declined by patient" in the spaces for the patient's name, address, and telephone number. This phrase may also be used in place of the suspect's name. A non-identifying address can also be used for the location of the assault (e.g., the address for the police department, or the 100-block of the assault location). The report form can be sent to the law enforcement agency with presumed jurisdiction over the assault. However, third party reports may also be provided on the phone, either instead of – or in addition to – a written report.

Resource: Mandated Reporting Laws and Payment for Forensic Examinations

Many professionals have questions about whether or not they are required by law to report a patient's disclosure of sexual assault to law enforcement. Answers can be found on the web page for the Sexual Assault Prevention and Response Office (SAPRO) of the U.S. Department of Defense, which has posted a summary of state laws compiled by the American Prosecutors Research Institute, National Center for the Prosecution of Violence Against Women. By clicking on a state, a document appears that summarizes any relevant laws pertaining to mandated reporting, payment for forensic examinations, and other reporting statutes that may impact rape victims (e.g., injuries). However, the materials were last updated in January of 2007, so they may not reflect recent changes in state statutes to comply with the 2005 Violence Against Women Act provisions governing sexual assault medical forensic examinations. The map is available at: http://www.sapr.mil/HomePage.aspx?Topic=ResourcesReports&PageName=ReportingLaws.htm.

Depending on the wishes of the victim, third party reports might include the victim's name and other identifying information – or they might be anonymous third party reports. The report can include as much or as little information about the sexual assault as the victim wants to provide. If a medical forensic examination was conducted, the SAFE or other health care provider will retain a more detailed report documenting the findings at their program office or facility.

Best Practice Recommendation: Health care providers should NOT report patient disclosures of sexual assault if not required by law

It is not recommended that health care providers report patient disclosures of sexual assault to law enforcement – if they include the victim's name and other identifying information -- if there is no legal requirement to do so. Some SAFE programs and other health care facilities have a written policy, or an unwritten rule, that they will do this. However, this practice clearly violates the spirit of the VAWA 2005 provisions, which were designed to increase access to medical forensic examinations for victims who are unsure, unwilling, or unable to report to law enforcement.

More importantly, this practice of reporting a patient's disclosure of sexual assault to law enforcement constitutes a violation of HIPAA if: (1) the report is not required or expressly authorized by state law, OR (2) the patient has not consented to this report being made. In other words, there are three general situations that can take place:

(1) If the law requires health care providers to report sexual assault disclosures to law enforcement, the patient does not have to consent to it. (However, the patient will still need to be notified of the fact that the report will be made, unless this notification will place them at further risk of harm).

(2) Whether or not there is a law mandating such reporting, health care providers can report sexual assault disclosures to law enforcement when the patient requests it or consents to it in writing.

(3) However, if there is no law mandating or expressly authorizing such a report – and the patient has not consented to it – health care providers will violate HIPAA if they report a sexual assault disclosure to law enforcement.

These three scenarios assume that the report to law enforcement includes the victim's name and/or other identifying information. On the other hand, SAFE programs or health care providers could design a protocol indicating that they will provide information about all sexual assault disclosures to law enforcement – <u>without the victim's name or other identifying information.</u> This type of protocol can meet the previously stated goals of anonymous reporting, while protecting the confidentiality of the victim. However, the protocol must be carefully designed with collaboration between law enforcement, health care providers, victim advocates, and other community professionals involved in sexual assault response. The protocol must also be supported with written documentation of a good faith agreement that law enforcement agencies will not investigate these reports, except in certain circumstances as previously described.

Storing evidence

When a SAFE or other health care provider reports a sexual assault to law enforcement, and the victim remains anonymous, a decision must be made regarding where to store the evidence. Most communities choose between two primary options:

- First, some communities have developed a protocol where the evidence will be stored by the SAFE program or other health care facility where the medical forensic examination was conducted.

- In other communities, the law enforcement agency with presumed jurisdiction over the assault location stores the evidence.

If a law enforcement agency stores the evidence, it can be transferred by the SAFE facility or health care provider following established procedures. If the evidence is stored by the SAFE program or health care facility, procedures must be developed to ensure that the evidence is stored properly. It is recommended that health care providers work with their local prosecutors and law enforcement agents when writing protocols for storing and transferring evidence -- to ensure that they are consistent with local law and policy. These protocols should address issues such as chain of custody as well as avoiding cross-transfer and contamination.

Informed consent: Evidence transfer and storage

Before the exam begins, victims will be provided with a wide range of information and asked to document their consent to various procedures. For example, victims who participate in the standard reporting process will need to sign a standard form releasing their evidence to the law enforcement agency with presumed jurisdiction.

For victims who elect to report anonymously – either directly or through a third party such as a SAFE or other health care provider – they will mark this designation on a form with reporting options. They will then sign the form authorizing the community procedures for transfer and storage of evidence.

- In communities where the evidence is stored by the SAFE program or other health care facility, victims will need to document their consent to the procedures that have been established for this purpose.

- In communities with law enforcement storage, victims will sign a form (similar to the one used in a standard reporting process), to provide consent for the transfer of evidence to the law enforcement agency with presumed jurisdiction.

It must also be clearly documented on this authorization form whether the evidence is truly stored anonymously – or if it includes the victim's name and other identifying information with protections for the victim's confidentiality. For example, some law enforcement agencies will store documentation with the evidence that includes the victim's name and other identifying information. It may be sealed inside the evidence kit, with a documented agreement that the

agency will not open the kit to investigate without the victim's consent. Some law enforcement agencies may even use the victim's name to log the evidence and/or enter other identifying information into their record keeping system.

In this type of situation, the reporting process is no longer technically anonymous. However, the spirit of an anonymous reporting procedure may still be achieved if there is a documented agreement with other community professionals that the victim's confidentiality will be protected and a good faith agreement that cases will not be investigated without the victim's consent, except perhaps in certain circumstances (e.g., in cases with a serial stranger rapist, when the sexual assault is committed by an intimate partner, or when the victim is severely injured). If prosecution is pursued, and a court issues a subpoena, the SAFE or other health care provider will of course be required to turn over the evidence and documentation/records from the medical forensic examination.

Best Practice Recommendation: Forensic Evidence Stored by Law Enforcement

As indicated above, some communities have implemented a procedure where evidence collected during a medical forensic examination is stored by the SAFE program or other health care facility conducting the exam (e.g., hospital, health care clinic). In these communities, it is recommended that health care providers work with their local prosecutors and law enforcement agents when writing protocols for storing evidence -- to ensure that they are consistent with local law and policy. These protocols should address issues such as chain of custody as well as avoiding cross-transfer and contamination.

This procedure may be implemented in communities where law enforcement is resistant to developing an anonymous reporting procedure. However, we believe that this does not represent best practice. Instead, we recommend that evidence be stored by the law enforcement agency with presumed jurisdiction over the sexual assault, following standard procedures.

Rationale for recommending law enforcement storage

Evidence storage clearly falls within the role of law enforcement, so police departments have already developed policies and procedures for properly addressing issues such as evidence integrity, chain-of-custody, and destruction of hazardous materials. Law enforcement agencies have also developed the necessary record-keeping systems, so evidence can be properly identified, retrieved, and linked with other information in the case (e.g., police reports, victim interviews, witness statements). The integrity of these policies and procedures are continuously tested, when law enforcement personnel are cross-examined by defense attorneys in criminal cases. This provides a means of identifying any problems in the process. While problems certainly do arise, challenges based on the transfer and storage of evidence are rather rare in criminal litigation.

For health care providers to store evidence, a number of policies and procedures must be implemented to protect against possible challenges. Maintaining chain of custody is of paramount concern, so storage facilities must be properly secured. This applies to facilities for dry storage as well as refrigerated storage. Access to these storage facilities must also be strictly limited to a very small number of people with a legitimate need to place evidentiary materials in storage or remove them for transferring to law enforcement. Whenever a person accesses materials in storage, this must of course be meticulously documented to preserve chain of custody.

Yet chain of custody is not the only concern. Health care providers who store evidence must also take careful steps to protect against possible cross-transfer and contamination. Conditions for storage and security must meet accepted standards in the field of law enforcement or the integrity of the evidence may be successfully challenged later in court. This requires health care providers to stay up to date on any developing knowledge and technology, which may prove difficult because these responsibilities fall outside the typical boundaries of their professional role.

The impact of the Crawford decision

Because of the central role that SAFEs and other health care providers play in these cases, some people have asked about the potential impact of the Crawford decision. It is unlikely that anonymous evidence collection will be utilized in cases with victims who are not competent to make legal decisions such as whether or not to participate in criminal investigations (e.g., minors, persons with disabilities that render them mentally incompetent, etc.). In sexual assault cases involving competent adult victims,[1] it is unlikely that the prosecutor will proceed without the victim because defendants commonly claim that their victims consented to the sexual acts in question, and it is almost impossible to overcome this type of consent defense in cases where a victim is legally able to consent without the victim's testimony. The Crawford decision only applies in cases where the victim does not testify or where his/her testimony does not satisfy the requirements of the Confrontation Clause.[2]

[1] *Competent adult* is used to represent those adults who are viewed by the legal system as capable of making decisions and giving legally recognized consent. Please refer to state law for definitions or interpretations of what constitutes a *competent adult* in a given state.

[2] A defendant's right to confront witnesses against him is set forth in the 6th Amendment of the US Constitution. See also: *Crawford v. Washington*, 541 U.S. 36, 124 S. Ct. 1354 (2004); *Giles v. California*, 128 U.S. ___, 128 S. Ct. 2678 (2008); Davis v, Washington, 126 S. Ct. 2266 (2006).

There is a question, however, that forensic examiners who store evidence may blur their professional boundaries with law enforcement -- and this could impact their ability to testify about a victim's statements made during the examination where the victim does not testify at trial or where her/his testimony does not satisfy the requirements of the Confrontation Clause. More practically, the practice will likely fuel the perception that forensic examiners are serving as members of the prosecution team, which will provide the defense with support for their arguments that the forensic examiner is biased. It is recommended that medical professionals creating procedures for anonymous evidence collection meet with their local prosecutors to ensure that the procedures created address any potential Crawford issues.

Documentation and recordkeeping

The SAFE or other health care provider will write the name of the victim and other identifying information on the standard form that is used for documenting detailed information (including findings) from a sexual assault medical forensic examination.

- For victims who make a standard report, this detailed form is provided to law enforcement, along with the evidence from the medical forensic examination, following established procedures.

- For victims who report anonymously – either directly or through a third party such as the SAFE or other health care provider – this detailed documentation of the medical forensic examination will not be provided to law enforcement. This detailed form will remain with the SAFE program or other health care facility for a period of time to be determined in the community protocol.

- For states with medical mandated reporting requirements, the SAFE or other health care provider will then complete the form that is used for this purpose. This form will likely include much more basic information than the detailed form that is used to document information (including findings) from the medical forensic examination. For example, the mandated report form might include the victim's name and contact information, suspect's name and contact information (if known), the location of the assault, and a very basic narrative account.

Additional medical documentation will follow the standard protocols and will not generally be released without signed authorization from the patient (unless a court issues a subpoena requiring the release of evidence, documentation, and/or records). Many SAFE programs, hospitals, and other health care facilities have protocols for storing such medical records that are kept distinctly separate from the procedures used for documenting the medical forensic examination.

Converting from an anonymous to a standard report

Victims who have reported anonymously will be advised that they can decide at any time to convert to a standard report and participate in a law enforcement investigation. To do this, they can either contact the law enforcement agency or the SAFE program (or other health care facility that provided the medical forensic examination). If they contact the law enforcement agency

first, they will need to mention to the responding officer that a medical forensic examination was conducted previously. It will obviously be important for the officer to note that this examination was conducted, so the information and evidence can be located and retrieved.

Victims can also choose to contact the SAFE program or other health care facility first. In that case, the SAFE or other health care provider can provide assistance to the victim in contacting the law enforcement agency with jurisdiction and providing information about the medical forensic examination that was conducted. In those communities where evidence is initially stored by the SAFE program or health care facility, procedures should be in place to transfer the evidence to law enforcement when the victim converts from an anonymous to a standard report.

Two Options for Contact: Converting an Anonymous Report to a Standard Report

Victims can be presented with both options for converting an anonymous report to a standard report, by contacting either the law enforcement agency or the SAFE program (or other health care facility conducting the medical forensic examination). However, some community protocols might designate one of the two options as preferable, and victims can be provided with this information. For example, many SAFE programs operate on a callout basis without any administrative time, which means that no one will be available to respond to victim contacts most of the time. For this reason, some community protocols might advise victims that the preferred method for converting an anonymous report to a standard report is to contact the law enforcement agency with presumed jurisdiction over the assault location.

At this point, an updated authorization form will need to be signed by the victim for the SAFE program or other health care facility to release the victim's name and identifying information. If the evidence is transferred from the SAFE program or other health care facility to law enforcement, the form would also need to document the victim's authorization of this release.

Tracking information about suspects

In some communities, the SAFE program or other health care facility offering medical forensic examinations can track the names of any named suspects in a database. In other communities this function might be performed by advocates from a Victim Advocacy Agency. If the same suspect is named by more than one victim, the informed consent forms signed by all victims who have named that suspect can then be reviewed. For any victims who have consented to be contacted in this particular situation, the VAA advocate, SAFE, or other health care provider will call victims to ask whether they want to talk with law enforcement at this time, considering the new information available. When victims consent, the VAA advocate, SAFE, or other health care provider will assist them in arranging contact with law enforcement.

Best Practice Recommendation: Track Information about Suspects

A primary purpose of anonymous reporting is to provide information to law enforcement about sexual assaults being perpetrated in the community that they would not otherwise know about. Therefore, best practice is to implement a system for tracking information on suspects who are named by more than one victim. Yet any community seeking to develop such a protocol will face a limited range of options for which professionals can perform this function. While other options are possible, the two primary candidates for fulfilling this role are the Victim Advocacy Agency (VAA) or the SAFE program or other health care facility offering medical forensic examinations. We argue that the latter option is generally better, although this might vary by community.

Clearly, there are some legitimate concerns with a protocol that has a SAFE program or other health care facility tracking information on suspects. Because this role is investigative, it blurs the professional boundaries to some extent for health care professionals. This issue may therefore be raised in cross-examination by defense attorneys at any future sexual assault trials in which the SAFE or other health care provider testifies. The protocol also raises some questions regarding logistics, including how records will be stored, reviewed, and kept confidential. Ethical and practical questions must be addressed when devising a system for contacting victims.

The other primary option is a Victim Advocacy Agency (VAA), and there are different concerns stemming from this choice. To protect their confidentiality of communications with victims, as well as their written records, advocates in many states need to clearly demarcate their role from any investigative function. Tracking suspects may therefore create a more significant problem for blurring their professional role as compared with the SAFE or other health care provider who conducted the medical forensic examination. After all, evidence collection is conducted for forensic purposes, for victims who might decide to participate in a law enforcement investigation.

No evidence collection: Medical examination only

In some communities, victims can opt to have a medical examination conducted by the SAFE or other health care provider, without collecting or documenting any forensic evidence. This is clearly best practice. In this situation, the SAFE or other health care provider can offer:

- An evaluation for any possible injuries
- Medication to treat any possible sexually transmitted diseases
- Emergency contraception for any possible pregnancy

In states with mandated reporting requirements, the SAFE or other health care provider must still file a report with law enforcement even in these situations where no forensic evidence is collected. Again, this fact must be communicated to victims clearly and in writing.

Some communities may be able to find a way to pay for these medical examinations, using a different source of funding than for exams that include evidence collection and documentation.

Follow-up responsibilities

When a medical forensic examination is conducted by the SAFE program or other health care facility, there are a number of possibilities for assigning follow-up responsibilities. The specific arrangement in a community will depend on a number of factors, including whether or not they have a specific agency to provide victim advocacy and/or medical forensic examinations. The number, type, size, and structures of these agencies will also vary widely. In general, however, any protocol for anonymous reporting must include careful attention to the question of whether, when, and how victims will receive follow-up contact.

Best Practice Recommendation: Assign Follow-Up Responsibilities

To achieve the goal of increasing access to the criminal justice system for victims of sexual assault, it is critically important that they receive the support they need to make that decision and follow through with their participation in the process. For victims who are initially unwilling, unable, or unsure about reporting to police, it may be unlikely that they would decide to participate in a police investigation without receiving any follow-up contact.

In many communities, an advocate from a Victim Advocacy Agency (VAA) is called out to the SAFE program or other health care facility when a medical forensic examination is conducted. This is clearly best practice, to provide victims with the information and support they need. When this is the case, a community protocol might assign the VAA primary responsibility for follow-up contact with victims. For example, the community protocol might specify that an advocate will try to reach the victim within 72-96 hours of the examination. This may be especially likely in communities where forensic examiners are available only on a callout basis with no administrative time that could be used to make follow-up contact with victims.

Of course all follow-up contact requires documented consent of the victim, as discussed in a previous section. In their follow-up, VAA advocates have the opportunity to contact victims to check on their well being, offer services, and provide referrals for other community agencies.

If no VAA advocate provides services to the victim at the time of the exam, the SAFE or other health care provider will likely have the primary responsibility for follow-up contact. Again, an example would be for the SAFE or other health care provider to contact the victim within 72-96 hours of the medical forensic examination. The SAFE or other health care provider could then take this opportunity to check on the victim's general well-being and offer referrals for services.

The SAFE or other health care provider may also need to follow up with victims based on their medical needs. In some situations, this may require checking the victim's physical well-being and follow-through on medical recommendations (e.g., medications, testing). In other situations, the victim may be asked to return to the SAFE program or other health care facility for a follow-up appointment, to evaluate medical treatment and possibly examine any injuries for signs of healing. As a secondary purpose, the SAFE or other health care provider may take photographs of any injuries for forensic evidentiary purposes.

For victims who report anonymously to law enforcement, follow-up contact can also be used to provide them with a tracking number obtained from the law enforcement agency. This offers an opportunity for the VAA advocate, SAFE, or other health care provider to answer questions and address any concerns the victim has regarding the decision to report to law enforcement.

In some communities, a tracking number will be provided by an officer who responds at the time of the exam. In other situations (especially when law enforcement does not respond at the time of the exam), the SAFE or other health care provider may request the tracking number by calling the law enforcement agency to make a medical mandated report. Community protocols should specify whether both options are available, or whether one of the two procedures is preferred.

Finally, victims may be given the option of whether they want to be contacted if further information becomes available about their assault or perpetrator (e.g., another victim names the same suspect, or describes the same M.O. in a future disclosure of sexual assault). This contact could be made either by the advocate or by the SAFE or other health care provider.

Evidence Destruction

The determination must be made whether a community protocol will require notification of the victim when the evidence associated with their report will be destroyed.

- Some community protocols require that the victim be notified when their evidence will be destroyed; this will likely be done some period of time before the actual destruction of evidence (e.g., 30-90 days before the scheduled destruction).

- Other communities develop a protocol where victims are notified of the timelines for evidence storage upfront, so they are not notified at the time the evidence is destroyed.

In either situation, it is critical that victims understand the timelines for evidence storage and any procedures for notification. This will need to be included in the materials for informed consent.

Best Practice Recommendation: Collect Data on Anonymous Reports

After implementing a protocol, data collection is critically important – to document how often victims convert from an anonymous report to a standard report, and how long it takes them to reach that decision. Other information that would be helpful for monitoring policy implementation would include: any problems with evidence collection, documentation, transfer, storage, and retrieval; the extent and quality of the law enforcement investigation for reports that convert from anonymous to standard; case dispositions and prosecutorial outcomes for converted reports; and levels of victim satisfaction with the process and services provided by various responding professionals. For more information on data collection and tools that can be used to assist with this process is available at the website for EVAW International at: http://www.evawintl.org/forensiccompliance.aspx?subpage=3#DC.

Community-Based Victim Advocacy Agencies (VAA): Roles and Responsibilities

Philosophy / Purpose

Some victims of sexual assault first access the community response system by contacting a community-based Victim Advocacy Agency (VAA) – typically a non-profit organization such as a rape crisis center, domestic violence shelter, or dual services agency. Victim advocacy services may also be provided by a more general community organization such as a YWCA.

Victims contact the VAA at various points in their recovery process, ranging from the immediate crisis following the sexual assault to years afterward. At each point, the role of a VAA advocate is to provide the victim with information and empowerment to make their own decisions, and to support and assist them in enacting those decisions. One of the key decisions that victims face is whether or not to report the crime to law enforcement. When they contact a VAA for services, victims vary widely with respect to their initial preferences regarding reporting to law enforcement. Some victims fully intend to report to law enforcement and actively participate in the process of an investigation and criminal prosecution. Some victims are absolutely unwilling to talk with law enforcement personnel. However, most victims range between these two extremes and express a range of questions and concerns about reporting to law enforcement.

VAA advocates can provide a range of services for victims, to support a community protocol for anonymous reporting. These services primarily focus on providing the victim with information, supporting their process of decision-making, and assisting them in enacting their choices. This can include accompanying victims to the medical forensic examination, law enforcement interviews, or other contacts with professionals involved in the community response system.

Procedures for medical forensic examinations

For victims who indicate that they were sexually assaulted within a specified time period, VAA advocates will explain the procedures for obtaining a medical forensic examination. They will also describe the process for standard reporting and anonymous reporting to law enforcement when a medical forensic examination will be conducted. This could include either direct anonymous reporting or third party anonymous reporting. For both types of anonymous reporting, written information about their options will be provided whenever possible.

Because law enforcement agencies are no longer required to authorize medical forensic examinations, some VAA advocates have a new responsibility to notify the SAFE program or other health care facility when a victim wishes to have an exam conducted without first talking with law enforcement. The VAA will need to specify these procedures in their protocol.

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Best Practice: Develop Protocol to Evaluate Exam Timelines a Case-by-Case Basis

Many community protocols specify a certain timeline for how many hours after a sexual assault incident a medical forensic examination will be conducted. The timeline is commonly in the range of 72, 96, or 120 hours. While the longest of these (120 hours) can be used as a general guideline, best practice is for each sexual assault to be evaluated on a case by case basis. The question of whether or not to conduct an exam should be based on the facts of the case, the victim's history, the likelihood of recovering evidence, and the types of evidence that will be needed for successful prosecution. This issue is discussed in detail in a Promising Practices article from the e-newsletter for Sexual Assault Training & Investigations (SATI), Inc. The e-newsletter was dated May 19th, 2005, and it is available at: http://www.mysati.com/enews/May2005/practices_0505.htm. The article was also published in *Sexual Assault Report*, Volume 10, Number 3, January/February 2007, p 33-47.

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Victims must also receive clear and detailed information about how the costs of a medical forensic examination will be paid. In some communities, the victim will never see a bill or pay any costs associated with the exam. This is clearly best practice, by encouraging victim access.

Other communities require the victim to pay for the exam and be reimbursed later. Still others submit a bill to the victim's private insurance. According to the Office on Violence Against Women (OVW), U.S. Department of Justice, both of these procedures can be compliant with the Violence Against Women Act (which was most recently reauthorized in 2005), as long as a number of conditions are met. First, victims must be fully reimbursed for any out-of-pocket costs for the medical forensic examination, regardless of their decision regarding whether or not to participate in the criminal justice process. Second, victims or their private insurance can not be billed by any state or territory that uses STOP Grant funding to pay for forensic exams. This type of procedure can only be used by states or territories using other funds to cover these costs.

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- examination of physical trauma
- determination of penetration or force
- patient interview; and
- collection and evaluation of evidence [28 C.F.R. § 90.2(b) (1)]

Thus the forensic components of the exam must be covered for states or territories to be deemed compliant with the 2005 Violence Against Women Act. Yet the legislation gives discretion to states regarding whether or not to pay for medical aspects of the exam (i.e., medical testing and treatment). The practice therefore varies both as a result of state laws and specific practices within communities. As a result, victims of sexual assault may find that all, none, or some of the costs for medical testing and treatment procedures are covered. Clearly, victims must be provided with information that is accurate and current.

Accessing medical care without a forensic exam

Victims will also be provided with information about how to access medical care and treatment without participating in a forensic examination. This information will be provided in a manner that is consistent with established practices for VAA advocates; it has long been part of their role to explain victim rights to health care and medical mandated reporting requirements in the state.

Information about the standard reporting process

VAA advocates will also provide victims with information about their reporting options, and help them weigh the advantages and disadvantages of various alternatives. The advocate will begin by explaining to victims the standard process of reporting to law enforcement. This will include a discussion of the benefits of prompt reporting and a summary of the victim's rights during the process. If victims are comfortable with this process, then previously established procedures for standard reporting to law enforcement will be followed.

Information about anonymous reporting

If victims express that they are unsure, unable, or unwilling to participate in the standard reporting process to law enforcement, the advocate will discuss anonymous reporting. This information should address the following issues:

- Advantages of prompt reporting to law enforcement
- Basic procedures for standard reporting and anonymous reporting
- Direct anonymous reporting versus third party anonymous reporting
- Types of evidence stored with an anonymous versus a standard report
- Where the evidence will be stored for each type of report
- Whether evidence is truly stored anonymously, or if it includes the victim's name and specific protections for the confidentiality of that information
- How long the evidence will be stored for each type of report, and whether victims will be notified as the deadline for evidence destruction approaches
- How long anonymous reports will be retained by law enforcement agencies
- How to change an anonymous report to a standard report
- How to have clothing returned (if possible)
- How and when victims will be contacted for follow-up
- Payment issues for medical and/or forensic components of the exam
- Crime Victim Compensation eligibility and procedures, particularly if anonymous reporting excludes the victim from eligibility for future financial reimbursement
- Where to call with questions

Communities offering anonymous reporting must develop an informational form for victims to describe their various options, and help them to weigh the advantages and disadvantages of each.

Informed consent: Follow-up preferences

An informational form can be used to describe the options for follow-up, and document whether victims want to be contacted for various purposes and/or at different times. Victims can also record on the form their preferred method(s) of being reached (e.g., phone number, email).

Follow-up responsibilities

When victims have a medical forensic examination, there are a number of possibilities for assigning follow-up responsibilities. The specific arrangement in a community will depend on a number of factors, including the number, type, size, and structures of agencies providing services. In general, however, any protocol for anonymous reporting must include careful attention to the question of whether, when, and how victims will receive follow-up contact.

Best Practice Recommendation: Assign Follow-Up Responsibilities

To achieve the goal of increasing access to the criminal justice system for victims of sexual assault, it is critically important that they receive the support they need to make that decision and follow through with their participation in the process. For victims who are initially unwilling, unable, or unsure about reporting to police, it may be unlikely that they would decide to participate in a police investigation without receiving any follow-up contact.

In many communities, an advocate from a Victim Advocacy Agency (VAA) is called out to the SAFE program or other health care facility when a medical forensic examination is conducted. This is clearly best practice, to provide victims with the information and support they need. When this is the case, a community protocol might assign the VAA primary responsibility for follow-up contact with victims. For example, the community protocol might specify that an advocate will try to reach the victim within 72-96 hours of the examination. Of course all follow-up contact requires documented consent of the victim, as discussed in a previous section. In their follow-up, VAA advocates have the opportunity to contact victims to check on their well being, offer services, and provide referrals for other community agencies.

If no VAA advocate provides services to the victim at the time of the medical forensic exam, the SAFE or other health care provider will likely have the primary responsibility for follow-up contact.

For victims who report anonymously to law enforcement, follow-up contact can also be used to provide them with a tracking number obtained from the law enforcement agency. This offers an opportunity for the VAA advocate, SAFE, or other health care provider to answer questions and address any concerns the victim has regarding the decision to report to law enforcement.

Finally, victims may be given the option of whether they want to be contacted if further information becomes available about their assault or perpetrator (e.g., another victim names the same suspect, or describes the same M.O. in a future disclosure of sexual assault). This contact could be made either by the advocate or by the SAFE or other health care provider.

Tracking information about suspects

In some communities, the SAFE program or other health care facility offering medical forensic examinations can track the names of any named suspects in a database. In other communities this function might be performed by advocates from a Victim Advocacy Agency. If the same suspect is named by more than one victim, the informed consent forms signed by all victims who have named that suspect can then be reviewed. For any victims who have consented to be contacted in this particular situation, the VAA advocate, SAFE, or health care provider will call victims to ask whether they want to talk with law enforcement at this time, considering the new information available. When victims consent, the VAA advocate, SAFE, or other health care provider will assist them in arranging contact with law enforcement.

Best Practice Recommendation: Track Information about Suspects

A primary purpose of anonymous reporting is to provide information to law enforcement about sexual assaults being perpetrated in the community that they would not otherwise know about. Therefore, best practice is to implement a system for tracking information on suspects who are named by more than one victim. Yet any community seeking to develop such a protocol will face a limited range of options for which professionals can perform this function. While other options are possible, the two primary candidates for fulfilling this role are the Victim Advocacy Agency (VAA) or the SAFE program or other health care facility offering medical forensic examinations. We argue that the latter option is generally better, although this might vary by community.

Clearly, there are some legitimate concerns with a protocol that has a SAFE program or other health care facility tracking information on suspects. Because this role is investigative, it blurs the professional boundaries to some extent for health care professionals. This issue may therefore be raised in cross-examination by defense attorneys at any future sexual assault trials in which the SAFE or other health care provider testifies. The protocol also raises some questions regarding logistics, including how records will be stored, reviewed, and kept confidential. Ethical and practical questions must be addressed when devising a system for contacting victims.

The other primary option is a Victim Advocacy Agency (VAA), and there are different concerns stemming from this choice. To protect their confidentiality of communications with victims, as well as their written records, advocates in many states need to clearly demarcate their role from any investigative function. Tracking suspects may therefore create a more significant problem for blurring their professional role as compared with the SAFE or other health care provider who conducted the medical forensic examination.

Best Practice Recommendation: Collect Data on Anonymous Reports

After implementing a protocol, data collection is critically important – to document how often victims convert from an anonymous report to a standard report, and how long it takes them to reach that decision. Other information that would be helpful for monitoring policy implementation would include: any problems with evidence collection, documentation, transfer, storage, and retrieval; the extent and quality of the law enforcement investigation for reports that convert from anonymous to standard; case dispositions and prosecutorial outcomes for converted reports; and levels of victim satisfaction with the process and services provided by various responding professionals. For more information on data collection and tools that can be used to assist with this process is available at the website for EVAW International at: http://www.evawintl.org/forensiccompliance.aspx?subpage=3#DC.

System-Based Victim Advocacy Agencies: Roles and Responsibilities

System-based advocates are employed by a public agency such as a law enforcement agency, office of the prosecuting attorney, or another entity within city, county, state, or federal government. Their roles and responsibilities will differ based on their host or governing agency, as will the specific term they use to describe themselves. For example, these professionals may describe themselves as victim advocates, Victim-Witness Assistance Coordinators, or other similar terms. Although their roles and specific responsibilities will vary, a primary goal of system-based advocates is to support victims in their role as a witness to a crime participating in the law enforcement investigation and criminal prosecution.

Victims typically come into contact with system-based advocates after they have reported their sexual assault to law enforcement. This is true because most system-based advocates work for the local police department or prosecutor's office. In some communities, this contact between victims and system-based advocates takes place after the initial response by law enforcement. For example, after completing the preliminary investigation, a responding officer may either refer the victim to the system-based advocate by providing contact information for the agency -- or provide the victim's case file to the system-based advocate who will then contact the victim.

However, some communities offer system-based advocacy services as part of their initial response. To illustrate, a system-based advocate might respond to the crime scene or other field situation with law enforcement, as part of a multidisciplinary response team. In almost all situations, victims will not meet a system-based advocate until after they have talked with law enforcement.

The only situation where it is likely that victims could meet with a system-based advocate before talking with law enforcement would be in the context of a forensic medical exam. Typically, any advocacy services offered to victims at an exam facility will be provided by community-based advocates. These are advocates who work for a community-based non-profit organization such as a rape crisis center, YWCA, or dual services agency for domestic violence and sexual assault. However, communities that do not have a community-based victim advocacy agency might consider developing a protocol where system-based advocates can respond to the forensic exam facility to meet with victims who do not wish to talk to law enforcement at the time of the exam.

Offering the option of anonymous reporting

Regardless of when they come into contact with a system-based advocate, some victims of sexual assault are extremely reluctant to participate in the standard reporting process. Many victims consider withdrawing their cooperation from the process. When victims express such a concern, system-based advocates can offer them the opportunity to report their sexual assault anonymously to law enforcement, either by providing information directly to an officer (direct anonymous reporting) or through a third party (such as a forensic examiner).

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For system-based advocacy agencies, decisions must be made regarding whether or how to offer services for victims who choose an anonymous reporting procedure (either direct or third party). These decisions will be determined in large part by the fact that system-based advocates do not have legally protected confidentiality in their communications with victims.

Lack of confidentiality in communications

While the level of privilege varies for community-based advocates in different states, system-based advocates typically never qualify for counseling privilege. In other words, nothing that a victim says to a system-based advocate will typically be protected as confidential. If a system-based advocate is called to testify, this information will need to be shared – with the prosecution and then the defense. The same is true for anything the system-based advocate observes or learns about the victim or case, not just what the victim says in their private communications.

This is because system-based advocates are employees of the government when they work for a law enforcement agency, prosecutor's office, or other governmental unit. As a result, anything that is considered their work product is discoverable. This means that system-based advocates cannot provide services to victims and protect their confidentiality if their identity is known.

Anonymous contact with victims

As previously described, some communities might develop a protocol where system-based advocates could meet with victims before they talk with law enforcement. This is only likely to be possible for victims who have a medical forensic examination but wish to remain anonymous and not talk with law enforcement (yet). It is also more likely to be seen in communities that do not have a community-based victim advocacy agency. In this situation, system-based advocates could potentially meet with the victim and provide a limited amount of services anonymously.

This anonymous contact would only allow system-based advocates to provide a limited amount of services. It would most likely involve: meeting with the victim to discuss immediate concerns, describing services that are available in the community, offering referrals, providing written information, and making sure victims have contact information for the law enforcement agency in case they later decide to participate in a standard reporting process.

System-based advocates could also talk with victims who choose to provide information about their sexual assault anonymously to law enforcement (i.e., make a direct anonymous report). This anonymous contact could take place either at an exam facility or any other location where the victim talks with law enforcement for the purpose of making a direct anonymous report.

It is worth noting, however, that this type of protocol for anonymous contact might be impossible to implement in a small community or any situation where the system-based advocate actually knows who the victim is. It could also jeopardize the victim's confidentiality, because any system-based advocate who personally knows the victim could not ethically deny it -- and could not refuse to provide this information if asked by law enforcement or the prosecuting attorney.

Agreements to respect victim confidentiality

The more common scenario for system-based advocates may not involve victim anonymity, but rather documented agreements among community professionals to respect victim confidentiality whenever possible. This type of agreement would pertain to any context where system-based advocates meet with victims, whether it is in an office, at the forensic exam facility, or in any field situation where law enforcement has responded to a victim's report of sexual assault.

- For example, system-based advocates working within a police department might be able to provide a limited amount of services to victims, without initiating an active investigation.

- Similarly, system-based advocates working within a prosecutor's office might be able to provide some assistance to victims even if they have not (yet) agreed to participate in the prosecution of their sexual assault.

Community protocols can include a statement that the confidentiality of victims receiving services from a system-based advocate will generally be respected. However, this would not constitute a legal protection of confidentiality – only a good faith agreement.

Proactive follow-up by system-based advocates

With a standard report to law enforcement, system-based advocates often reach out proactively to victims of sexual assault in order to offer their services. They may be provided with the victim's file when the sexual assault is reported to law enforcement or referred to the prosecutor's office. System-based advocates often use this information to determine the victim's eligibility for services and other resources, including Crime Victim Compensation.

System-based advocates can therefore contact victims proactively to describe their services and offer assistance – sometimes even attempting more than once to contact them. Obviously, this type of follow-up contact cannot be made for victims who remain anonymous. However, system-based advocates can contact victims with the type of protocol described above that includes a good faith agreement to protect the confidentiality of victims who do not (yet) wish to actively participate in the process of an investigation or prosecution of their case. The victim would of course need to consent to have a system-based advocate contact them; this would be established by the professional who had initial contact with the victim (typically a police officer).

Follow-up contact by other professionals

For anonymous reports (whether made directly by the victim or by a third party), follow-up contact will typically be assigned either to a community-based victim advocacy agency and/or the SAFE or other health care provider who conducted the medical forensic examination.

Prosecuting Attorney's Office: Roles and Responsibilities

The Prosecuting Attorney's Office has the responsibility for reviewing cases investigated by law enforcement agencies in their jurisdiction, determining which charges to file (if any), and pursuing the prosecution of charges that are filed. This often includes conducting additional investigation to collect and document evidence.

Because the Prosecuting Attorney's Office is not typically involved in the first response to sexual assault cases, many of the procedures outlined here will not change the day-to-day operations of the agency. However, this MOU documents a good faith agreement by the Prosecuting Attorney's Office that any anonymous reports of sexual assault that later convert to a standard report will be treated without prejudice.

Other Agencies to Include in Anonymous Reporting Protocol

Participating Law Enforcement Agencies

- City Police Department(s)
- County Sheriff's Office
- Campus Police Department(s)
- Tribal Police Agency/ies
- Military Police Agency/ies
- Communications Personnel (911 Call Takers, Dispatchers)
- Prosecuting Attorney's Office
- Crime Laboratory

Carefully consider whether any other law enforcement agencies should be included

Additional Participating Agencies:

- Community-Based Victim Advocacy Agency/ies
- System-Based Victim Advocacy Agency/ies
- Sexual Assault Forensic Examiner (SAFE) Program(s)
- Hospital(s) / Other Health Care Facility/ies

Carefully consider whether any other participating agencies should be included