



Forensic Science Regulator Guidance

**Guidance for the Assessment, Collection and
Recording of Forensic Science Related Evidence in
Sexual Assault Examinations**

FSR-G-212

Issue 1

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1. Introduction

- 1.1.1 This guidance should be used alongside Sexual Assault Examination: Requirements for the Assessment, Collection and Recording of Forensic Science Related Evidence FSR-C-116, which sets out the requirement for [accreditation](#) to the international standard ISO 15189 Medical laboratories – Requirements for quality and competence for the [forensic medical examination](#)¹ services relating to alleged sexual assault.
- 1.1.2 The remit of the Forensic Science Regulator covers obtaining samples for scientific analysis in criminal investigations and does not cover medical practices; any reference to medical practice is included for context, as forensic sampling and the medical care of [patients](#)² overlap.
- 1.1.3 Throughout this guidance, reference is made to sexual offences and sexual assaults rather than alleged offences and alleged assaults. This is because some patients have not themselves made allegations.

2. Background

- 2.1.1 Sexual offences are devastating crimes; the impact of sexual violence is now well evidenced and can include significant consequences to the long-term health and well-being of patients. In the aftermath of an assault all patients, regardless of age or gender, should have access to a timely, high-quality [forensic medical examination](#):
- a. to address their concerns;
 - b. minimise trauma; and
 - c. aid and support their recovery.
- 2.1.2 At the same time the collection of [evidence](#) can provide patients with the option to assist in any criminal investigation. The evidence collected in the form of information and [items](#) may aid a criminal prosecution, prevent further sexual violence or assist with the exoneration of the innocent.

¹ Activity includes recording, collecting samples for scientific analysis and documenting injuries.

² In the context of this document, a patient is an individual subjected to or suspected of being subjected to sexual assault.

2.1.3 The provision of dedicated services for the health and well-being of patients and delivery of justice has considerable benefits. Such services provide patients with the opportunity for high-quality care alongside forensic medical examination³ and the possible collection of samples/evidence. This provides both the police and the patient with the best possible opportunity to recover evidence for use within an investigation, if the patient so chooses, and minimises the risk of a miscarriage of justice:

- a. the risk of wrongful conviction(s);
- b. wrongful acquittal(s); or
- c. obstructing or delaying investigation(s).

2.1.4 Whilst the need to provide high-quality medical care is of primary importance, it is essential that due consideration is given to the demands of the forensic context to achieve high-quality samples for scientific analysis. Defined [standards](#) are necessary for all stages of the patient's 'journey' immediately before and during the forensic medical examination. These ensure that there is confidence in the relevance of any medical [findings](#) documented during the examination, and in any subsequent scientific results from the samples taken during the examination. The patient's care pathway varies, based on the individual case and local variation of service delivery. However, this should not detract from achieving the best health and justice outcomes for the patient.

2.1.5 The implementation of standards and guidance as part of an process is assessed by a third party, the United Kingdom Accreditation Service (UKAS). UKAS is the national accreditation body that provides external scrutiny and assurance that the appropriate standard is being met in the UK.

2.1.6 Safeguarding issues, safety plans specifically relating to [children](#), and social issues are very important, and reference is made to the medical and therapeutic needs of the individual. However, these fall outside the Forensic Science Regulator's remit and are therefore not part of this guidance; this guidance covers the following areas related to forensic science practice:

³ The medical and therapeutic needs may override the requirement to collect forensic science related evidence.

- a. training and ongoing competence of personnel;
- b. accommodation and environmental conditions;
- c. equipment used for the examination;
- d. examination process and methods;
- e. handling, storage and transport of forensic samples;
- f. the notes, [reports](#) and [statements](#) generated;
- g. quality management; and
- h. continuous improvement, review and audit.

2.1.7 This document provides good practice for the forensic medical examination of patients who may have been subjected to sexual assault. These encompass:

- a. the gathering of information;
- b. retrieval of personal samples and other trace evidence from an individual for forensic purposes;
- c. the collection of clothing from the individual; and
- d. recording the presence or absence of injuries.

3. Scope

3.1.1 This guidance applies to cases submitted to criminal courts in England and Wales. Scotland and Northern Ireland may also institute parallel arrangements for their jurisdictions.

3.1.2 The purpose of this guidance is to support meeting the standard ISO 15189:2012 Medical laboratories – Requirements for quality and competence and the requirements set out by the Forensic Science Regulator in the Codes⁴ and in Sexual Assault Examination: Requirements for the Assessment, Collection and Recording of Forensic Science Related Evidence FSR-C-116⁵.

3.1.3 This guidance covers the facility where a forensic medical examination and the collection of evidence from a patient takes place. The most frequently used type of facilities in England and Wales are known as sexual assault referral centres (SARCs). Other facilities also exist within police premises, such as patient

⁴ Forensic Science Regulator, Codes of Practice and Conduct for Forensic Science Providers and Practitioners in the Criminal Justice System.

⁵ Forensic Science Regulator, Sexual Assault Examination: Requirements for the Assessment, Collection and Recording of Forensic Science Related Evidence FSR-C-116.

examination suites or sympathy suites, and within National Health Service premises. For the purpose of the Forensic Science Regulator’s Sexual Assault Examination: Requirements for the Assessment, Collection and Recording of Forensic Science Related Evidence FSR-C-116 and this guidance, these facilities wherever they are located are referred to collectively as a ‘medical examination and sample collection facility’ (the [facility](#)) and are recognised as a [forensic unit](#) for the purposes of relevant forensic science standards and guidance.

- 3.1.4 This guidance encompasses parts of the pathway from the first disclosure or first suspicion, to the completion of the forensic medical examination and directly related activities within the facility. Other services provided to the patient, such as counselling, practical and emotional support, are outside the scope of this guidance. The use of [early evidence kits](#) (EEKs) is included, as these may be used at the facility, if not prior to the patient’s arrival at the facility.
- 3.1.5 Figure 1 (for adults) and Figure 2 (for children), set out in the Forensic Science Regulator’s Sexual Assault Examination: Requirements for the Assessment, Collection and Recording of Forensic Science Related Evidence FSR-C-116, outline where the facility’s practices and procedures occur within the patient’s ‘journey’ from the incident to court.⁶ These figures also identify where the various standards and guidance apply.
- 3.1.6 It is important to note that the facility may require the input of multiple service providers working together to deliver the service for the patient. Due to the historical commissioning and funding arrangements that have evolved in England and Wales, a range of service providers may come together to deliver different elements of the service provision. The forensic medical provider will, in many services, be different to the provider of [crisis workers](#), other professionals and core administrative staff.
- 3.1.7 This guidance applies to all personnel involved in performing and supporting the medical examination and managing the facility, including services provided by

⁶ These diagrams are not care pathways nor are they intended to be used as referral routes.

different or multiple providers regardless of the commissioning arrangements or funding structure.

3.1.8 Areas such as medical evaluation and treatment, suicide risk and mental health assessments, medical case reviews and post-forensic examination treatment/follow-up are outside the scope of this guidance. These come under the responsibility of clinical governance.

3.1.9 For the purposes of this guidance it is assumed that all relevant training, processes and reporting to meet the requisite legal, medical and safeguarding requirements are already in place.

4. Implementation

4.1.1 The requirements set out in this guidance and the Forensic Science Regulator's Sexual Assault Examination: Requirements for the Assessment, Collection and Recording of Forensic Science Related Evidence FSR-C-116 shall be incorporated into the policies, processes and procedures within the facility.

4.1.2 This document is available for incorporation into an organisation's standard operating procedures and [quality management system](#) (QMS) from the date of publication.

5. Modification

5.1.1 This is the first issue of this document.

6. Terms and Definitions

6.1.1 The terms and definitions set out in the Forensic Science Regulator's Codes of Practice and Conduct (the Codes), DNA Anti-Contamination – Forensic Medical Examination in Sexual Assault Referral Centres and Custodial Facilities FSR-G-207, Sexual Assault Examination: Requirements for the Assessment, Collection and Recording of Forensic Science Related Evidence FSR-C-116 and the glossary section apply to this document. Those in ILAC G19:08/2014⁷ apply where there is no corresponding definition set out in the Forensic Science Regulator's guidance and the Codes.

⁷ ILAC G19:08/2014 Modules in a Forensic Science Process.

6.1.2 The word 'shall' has been used in this document where there is a corresponding requirement in ISO 15189:2012, the Codes and FSR-C-116; the word 'should'⁸ has been used to indicate generally accepted practice where the reason for not complying, or any deviation, shall be recorded. The word 'may' has been used for recommendations. Recommendations have been used to indicate what ideal practice is when it is practicable.

7. Management Requirements

7.1 General (ISO 15189 4.1)

7.1.1 A nominated senior manager from the service provider with responsibility for the facility shall be identified, to support the delivery of good practice and the quality standards stated.

7.1.2 This guidance defines requirements for quality and competence that fall into two main categories:

- a. technical requirements, which are covered in section 8 of this document; and
- b. management requirements, which are covered in this section.

7.2 Organisation and Management Responsibility (ISO 15189 4.1)

7.2.1 The organisation and management responsibility of the facility shall be defined and documented.

7.2.2 The management responsible for the facility shall produce an organisation chart that makes clear the lines of responsibility, clinical governance structures and legal responsibilities that cover all aspects of the services, including all personnel working therein.

7.2.3 The role and responsibilities for all personnel working within the facility shall be defined and documented to manage resources, training, [competency](#) and service provision.

⁸ In good medical practice 'should' is used when providing an explanation of how to meet the overriding duty and where the duty or principle will not apply in all situations or circumstances, or where there are factors outside the practitioner's control that affect whether or how guidance can be followed (General Medical Council, 2013).

7.2.4 The facility shall be managed by a person or persons with the competence, authority and responsibility for all aspects of the services provided.

7.3 Quality Management System (ISO 15189 4.2)

7.3.1 A quality management system (QMS) shall be established and maintained that directs and controls the quality of services at the facility by all providers . The legal entity that takes overall responsibility and accountability for quality at the facility shall be defined.

7.3.2 A quality manager shall be appointed to ensure that the QMS functions correctly. The QMS shall include the elements outlined in 7.4 to 7.6 below.

7.4 Quality Manual (ISO 15189 4.2.2.2, 4.1.2.3)

7.4.1 The quality manual shall include the following elements.

- a. A quality policy signed by the senior management of the legal entity for the facility. This shall include:
 - i. a commitment to good professional practice;
 - ii. the provision of quality examination; and
 - iii. compliance by all staff with the standards and good practice to which the facility operates.
- b. A statement of the facility's service standards and a description of the objectives of the quality system.
- c. Quality objectives and plans.
- d. A description of the organisation, structure, responsibilities and authorities.
- e. A description of the elements of the quality system and any references to documented quality system procedures including:
 - i. control of documents;
 - ii. control of records; and
 - iii. control of collected samples and material.

7.5 Procedures, Instructions and Forms (ISO 15189 4.2, 5.5.3)

7.5.1 The procedures, instructions and relevant forms sit below the quality manual in the hierarchy of required documentation and shall include the following.

- a. Policies that document the intentions and direction of the facility, as formally expressed by its senior management.
- b. Procedures (often called standard operating procedures or SOPs) that outline the practical way to translate the policies into action.
- c. Day-to-day work instructions that are needed in the work area for easy reference, for example, step-by-step guidance on how to use a particular instrument, or decontaminate a work surface.
- d. Forms, that is, documents on which records are made that provide evidence that a procedure and/or related instructions have been carried out.

A Document Control System (ISO 15189 4.3)

7.5.2 A document control system may be an electronic or paper-based system and requires that:

- a. documents are authorised for adequacy prior to issue;
- b. documents are reviewed and updated as required, and re-authorised with the changes highlighted;
- c. relevant versions of documents are available at the point of use; and
- d. unintended use of obsolete documents is prevented.

Continual Improvement Process (ISO 15189 4.12)

7.5.3 Opportunities to improve the effectiveness of the management of quality in the facility arise in a number of ways. They fall into three major categories of documented procedures that identify the sources for corrective, preventative and improvement actions.

- a. These may include evaluation and audits, trials and customer feedback, [peer review](#) and checking of outputs, self-assessment and suggestions from staff.
- b. Regardless of source, all shall be logged into an improvement, corrective, preventative process for subsequent assessment and action. All actions are classified and prioritised on the basis of a risk assessment.
- c. Those taken forward are allocated to an appropriate owner to be resolved by an agreed target date.

- d. These are included as part of the management review.

Evaluation And Audits (ISO 15189 4.14)

7.5.4 The facility shall have an ongoing rolling audit programme for the coming year and beyond. This shall include across the audit programme cycle:

- a. each area of work;
- b. all stages of the examination; and
- c. an assessment of staff competency in both practical work and in report writing.

7.5.5 Audits typically fall into two categories: internal (or in-house) and external.

- a. Internal audits are carried out by the facility itself, focusing on some aspect of activity, for example, that staff are up to date with their training and competency records.
- b. External independent assessment by auditors from other facilities or by the United Kingdom Accreditation Service (UKAS) are carried out if, for example, the facility is seeking accreditation or is accredited to ISO 15189.⁹
- c. Audits provide an important mechanism for detecting and investigating quality issues or 'non-conformities' and provide a major input into the management review.

7.6 Management Review (ISO 15189 4.15)

7.6.1 Regular management reviews shall be conducted by the facility management team to ensure that performance of the unit and the procedures followed are, and continue to be, effective from a quality perspective. This should be discussed and highlighted as part of the induction of any new staff members.

7.6.2 As a minimum the management review shall be conducted annually. However, initially these shall be undertaken more frequently as the review process beds in

⁹ Current published standard is ISO 15189:2012 Medical laboratories – Requirements for quality and competence.

and the frequency becomes appropriate to the maturity of the quality management system. Inputs to the review shall include the following.

- a. Significant changes in organisation and management, staff (including the induction of new staff members) and other resources or processes.
- b. Post-implementation review of changes to procedures and practice.
- c. Assessments and audits of quality. These may include reports of assessments of outside bodies, internal audits of the quality management system and of the examination procedures.
- d. New quality incidents (i.e. occasions where a mistake has occurred, or quality procedures have not been adhered to).
- e. A review of the status of preventative, corrective and improvement actions.
- f. Patient survey, complaints or feedback.

7.6.3 A report of the management review shall be generated that includes the following.

- a. A summary of the successes and failures since the last review.
- b. Decisions made and actions taken with regard to:
 - i. the needs of users;
 - ii. resource management (personnel, accommodation, equipment, [consumables](#));
 - iii. quality management, including audits and assessments;
 - iv. health and safety;
 - v. education and training; and
 - vi. financial requirements.
- c. Future quality objectives and priorities.

7.6.4 This report should be readily available (in electronic or paper form) and be shared with staff within the facility.

8. Technical Requirements

8.1 Personnel: Training and Competence (ISO 15189 4.4, 5.1; ILAC G19 3.3)

8.1.1 All personnel working within the facility, including any non-facility staff shall have undergone:

- a. training and assessment of competency; and
- b. ongoing competency in the theoretical and practical aspects of forensic science according to the role(s) within which they are working.

8.1.2 The [forensic healthcare practitioner](#) and their organisation shall ensure that the practitioner accesses and undertakes continuing professional development to maintain ongoing competency,¹⁰ and that records are kept to evidence this.

8.1.3 The guidance and requirements refer to all personnel working and/or providing services (ISO 15189 4.4) within the facility. Information and guidance for practitioner-related roles, including others is provided in Annex A of this guidance.

8.2 Accommodation and Environmental Conditions (ISO 15189 5.2; ILAC G19 3.11)

General

8.2.1 Accommodation at the facility shall be age appropriate, accessible to the community it serves and with adequate security for the service users and staff. For example, consideration should be given to the style of decor and availability of toys where the facility is being accessed by child patients.

8.2.2 The Department of Health and Social Care has published Building Notes¹¹ that provide best practice guidance on the design and planning of new healthcare buildings and on the adaptation or extension of existing facilities, for example:

- a. outpatient department;¹²
- b. sexual and reproductive health clinics;¹³
- c. sanitary bathroom;¹⁴

¹⁰ Example guidance is provided in Faculty of Forensic and Legal Medicine (2017a).

¹¹ Department of Health Building Notes (HBN) series.

¹² Department of Health Building Note 12: Designing an out-patients department.

¹³ Department of Health Building Note 12-01: Consulting, examination and treatment facilities. Supplement A: Sexual and reproductive health clinics.

¹⁴ Department of Health Building Note 00-02: Designing sanitary spaces like bathrooms.

- d. sterile environments;¹⁵ and
- e. hospital accommodation for children.¹⁶

8.2.3 It is expected that generic requirements such as lighting and sound/acoustics are already provided in the relevant Building Notes. The following requirements are specific to those facilities that conduct forensic medical examinations.

Layout

8.2.4 There should be an entrance for access to the facility by the patient and their companions that is separate and not open to public traffic.

8.2.5 The design of the facility shall include measures to prevent cross-transfer and environmental contamination. This is to take account of the increasing sensitivity of methods used within forensic science and the high volume of throughput for such a facility.

8.2.6 The layout of the rooms and corridors should enable the workflow to progress through the sexual assault referral centre (SARC) in one direction, to minimise cross contamination and control designated DNA clean rooms or areas.

8.2.7 The forensic area of the facility shall include the following.

- a. A pre-examination waiting room that is a separate waiting area for patients who may undergo a forensic medical examination. This area cannot be classed as DNA clean if it is used by patients and their supporters who may be conversing and interacting whilst not wearing [personal protective equipment](#) (PPE). It can be designated as a [DNA clean area](#), if its use is controlled such that those entering (other than the patient) are wearing PPE and actions to mitigate against [DNA contamination](#) are undertaken.
- b. A dedicated forensic medical examination room that shall be a designated DNA clean area – this is where the forensic medical examination will take place, the patient's clothing shall be removed (if not previously collected) and forensic samples are collected. The room shall have access to the bathroom/toilet facility, if linked to the medical examination room, the

¹⁵ Department of Health Building Note 13: Sterile services department.

¹⁶ Department of Health Building Note 23: Hospital accommodation for children and young people.

bathroom is also considered to be a DNA clean area for cleaning and [environmental monitoring](#) (EM) purposes.

- c. A dedicated bathroom/toilet facility which shall have access from the medical examination room and corridor, where early evidence collection can be conducted and/or the patient can shower post-examination.
- d. A dedicated area for staff and visitors to change into or put on barrier/ personal protective clothing that is away from the DNA clean examination area.

Structure

8.2.8 The forensic medical examination room shall have adequate space to minimise the risk of cross-contamination¹⁷ between the patient's outer clothing and the forensic medical examination area and equipment.

8.2.9 The size of the forensic medical examination room should be adequate to house:

- a. the examination couch;
- b. storage units;
- c. equipment including photographic equipment;
- d. the screen/curtain; and
- e. the maximum number of individuals who could be in attendance with the patient (crisis worker, paediatrician, forensic medical clinician, interpreter, companion).

8.2.10 The layout of the forensic medical examination room should effectively shield the patient from the non-medical practitioners during the examination and sample recovery stage to avoid cross-contamination from these individuals.

8.2.11 Ceilings should be hard plasterboard or laminated tiles of smooth finish resistant to degradation from frequent cleaning.¹⁸ Fitting should be flush or anti-

¹⁷ Although the focus is DNA contamination other evidence types (such as dried flaking body fluids, hairs, fibres and particulate debris) can also cross-contaminate.

¹⁸ The active agent, corrosive nature and downstream effects from the cleaning materials used need to be understood; surfaces need to be resistant to degradation because of frequent contact with the cleaning reagents.

ligature to allow ease of cleaning. Neither unbagged insulation nor fibrous material should be used above the ceiling.

8.2.12 Walls should be of smooth finish, sealed and resistant to degradation from frequent cleaning.

8.2.13 Floors should be of a readily cleanable durable material, for example, vinyl, and fully sealed.

8.2.14 The edges between the floors, walls and ceilings should utilise coving that provides a smooth curved join rather than a right angle, to facilitate cleaning by avoiding crevices and dust traps.

8.2.15 Window glazing shall be sealed to prevent draughts and ideally the sills slope downwards with an easily cleanable surface. Where blinds are required, ideally these should be on the outside of the window or within a sealed window unit.

Air Quality and Airflow

8.2.16 Airflow within and between designated forensic areas of the facility shall be kept to a level that minimises the risk of trace evidence being transferred from the patient to the environment and from environmental background DNA to the patient. This means that portable fans shall not be used and there shall be no strong air currents notably through vents or windows that may be positioned near the examination couch, sampling and packaging areas.

8.2.17 For the forensic medical examination room, the air in and out should be balanced, if there is a differential in pressure then there should be positive pressure within the examination area, so that air is not sucked in from outside.

8.2.18 The use of any air conditioning/ventilation system shall be designed to minimise the risk of cross contamination using suitable filtration and the control of airflow to minimise draughts. Any air supplied from outside the room shall be filtered to reduce the risk of external contaminants.

8.2.19 A minimum airflow of 20 times whole room replacement per hour should be used. The clean air should enter the room over the examination couch using, for example, a sock diffuser to reduce air wafts with extraction near door/exit.

8.2.20 Where physical building changes or new build has been identified or is necessary then the requirements set out in Sexual Assault Examination: Requirements for the Assessment, Collection and Recording of Forensic Science Related Evidence FSR-C-116, section 7.2.2 applies.

8.3 Forensic Medical Examination Room Furnishings, Equipment, Reagents and Consumables (ISO 15189 5.2, 5.3; ILAC G19 3.12)

8.3.1 The style and finish of fixtures and fittings, such as air-conditioning, ceilings, lighting and working space shall allow for effective repeat cleaning by either being flush or anti-ligature.

8.3.2 The furnishings, equipment, reagents and consumables that are utilised within the facility shall be such that they minimise the risk of DNA contamination. The Faculty of Forensic and Legal Medicine (FFLM) has provided guidance on the equipment for use in forensic medical examination rooms.¹⁹

Environment, Furnishings and Equipment

8.3.3 The work surfaces and chairs should be of smooth finish, sealed, readily cleanable and resistant to degradation from frequent cleaning.²⁰ Workstation drawer units should provide sufficient storage capacity to enable work surfaces to be kept clear, other than equipment in daily use.

8.3.4 The following criteria for furnishings and equipment shall apply.

- a. Workbench surfaces, storage cupboards, seating and examination couches shall be impervious to water, easy to clean and resistant to disinfectants and cleaning reagents.
- b. In areas where a patient undresses and where they are then subsequently forensically examined, floor surfaces shall be impervious and any joins in the floor shall be sealed.
- c. Computer keyboards, colposcopes and equipment controls shall be protected by removable flexible covers that can be cleaned or replaced

¹⁹ Faculty of Forensic and Legal Medicine (2016b).

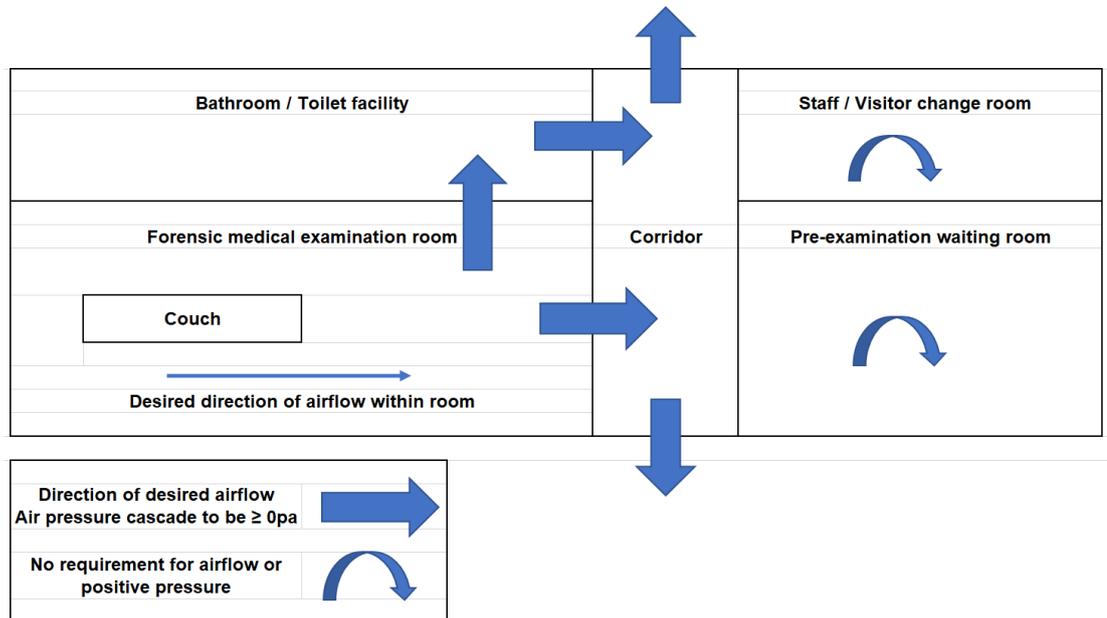
²⁰ The active agent, corrosive nature and downstream effects from the cleaning materials used need to be understood; surfaces need to be resistant to degradation because of the frequent contact with the cleaning reagents.

(for example, keyboard, colposcope arm and head covers). Equipment with flat surfaces and smooth clean lines is preferable (for example, touch screens).

- d. Where a curtain shields the examination couch, the curtain shall be disposable. The frequency of curtain replacement will depend on the number of forensic medical examinations conducted in the room and shall be subject to risk assessment. For example, in a facility where more than 20 patients are forensically examined each month, the curtain should be changed monthly. Where fewer medical examinations are conducted the disposable curtain should be replaced at least every three months. However, if any staining is visible on the curtain or material is thought to have been inadvertently transferred to the curtain, it shall be replaced immediately. A record of the date and reason for changing the curtain shall be kept.
- e. There shall be a designated hand-wash basin within the room where the patient is being examined. The taps shall be capable of being operated without being touched by hand.
- f. The medical examination couch shall have height and position adjustments to allow for ease of movement. The couch should have disposable covering, which is changed between each examination.
- g. Wall clocks, height charts and weighing scales shall have surfaces that can be wiped.
- h. There shall be a labelled storage area for keeping consumables used for the forensic medical examination and packaging of samples.
- i. A colposcope shall be available for all child examinations and for adults as appropriate to record relevant injuries and findings.
- j. There shall be an approved sharps box and clinical and domestic waste receptacles, and appropriate disposal provisions arranged.
- k. There shall be equipment to enable photo documentation for general injuries and/or general observations.

8.3.5 The areas of the facility (the pre-examination waiting area, examination area and the dedicated bathroom/toilet facility) shall always be secure; entry into and exit from the forensic medical examination room shall be controlled and all

personnel accessing the room shall be recorded to include date, time and activity/role.



8.3.6

Figure 1: Simple schematic of relative airflow direction and pressure for the forensic medical examination room

DNA Decontamination

8.3.7 Cleanliness of the forensic examination area of the facility is important to maintain the quality of the forensic medical examination and minimise the risk of contamination. Monitoring cleanliness enables corrective actions to be undertaken where contamination is established. It also provides evidence of due diligence and effective cleaning. See sections 9.4, 9.5, 9.6 and 9.7 in this guidance for further details.

8.3.8 Guidance on cleaning processes can be found in The control and avoidance of contamination in laboratory activities involving DNA evidence recovery and analysis FSR-G-208, section 8.6.²¹ The following practices shall apply to the forensic medical examination room.

- a. Cleaning of the designated DNA clean controlled areas shall be undertaken prior to and/or after each examination.

²¹ Forensic Science Regulator, The control and avoidance of contamination in laboratory activities involving DNA evidence recovery and analysis FSR-G-208.

- b. Deep cleaning should be undertaken at least every month.²²
- c. The room shall be sealed or locked after each clean and the door labelled to identify the status of the room. This does not negate the requirement for monthly deep cleaning if the room is still sealed more than a month from the previous cleaning.
- d. The date of cleaning, (time if appropriate) and by whom shall be recorded in the cleaning logs and retained.

Reagents

- 8.3.9 Cleaning products and spillage kits that have been demonstrated to be effective in removing and denaturing DNA in conjunction with appropriate cleaning procedures shall be used.²³ These chemicals shall always be used in a manner compliant with relevant health and safety requirements.
- 8.3.10 The facility may take advice from [forensic science providers](#) (FSPs) as to which validated cleaning product²⁴ to use, but shall demonstrate that the cleaning product is effective,²⁵ in their hands at their facility.
- 8.3.11 The application of the cleaning product shall be carried out according to the manufacturer's guidelines and in line with standard operating procedures – it is the combination of the cleaning agent and how it is physically used that determines its effectiveness. The effectiveness of the cleaning at removing DNA shall be demonstrated by environmental monitoring (see section 9.7 for more details) undertaken at regular intervals

²² Environmental monitoring results will be required to demonstrate a trend that there is little to no risk for deep cleaning to be conducted more than one month apart.

²³ Further guidance is available in Forensic Science Regulator, The control and avoidance of contamination in crime scene examination involving DNA evidence recovery FSR-G-206; Forensic Science Regulator, DNA Anti-contamination – Forensic Medical Examination in Sexual Assault Referral Centres and Custodial Facilities FSR-G-207; and Forensic Science Regulator, The control and avoidance of contamination in laboratory activities involving DNA evidence recovery and analysis FSR-G-208.

²⁴ Examples of cleaning agents include 10% sodium hypochlorite (bleach, Presept™) solution, 1% Solution Rely+On™ Virkon®, Microsol (10%) and Distel (1%) (Trigene Advance).

²⁵ National Institute of Justice Forensic Technology Center of Excellence (2011).

Consumables Including Personal Protective Equipment/Barrier Clothing

- 8.3.12 Consumables are single-use commodities used in the collection, preservation and processing of material for forensic analysis, and are bought and used up recurrently. These include PPE or barrier clothing, tamper-evident containers, swabs, and packaging that comes into direct contact with the material for forensic analysis. A consumable can also be equipment used in the collection, processing and safe handling of the material, for example, disposable tweezers and scissors.
- 8.3.13 The use of barrier clothing/PPE is detailed in section 9.2; it is required to minimise contamination and shall be single-use. Barrier clothing/PPE include:
- a. disposable outer barrier clothing such as scrubs or an apron with disposable long sleeve covers;
 - b. non-latex unpowdered gloves in a range of sizes;
 - c. face mask;
 - d. mob cap; and
 - e. shoe covers.
- 8.3.14 Consumables that are free from detectable DNA²⁶ or [forensic DNA grade](#)²⁷ shall be used where these exist for sampling. The kit modules shall have a batch/lot and use-by date information recorded on them to ensure shelf life rotation. A record of the batch/lot information and expiry date shall be recorded on the examination records.
- 8.3.15 Exhibit packaging is required to preserve forensic science related evidence. It is an important principle that the packaging standards used for the collection of evidence are the same for patients who self-refer to the facility and those who are referred to the facility by the police. Such packaging includes:
- a. paper exhibit bags of varying sizes;
 - b. plastic tamper-evident bags of varying sizes;
 - c. breathable exhibit bags for wet exhibits;

²⁶ 'Detectable' means by the most sensitive DNA method(s) used in forensic analysis. This information may be available through the Association of Forensic Science Providers (AFSP) body fluid forum (BFF).

²⁷ Produced in compliance with ISO 18385:2016 Minimizing the risk of human DNA contamination in products used to collect, store and analyse biological material for forensic purposes.

- d. white securitainers of varying sizes;
- e. labels;
- f. sealing tape;
- g. vomit collection vessels;
- h. white disposable paper towel rolls; and
- i. dedicated forensic kit modules to ensure comprehensive forensic sample collection.²⁸

8.3.16 The consumables (including barrier clothing) and reagents used shall not be past their expiry date, be stored and handled appropriately to minimise contamination of them prior to and during use.

8.4 Examination Methods and Procedures (ISO 15189 4.4, 5.4.2, 5.5)

General Principles

- 8.4.1 All professionals working at the facility who come into contact with patients shall have the relevant skills, knowledge and competency to work with patients in the aftermath of a sexual assault.
- 8.4.2 Facility staff shall have a clear understanding of the different ways that patients who have been subjected to sexual assault may behave following an assault. A non-judgemental approach shall be adopted in every case.
- 8.4.3 It is well known that some patients will be unable to make an immediate decision about whether they wish to report the assault to the police or be involved in the criminal justice process. It is widely accepted that pressure to report may discourage the future involvement of the patients in any subsequent court proceedings. However, the patient shall be informed that a forensic medical examination could assist them to make the decision to report at a later date and offered the option of the [self-referral](#) route.
- 8.4.4 It is an important principle that acute medical needs take precedence over evidential needs. Therefore, the initial response to acute injury, the need for

²⁸ Faculty of Forensic and Legal Medicine (2018a).

trauma care, and the safety needs of the patient will take priority over the collection of forensic science related evidence.

- 8.4.5 While the time spans of the assault will be an important factor in determining whether a forensic medical examination should take place, each case shall be properly considered, with the needs of the patient being the paramount consideration.
- 8.4.6 It is common for patients who have been subjected to sexual assault to have showered, eaten or taken other self-protective actions that may have destroyed evidence prior to engaging with the facility. Staff shall react in an understanding and non-judgemental manner if this has happened. Staff shall record the actions that have been taken by the patient on the forensic examination paperwork (see section 10.1 in this guidance for more details).
- 8.4.7 Gathering information about the assault can be a difficult process for patients who have been subjected to sexual violence. Not only can discussing the assault cause them to feel re-violated, but also their emotional and physical condition may make communication difficult. They may also be uncomfortable discussing personal matters with involved professionals. Those seeking information about the assault shall seek to create an information-gathering process that is as respectful to the patients as possible and minimises repetition of questions relating to the assault.
- 8.4.8 It is important to note that the forensic medical examination should be a thorough process that can take a considerable length of time to conduct. An open mind shall be kept as to all forensic opportunities, rather than a focus solely on DNA. The speed of the examination process shall always be dictated by the needs of the patient.

Prior to the Patient's Arrival at the Facility – Initial Contact

- 8.4.9 It is important that staff at the facility ensure that patients are always given the correct information and advice regarding a forensic medical examination and the options available to them. Where possible the facility shall seek to work in partnership with other relevant services (such as the police, social workers,

health professionals and other support organisations). The facility shall ensure that such partners have been made aware of:

- a. the services that can be provided at the facility; and
- b. the importance of the recovery of forensic science related evidence if they provide the initial contact/first response to the patients.

8.4.10 Staff at the facility shall be able to provide basic information to the patient about:

- a. options to attend the facility and the opportunity to undertake a forensic medical examination, treatment and advice;
- b. options to report the sexual offence to the police if they so choose;
- c. potential medical concerns of the patient that relate to the sexual assault; and
- d. the importance of body fluids and the recovery of such forensic science related evidence.

8.4.11 In relation to the collection of forensic samples, the facility staff providing the initial contact/first response to the patient shall be able to explain the impact that the following might have on the collection of that evidence:

- a. washing and method undertaken, for example, showering or bathing;
- b. urinating;
- c. defecating;
- d. smoking;
- e. drinking;
- f. eating;
- g. brushing hair or teeth;
- h. vomiting;
- i. rinsing mouth; and
- j. sexual activity.

8.4.12 In particular where the patient reports vaginal or anal assault, samples shall be taken in accordance with current Faculty of Forensic and Legal Medicine (FFLM) guidance.²⁹ Where the assault is suspected of being drug/alcohol

²⁹ Faculty of Forensic and Legal Medicine (2018a).

facilitated, then an appropriate urine or hair sample from the patient should be taken. Ideally, the urine sample should be collected using an early evidence kit (EEK). However, if the patient is unable to wait to urinate until an EEK is available, the professional providing the initial contact/first response shall explain to the patient how they could collect a sample of their urine in a clean receptacle that can be handed to the police or staff at the facility later. At the earliest opportunity, this sample shall be transferred to the EEK collection vessel and the original receptacle shall be retained.

- 8.4.13 The staff at the facility providing the initial contact to the patient will need to explain that the clothing worn at the time of the assault and any current underwear (if the clothing has been changed) may be taken as evidence; the patient should retain the clothing and not wash any of it. This also applies to sanitary products or underwear liners being worn or discarded, but available for evidence collection.

Decision to Undertake an Examination

- 8.4.14 Forensic samples are only one consideration in deciding upon the merits of undertaking a forensic medical examination. Opportunities to recover other forensic science related evidence, such as the presence of injuries and their sequelae,³⁰ as well as an evaluation of therapeutic issues for the patient shall be considered. The time spans for conducting a forensic examination will vary on a case-by-case basis.
- 8.4.15 Where there is any question about whether a forensic medical examination is required immediately, or indeed at all, the forensic healthcare practitioner shall be consulted as soon as possible. The decision about whether and when to carry out the examination should be made in accordance with the flowcharts for pre-pubertal and post-pubertal [complainants](#) provided by the FFLM in the Guide to Establishing Urgency of Sexual Offence Examination,³¹ the Recommendations for the Collection of Specimens from Complainants and

³⁰ Preceding injury in the same individual.

³¹ Faculty of Forensic and Legal Medicine (2016c).

Suspects³² and the medical needs of the patient (for example, HIV post-exposure prophylaxis, emergency contraception).

8.4.16 Where children disclose sexual offences the need for, and timing of, a forensic medical examination could be particularly pertinent. It shall not be for the police officers/investigators and/or social workers to make decisions about whether children disclosing sexual abuse shall be examined or at what time. In these circumstances the forensic healthcare practitioner and/or paediatrician shall be consulted for advice on the recovery of potential forensic science related evidence.

8.4.17 Where it is necessary for the patient to be taken to an emergency department from the facility (where the patient appears to have serious injuries or an altered level of consciousness) the forensic healthcare practitioner shall attend at the hospital. It is generally accepted that in these circumstances forensic integrity may be compromised. However, the needs of the patient shall come before the gathering of forensic science related evidence. In these cases forensic healthcare practitioners shall work alongside other healthcare providers or provide advice to those who are treating the patient. Any forensic samples shall be collected using recognised forensic sample kit modules (please see section 8.3.14 above). Hospital swabs are not fit for forensic purposes and shall not be utilised. Blood and urine samples taken at hospitals, although not necessarily containing appropriate preservative, may still provide useful evidence and in the absence of any more suitable specimens shall be considered for forensic analysis.

Attendance of the Forensic Healthcare Practitioner

8.4.18 Local policy will dictate who has the responsibility for requesting the attendance of the forensic healthcare practitioner and the expected time frames for attendance at the facility.

³² Faculty of Forensic and Legal Medicine (2018a).

- 8.4.19 The provider of the forensic medical workforce should ensure that they are able to “provide a timely response (within 2 hours, or as agreed for a particular case) to reflect the clinical and forensic needs of patients”.³³
- 8.4.20 To prevent cross-contamination, the forensic healthcare practitioner attending the forensic medical examination of the patient of a sexual offence shall not provide any medical examination or any other service to the suspect in that case, for example, where the suspect(s) is in custody. Where the provider of the forensic healthcare practitioner for the facility is also the provider of the forensic healthcare practitioners in the custody setting, there shall be two separate rotas in operation. These shall ensure that the forensic healthcare practitioner available for sexual offence forensic medical examinations is not also used for custody medicine at that time. Where more than one patient is referred who may be involved within the same incident, or different patients are thought to be part of a linked series of cases, they should be examined in separate suites and by different forensic healthcare practitioners.
- 8.4.21 In exceptional circumstances (for example, very remote locations) it may become necessary to use the same forensic healthcare practitioner. In this case, the reason and rationale behind the decision should be documented, together with the steps that have been undertaken to reduce the risk of contamination. For example, cleaning of mobile equipment, showering, change of clothes shall be recorded, documented and disclosed to the forensic unit processing the samples and in any subsequent report or statement provided for the criminal justice system.

Arrival of the Patient

- 8.4.22 On the patient’s arrival at the facility, a crisis worker (CW) or equivalent shall meet the patient (and their supporters). The CW shall accompany the patient to the pre-examination waiting area of the facility to provide privacy for the patient and support their sense of safety and security.
- 8.4.23 The CW shall provide immediate support to the patient by explaining to them:

³³ Faculty of Forensic and Legal Medicine (2016a).

- a. their role in supporting and advocating for the patient throughout their time at the facility;
- b. the options available to the patient, including the opportunity to have a forensic medical examination (8.4.10) and how the CW will be supporting them throughout the forensic medical examination;
- c. the purpose of the forensic medical examination and its potential value, both in terms of the medical examination and the collection of forensic samples; and
- d. how the medical examination will be conducted.

8.4.24 Although the CW may be repeating what has already been relayed to the patient by the professional providing the initial contact/first response, it is important that the patient understands why they are at the facility and the options available to them at that time.

8.4.25 Where a urine sample has not already been collected, the CW shall ensure that a urine sample is collected where appropriate, using the EEK³⁴ (if the patient is able to pass urine at that time). Where there is any suggestion that penis–mouth penetration (fellatio) may have taken place, or the nature of the sexual assault is unknown, the CW shall obtain oral samples using the EEK.³⁵ The CW can also collect non-intimate skin swabs, for example, hand swabs where appropriate.

8.5 Medical Examination and Evidence Collection (ISO 15189 5.4.3, 5.4.4, 5.5; ILAC G19 4.3.3)

Preliminary Matters

8.5.1 When the CW is satisfied that the patient is ready for the forensic medical examination to take place, the forensic healthcare practitioner shall introduce themselves to the patient (and their family if the patient is a child) and explain what is going to happen during the medical examination.

³⁴ Faculty of Forensic and Legal Medicine (2018a).

³⁵ *Ibid.*

8.5.2 Where specialised equipment, such as a colposcope,^{36,37} is to be used during the examination, the forensic healthcare practitioner shall explain the purpose and function and how it will be used during the examination.

8.5.3 The forensic healthcare practitioner shall explain to the patient that they can:

- a. ask questions at any time during the examination;
- b. have a break at any time during the examination;
- c. decline any part of the examination or evidence collection; and
- d. stop the examination at any time.

Obtaining Consent

8.5.4 The forensic healthcare practitioner shall obtain informed consent³⁸ from the patient for:

- a. a full medical history;
- b. a forensic medical examination;
- c. the collection of forensic and/or medical specimens;
- d. taking of notes, body diagrams, photographs/videos/digital images for recording information to be used for evidential purposes, second opinions from medical experts, peer review and audit;
- e. completion of a report or statement for the police (if the police have already been involved and if a report or statement is requested);
- f. agreement, where applicable, to the use of their anonymised photographs/videos/digital images/medical notes for teaching or research purposes;
- g. (for self-referrals) offer retaining and storing their samples³⁹ for a defined period of time if the patient is unsure whether or not to send samples for anonymous testing or to proceed with a police complaint before destruction;

³⁶ Faculty of Forensic and Legal Medicine (Reviewed, 2017b).

³⁷ Faculty of Forensic and Legal Medicine (2017c).

³⁸ See Supreme Court judgment UKSC11 2015 *Montgomery v. Lanarkshire Health Board*.

³⁹ Faculty of Forensic and Legal Medicine (2016d).

- h. (for self-referrals who do not want to progress to a police complaint) obtain permission to process samples anonymously (if available) before destruction.

8.5.5 The forensic healthcare practitioner shall ensure that valid consent is given in accordance with guidelines from the FFLM,⁴⁰ the General Medical Council (GMC), the Nursing and Midwifery Council (NMC) and the Health and Care Professions Council (HCPC) in accordance with the Mental Health Capacity Act 2005. In situations where there is no capacity to consent, the detail of the decision making shall be documented such that the basis of the decision can be reviewed by another competent forensic healthcare practitioner.

8.5.6 The forensic healthcare practitioner shall ensure that the patient understands the purpose of the examination and that consent is freely given.

8.5.7 The forensic healthcare practitioner shall ensure that the patient is aware that there is no obligation to give consent and that it can be withdrawn at any time during the examination. If consent to any part of the examination is declined at any stage, that refusal and any reason should it be offered, shall be recorded.

8.5.8 Where the patient is a child, reference shall be made to the GMC⁴¹, the Royal College of Paediatrics and Child Health (RCPCH)⁴² and the FFLM⁴³ guidances for obtaining valid consent. Consent for a forensic medical examination shall be obtained from one of the following:

- a. parents/carers with parental responsibility;
- b. a child of sufficient age and understanding (as assessed by the forensic healthcare practitioner with advice from professionals);
- c. children's services, where the child is the subject of a Care Order, or an interim Care Order;
- d. a Family Proceedings Court as part of a direction attached to an interim Care Order, an Emergency Protections Order or a Child Assessment Order.

⁴⁰ Faculty of Forensic and Legal Medicine (2011).

⁴¹ General Medical Council (2012).

⁴² Royal College of Paediatrics and Child Health Child Protection Companion.

⁴³ Royal College of Paediatrics and Child Health and Faculty of Forensic and Legal Medicine (2015).

First Account

- 8.5.9 Where an adult patient has already reported the assault to the police, the forensic healthcare practitioner shall take an initial account of the assault from the professional attending with the patient, usually a police investigator. For adult patients who self-refer the healthcare practitioner will need to take the initial account.
- 8.5.10 If the patient is a child the initial account may be provided by a social worker or a police investigator, though the recommendation is for a police investigator to be present.
- 8.5.11 It shall be noted that police representatives will want to collect information from the patient to help in the apprehension of suspects and the investigation. However, an achieving best evidence (ABE) interview shall not take precedence where a timely forensic medical examination is required.
- 8.5.12 The forensic healthcare practitioner may confirm and record the first account with the patient and seek any clarification about the account where necessary, minimising re-traumatisation. This is unlikely to be appropriate with a young child or vulnerable adult.
- 8.5.13 If the patient has not reported the assault to the police and has self-referred to the facility, the forensic healthcare practitioner (where appropriate) will take the account directly from the patient after consent has been given.

Medical/Social History

- 8.5.14 The forensic healthcare practitioner (where appropriate) shall take a medical/social history from the patient in sufficient detail to enable them to undertake a holistic assessment of the therapeutic needs of the patient and any issues which may impact on interpretation of scientific or medial evidence. Where the patient is a child, a full paediatric history will be taken. This may be from a parent, care-giver or from the child themselves – depending on the age and capacity of the child. In line with current practice, the child shall be given the opportunity to talk to the practitioner independently of carers. Care shall be taken to ensure that questions are pertinent to the purpose of the medical examination and any subsequent findings. The FFLM has produced sample

forms that can be utilised to ensure that important information is routinely asked by forensic healthcare practitioners⁴⁴ and paediatricians⁴⁵.

- 8.5.15 The forensic healthcare practitioner shall use the medical history, together with the first account, to guide the examination, evidence collection and support any subsequent forensic laboratory examination and findings.

Safeguarding

- 8.5.16 Safeguarding is an important aspect of the holistic assessment of the patient. Consideration of safeguarding issues needs to be addressed in all cases particularly if the patient:
- a. is a child;
 - b. is a carer for children; or
 - c. is a carer for an adult at risk.

Addressing Practical and Emotional Needs

- 8.5.17 Forensic healthcare practitioners should ensure that the therapeutic, practical and emotional needs of the patient, both prior to and during the examination, are met wherever possible. Pressing issues (for example, for the treatment of serious injuries, crisis intervention and support, translation and interpretation) shall be addressed before commencing with the examination.
- 8.5.18 The facility shall have procedures in place and forensic healthcare practitioners shall be trained to accommodate the patient's communication skill level and preferred mode of communicating. This is particularly important for patients with communication-related disabilities and/or where English is not their first language.
- 8.5.19 Where interpreters are necessary, family members shall not be used and the gender preference of the patient shall be taken into account. Where interpreters are in attendance as opposed to online resources, they shall be present prior to

⁴⁴ Faculty of Forensic and Legal Medicine (2010, Revised 2014).

⁴⁵ Faculty of Forensic and Legal Medicine (2012).

questioning and there should be space for them in the examination room to interpret for the patient.

Record of Attendees

- 8.5.20 A record of all persons in attendance at any time during the forensic medical examination shall be made. The name and contact details for each visitor, including non-facility professionals in attendance, which areas they accessed and whether they wore full or partial PPE/barrier clothing in the DNA clean controlled areas shall be recorded. This is in case a DNA sample is required from them at a later date for contamination elimination purposes. (Please refer to section 9.3 in this guidance for more details.)

Roles and Responsibilities of those conducting the examination

- 8.5.21 Where more than one person is conducting the examination, for example, in the case of a child where a paediatrician and another forensic healthcare practitioner might be present, all practitioners shall agree and document their respective roles and responsibilities within the examination before it commences.

Removal of Clothing

- 8.5.22 Clothing worn at the time of the incident, or afterwards, may contain important evidence in sexual assault cases as it provides a surface upon which traces of foreign materials, such as semen, saliva, blood, hairs, fibres, and debris from the crime scene, may be found.
- 8.5.23 Where damage to clothing is detected, the forensic healthcare practitioner shall ask the patient whether the damage relates to the assault. Damaged or torn clothing may be significant as it may be evidence of force. It is good practice for the forensic healthcare practitioner to see the patient in the damaged clothes before they are removed and take photographic evidence of the observations where appropriate – this may indicate or correlate with the presence of physical injuries. Any existing holes, rips or stains on clothing shall not be cut through on removal of the clothing. This is particularly important if the patient is receiving

emergency medical treatment by other medical staff such as in an emergency department.

- 8.5.24 The patient shall be permitted to remove their clothing in the forensic medical room where they can be afforded some privacy by being able to stand behind a curtain or screen.
- 8.5.25 Consideration shall be given to the use of a disposable floor standing sheet to collect foreign material dislodged from clothing during undressing. It shall be placed onto the floor to act as a barrier. Care shall be taken to avoid any evidence transfer. The patient shall be asked to remove footwear first and these shall be individually packaged if they are likely to yield relevant evidence, for example, debris from an outdoor scene location.
- 8.5.26 The patient shall be asked to disrobe, one item at a time, trying to maintain the orientation that the garment is worn during removal. Damage may be noted or highlighted during undressing and it may be appropriate to photograph this before the item is removed (for example, damaged tights).
- 8.5.27 The professional/practitioner collecting and subsequently packaging the clothing shall wear two pairs of gloves (doubled gloved) and hold an exhibit bag open for the patient to place the item inside. The outer gloves worn by the professionals do not require changing unless the professional handles individual items of clothing. Where the patient is a self-referral or a [non-police-referral](#), the professional collecting the clothing will be a CW. Where the patient is a [police-referral](#), the professional collecting the clothing could be a police investigator, specialist trained officer (STO) or a CW.
- 8.5.28 No more than one item shall be placed in each exhibit bag; for example, each sock or shoe shall be packaged individually.
- 8.5.29 Any staining/soiling or detectable odours on the clothing shall be noted on the exhibit label and on the forensic medical examination exhibit collection documentation. If the facility utilises exhibit bags with windows, the soiled areas, where possible, should be visible through the window. Heavily soiled or notably wet items shall either be double bagged for transporting to a drying facility or placed in a breathable bag if available. Wet items can also be packaged in a plastic tamper-evident bag and frozen with clear information about the condition

of the item (for example, wet/damp/heavily soiled) being recorded on the exhibit label. Double bagging involves the item being placed in an open plastic exhibit bag, which is then inserted inside a sealed paper evidence bag.

8.5.30 All exhibit bags shall be sealed at the open end using adhesive tape, even where self-seal bags are utilised, before they are transported for storage either within the facility or at an agreed alternative storage facility. Additional sealing/labelling of the exhibits shall be the responsibility and ownership of the professional/practitioner collecting the items from the patient. This should be done as soon as practically possible before items are stored.

8.6 The Examination Process (ISO 15189 5.5; ILAC G19 4.7)

8.6.1 The forensic healthcare practitioner shall consider the medical, psychological and safeguarding needs of the patient, alongside the collection of information that could potentially be used to support an investigation or subsequent court case relating to the assault. It is important that the forensic medical examination shall be carried out methodically to ensure that all relevant information relating to the assault is sought.

8.6.2 With regard to the collection of forensic samples, forensic healthcare practitioners, as part of the forensic medical examination, shall routinely collect the following information from the patient or if not appropriate (for example, the patient is a young child), then from alternative sources:

- a. time and date of the sexual assault(s);
- b. nature and description of sexual assault(s);
- c. recent consensual sexual activity;
- d. post-assault activities, for example, washing;
- e. assault-related medical information (including physical injuries);
- f. details of known medication(s) and alcohol consumption and/or other drug use by the patient;
- g. description of assailant (if known) – to assist in risk assessment for HIV, etc.

- 8.6.3 There is a FFLM pro forma designed to assist forensic healthcare practitioners in the assessment of adult male and female patients.⁴⁶ Organisations can use their own pro forma provided that it meets the FFLM content as the minimum requirement. The FFLM has also designed a similar form for children.⁴⁷
- 8.6.4 Where the patient is a child or young person the paediatric forensic medical examination⁴⁸ shall include a comprehensive assessment. This shall consider the physical development and emotional well-being of the child or young person against the background of any relevant medical, family or social history that is known. The forensic medical assessment provides an opportune health screen for previously unknown medical conditions and learning/social communication difficulties. Children may be particularly vulnerable and subject to other forms of abuse such as neglect. This enables a full evaluation of the degree of significant harm suffered, or likely to be suffered, by the child as described in the Children Act 1989 and 2004. This assessment shall also lead the planning of any ongoing investigation or treatment required by the child, and appropriate reassurance for the child and family. Use should be made of the FFLM pro forma designed to assist the forensic healthcare practitioner in the assessment of a child or young person who may have been sexually abused.⁴⁹ Organisations can use their own pro forma, provided that it meets the FFLM content as the minimum requirement.
- 8.6.5 Forensic healthcare practitioners shall seek to collect as much evidence (samples, injuries, trace evidence) from the patient as possible, guided by the scope of the informed consent.
- 8.6.6 The forensic healthcare practitioners shall thoroughly examine the patient from top to toe and check for any injuries, areas of pain or soreness. It is important that the forensic healthcare practitioner notes any medical signs that may impact on a differential diagnosis, either positive or negative. The forensic healthcare practitioner shall check with the patient how any findings may have

⁴⁶ Faculty of Forensic and Legal Medicine (2010, Revised 2014).

⁴⁷ Faculty of Forensic and Legal Medicine (2012).

⁴⁸ Faculty of Forensic and Legal Medicine and Royal College of Paediatrics and Child Health (2012).

⁴⁹ Faculty of Forensic and Legal Medicine (2012).

occurred and this shall be documented. All injuries shall be photographed⁵⁰ and if appropriate noted on a body diagram to demonstrate the relationship between multiple injuries.

8.7 Sample Collection and Handling (ISO 15189 5.2.5, 5.4.3, 5.4.4.3, 5.4.5, 5.4.6, 5.4.7; ILAC G19 4.3.3)

8.7.1 Having regard to the medical history and the first account of the assault, appropriate forensic samples shall be taken by the forensic healthcare practitioner. The FFLM has produced recommendations for the collection of samples.⁵¹ While the FFLM recommendations refer to specific time spans, it is important to note that these will vary on a case-by-case basis.

8.7.2 Where recommendations provide the order of sampling for a particular site, for example, the vagina, this should be followed. If for any reason it is not, then this shall be recorded:

- a. in the documented notes with the reasons why; and
- b. on the associated documentation, for example, on the exhibit list and/or forensic medical examination paperwork.

8.7.3 During the collection of the samples, the forensic healthcare practitioner shall take steps to minimise contamination (see also sections 8.3.12 and 9.2 in this guidance).

8.7.4 The facility shall have clear policies for packaging, labelling and sealing samples since this is critical for their admissibility during criminal proceedings.

8.7.5 It shall be the responsibility of the person who obtains the sample to ensure that each sample is appropriately labelled as detailed in the FFLM guidelines on the labelling of samples.⁵² In the event that a CW, STO, police investigator or scenes of crime officer (SOCO), also known as crime scene investigator (CSI), is requested to assist with the labelling process, the responsibility to ensure that

⁵⁰ Faculty of Forensic and Legal Medicine (2017c).

⁵¹ Faculty of Forensic and Legal Medicine (2010, Revised 2014).

⁵² Faculty of Forensic and Legal Medicine (2016e).

the samples are correctly labelled remains with the forensic healthcare practitioner.

- 8.7.6 Handling of the forensic samples shall be restricted to those persons necessary, who are involved and recorded in the [chain of custody](#).
- 8.7.7 The identification/exhibit number and/or timings shall reflect the order of sampling. Where two swabs have been taken from the same site there shall be a clear indication on the swab label regarding the order in which the swabs were obtained. These are normally indicated by 'wet' and 'dry' and utilising the letters 'A' (for the first sample) and 'B' (for the second sample). Where the order of sampling is reflected on the swab label (for example, A and B), the timings can then be recorded as the same.
- 8.7.8 A chain of custody is required for all forensic samples and for sexually transmitted infection (STI) samples where they may be relevant to the forensic case.

Transfer of Samples

- 8.7.9 Where the patient has reported the assault to the police, it shall be the responsibility of a police investigator to transfer evidence from the facility to the designated storage site used by the police, or directly to the forensic science provider's laboratory. This shall be documented appropriately to demonstrate the chain of custody.
- 8.7.10 Where the patient has not reported the assault to the police, it shall be the responsibility of the forensic healthcare practitioner or CW to transfer evidence from the examination room to the storage room(s) within the facility. This shall be documented appropriately to demonstrate the chain of custody.
- 8.7.11 It is important that the transit time between collection and storage of samples shall be minimised wherever possible. Samples shall be packaged to avoid potential degradation. For example, all samples collected during the forensic medical examination shall be transported in a timely fashion in suitable insulated carrying containers to keep the samples cold during transportation.

Storage of Samples

- 8.7.12 Samples collected before or during the forensic medical examinations shall be stored in secure locations at the facility with access restricted to authorised nominated personnel (for both police and non-police (self) referrals).
- 8.7.13 All forensic medical samples shall be properly stored until required for forensic examination in the laboratory. Detailed information on the required storage conditions is given in the FFLM recommendations.⁵³
- 8.7.14 The facility shall follow sample storage policies agreed with the police and the forensic science provider to ensure that:
- a. optimal storage conditions are adopted for all samples collected as part of the forensic medical examination; and
 - b. the hazards for handling and storing evidence such as blood and urine are understood.
- 8.7.15 Where samples are held in cold storage at the facility, a system shall be in place to ensure that samples are kept at a specified temperature at all times. This system shall include maintaining temperature monitoring logs and the ability to identify failure of the equipment in a timely manner.
- 8.7.16 The facility shall ensure that policies are in place to address evidence storage in cases where the patient is undecided about reporting to the police. It is important that there is adequate space and provision at the facility to store samples taken from patients who self-refer.
- 8.7.17 Where a limited-time policy for storage of samples is implemented at the facility, i.e. agreement to store a self-referral patient's samples for a limited time only, it is important that the patient is informed at the time of the forensic medical examination regarding the length of time that their samples will be stored. This is critical as it will be the period of time within which the patient has to decide whether to report the assault to the police.
- 8.7.18 In the event that the patient does not pursue a police complaint within the agreed time limit, then if they choose to provide consent to analyse the samples

⁵³ Faculty of Forensic and Legal Medicine (2018a).

anonymously, then where this service is offered these should be provided to the police to process anonymously (real name withheld and name not on the exhibit labels). Otherwise the samples shall be destroyed in a safe and timely manner. The patient shall be furnished with suitable information regarding this retention and destruction policy.

Sample Management

- 8.7.19 The sample management processes for documentation, labelling, handling, transfer and storage of samples and evidence collected as part of the forensic medical examination shall be documented. The processes should ensure that there is no loss, contamination or alteration of evidence, for example, the use of barriers on surfaces and the wiping of exhibit bag exteriors as appropriate to minimise the transference of DNA.
- 8.7.20 The forensic healthcare practitioner shall have the responsibility for maintaining control of the collection, labelling and sealing of samples obtained as part of the forensic medical examination until the samples are handed over. Where the referral is a police-referral the samples shall be handed:
- a. to authorised police personnel for transport to a designated storage site used by the police; or
 - b. directly to the forensic science provider's laboratory for police-referrals.
- This handover shall be documented and a record retained. The documentation shall continue with each transfer of the evidence.
- 8.7.21 Where the referral is a self- or non-police-referral, the samples shall be placed in storage at the facility by the forensic healthcare practitioner or handed to a CW. This handover shall be documented. The responsibility for maintaining the integrity of the samples thereafter shall sit with the facility's management team. Any subsequent movement or transfer of the samples shall be documented and a record retained.

Images

- 8.7.22 The facility shall determine the conditions (including specialist lighting) required for obtaining the resolution and image quality to:

- a. allow for re-sizing downstream processing to achieve life size images; and
- b. demonstrate the features of interest clearly.

8.7.23 The method(s) used for the electronic capture, storage and transfer of images shall maintain the security and integrity of the data.

8.7.24 It is the responsibility of the facility to ensure that any images taken by medical personnel at the facility adhere to the following process.

- a. The images are taken by personnel who:
 - i. understand the concept of image quality and resolution;
 - ii. understand the effect and degradation of resolution by the capture and processing of images being used; and
 - iii. are appropriately trained and competent to carry out the role – this may vary depending on whether the image is intimate or non-intimate.
- b. The images are retained and stored securely.
- c. Their existence and location is recorded by the facility and acknowledged in the patient's medical records.

8.7.25 Due to the highly personal nature of the photography (including still photographs, video, CD or DVD) involved in sexual assault cases and due to the likelihood that this photo documentation will be used for second opinions and/or peer review, it shall be the responsibility of the forensic healthcare practitioner to obtain the forensic images of intimate areas during the forensic medical examination. Where the patient is a child and a permanent record is not obtained, the forensic healthcare practitioner shall record the reason for this in the documentation. The FFLM has published guidelines on photography.⁵⁴

8.7.26 The forensic healthcare practitioner (where appropriate) shall be appropriately trained and familiar with how to operate the equipment required to capture the permanent record.

⁵⁴ Faculty of Forensic and Legal Medicine (2017c).

8.7.27 Imaging records taken by forensic healthcare practitioners shall be stored securely by the facility. Each facility shall have a defined system for the secure storage of records, which protects the anonymity of the patient.

8.7.28 Procedures shall be in place to enable the disclosure of images where a request is made in court proceedings. The FFLM has produced detailed guidance on the handling and disclosure of intimate images.⁵⁵

9. Ensuring The Quality Of Examination Procedures (ISO 15189 5.6; the Codes)

9.1.1 To ensure optimum levels of cleanliness, evidence of the following shall be routinely sought at regular intervals. The interval will vary depending on how often forensic medical examinations are conducted and any level of risk identified during audits of the facility.

- a. Adherence to procedures that minimise the possibility of contamination from the moment a patient arrives at the facility to undertake a forensic medical examination until completion of that examination.
- b. Record keeping for the use of locks/security seals to rooms in the forensic area of the facility i.e. the pre-examination waiting room, medical examination room and bathroom.
- c. Steps that have been taken to identify contamination (or the possibility of contamination occurring). Environmental monitoring (EM) sampling is considered as good practice and shall be undertaken, see 9.7 in this guidance.
- d. Staff engaged at the facility understand the scientific basis for both preventative and decontamination procedures and are competent in conducting practical cleaning regimes and associated record keeping.
- e. Staff engaged at the facility understand the difference between a deep clean, cleaning requirements for DNA clean controlled areas and a

⁵⁵ Faculty of Forensic and Legal Medicine (2017b).

general clean.⁵⁶ Staff undertaking the role of cleaning shall be trained in these procedures and shall be monitored annually to ensure compliance.

9.2 Use of Personal Protective Equipment/Barrier Clothing (ISO 15189 5.2.5)

9.2.1 To undertake a medical examination, the forensic healthcare practitioner shall wear personal protective equipment (PPE)/barrier clothing as defined in 8.3.13 and below.

- a. Disposable single-use barrier clothing such as scrubs or aprons and disposable sleeve covers. As a minimum, the arms shall be covered.
- b. Non-latex powdered gloves in a range of sizes.
- c. Face mask.
- d. In addition it is preferable to wear the following:
 - i. mob cap; and
 - ii. overshoes.

9.2.2 The purpose of wearing a face mask to reduce the risk of contamination shall be explained to the patient. If the patient objects or where the forensic healthcare practitioner considers the use of a face mask to be upsetting and the face mask is subsequently not worn, then this shall be recorded in the examination case notes with the reasons. However, the forensic healthcare practitioner's DNA profile shall be available for contamination elimination purposes (please refer to section 9.3 below for more details)

9.2.3 The order for putting on PPE/barrier clothing shall be undertaken in an appropriate sequence. The following order is an example:

- a. face mask;
- b. overshoes;
- c. mob cap;
- d. inner base gloves;
- e. scrubs or apron and sleeve covers; and
- f. outer gloves.

⁵⁶ Forensic Science Regulator The control and avoidance of contamination in laboratory activities involving DNA evidence recovery and analysis FSR-G-208.

- 9.2.4 PPE/barrier clothing shall be changed after every forensic medical examination, cleaning or maintenance task. The PPE/barrier clothing shall be appropriately disposed of after use.
- 9.2.5 Hand hygiene is a key part of the examination procedure. Hands shall be decontaminated by washing⁵⁷ before donning gloves and following their removal. Non-sterile gloves may be used where it is possible to undertake evidence collection without touching any key parts of the patient, for example, by utilising aseptic non-touch techniques and venepuncture where blood for toxicology is collected. Where swabs are used the sampler shall hold them at the base, away from the sampling end.
- 9.2.6 Double gloving should be employed with the top gloves being changed for different sample sites or after touching surfaces such as taps or door handles in the forensic examination room. Top gloves shall also be changed after manoeuvring the curtain around the couch regardless of whether it is a disposable variety or other type.
- 9.2.7 Gloves shall not be washed and alcohol gel shall not be applied as this may compromise the integrity of the gloves.⁵⁸
- 9.2.8 Any other person entering the forensic areas of the facility (including family member, friend or supporter) shall be made aware of the potential contamination risks. The forensic healthcare practitioner and other professionals in attendance shall wear PPE/barrier clothing to mitigate against extraneous DNA being deposited in the facility's DNA clean examination room. A family member, friend or supporter in attendance should also wear PPE/barrier clothing if entering the medical examination room. If the individual objects consideration should be given to excluding that individual from the medical examination room. If the forensic healthcare practitioner considers it to be too upsetting for the supporter to wear full PPE/barrier clothing for the examination, this shall be recorded in the case notes and increases the requirement for effective cleaning and the requirement for a DNA elimination

⁵⁷ Liquid soap with good hand washing technique should be adequate, if further guidance is required then the DNA forensic science providers may be able to advise on current best products.

⁵⁸ Chalmers and Straub (2016).

sample (see 9.3 below). All attendees shall be recorded (see 8.5.20 in this guidance).

9.3 DNA Elimination Samples (ISO 15189 5.2.6; FSR-P-302)

9.3.1 Any individual entering a facility may inadvertently introduce their DNA into the environment. This may subsequently contaminate an exhibit or sample during or after its recovery, which may mislead⁵⁹ an investigation, waste resources and cause unnecessary delay. The provision of an elimination sample, and for the DNA profile derived to be included on a searchable [elimination database](#) as appropriate, assists in detecting contamination and ensuring the relevance of detected DNA profiles.

9.3.2 The facility shall ensure that a policy is in place to address the following:

- a. agreement/consents for sample donation and the use of profile information;
- b. security and access of information at a local/national level;
- c. secure storage and retention of samples;
- d. secure and recorded transfer of samples in accordance to guidance provided by the forensic science provider⁶⁰ that will undertake the DNA profiling for elimination purposes; and
- e. sharing of profile information (between staff member, facility management, forensic medical provider, police investigator and elimination database provider).

9.3.3 All staff working within the facility shall provide a DNA elimination sample prior to entering any part of the forensic area of the facility. This shall include (but is not limited to) the forensic healthcare practitioner, paediatricians, crisis workers (CWs), cleaning staff and contractors. All other attendees entering the facility, (including the patient, whether police-referral or self-referral cases, interpreters, friends and family) should provide a DNA elimination sample prior to entry otherwise they shall have their details and contact information recorded in case there is a need to request a sample at a later date for contamination elimination

⁵⁹ Gill (2014).

⁶⁰ This could be the police force if the force acts as an intermediary.

purposes. Consideration should be given to excluding from the medical examination room any individual(s) who are not willing to provide their details.

9.3.4 A record shall be kept of:

- a. which room is used for each examination;
- b. the date and times of the examination: and
- c. the names of all persons who enter the examination room during the examination, including interpreters and any person who supports the patient (please see section 8.5.20 in this guidance for more details).

9.3.5 The policy and procedures for taking and managing DNA elimination samples and the investigation of any identified contamination should be in accordance with the Forensic Science Regulator protocol FSR-P-302.⁶¹

9.4 Decontamination Measures (ISO 15189 5.2.6; FSR-G-208)

9.4.1 In the event that multiple patients from the same incident attend the facility at the same time, staff shall ensure that they do not have contact with more than one patient to prevent cross-contamination. If this is absolutely unavoidable, steps shall be taken to ensure that appropriate precautions are taken to minimise cross-contamination. This shall include staff showering, including washing their hair, and changing their own clothes between each patient. As a minimum, all PPE/barrier clothing shall be changed between contacts. The forensic medical examination room, including equipment, shall be cleaned between each examination.

9.5 Cleaning (ISO 15189 5.2.6; FSR-G-208)

9.5.1 Each area shall have a cleaning schedule, with the frequency of cleaning dependent on the extent of use of the area and the equipment within it. Cleaning shall be carried out and recorded on a cleaning log to show all activities undertaken as per the schedule.

⁶¹ Forensic Science Regulator DNA contamination detection – the management and use of staff elimination databases FSR-P-302.

- 9.5.2 As a minimum cleaning shall be undertaken using cleaning equipment dedicated solely for use in each area and using a cleaning regime validated or verified to provide effective⁶² DNA decontamination.
- 9.5.3 Verification of the efficacy of the cleaning materials, processes and staff using the standard operating procedures (SOPs) shall include sampling areas immediately after cleaning by an individual not involved with cleaning, and processing of the samples as for environmental samples. Any profiles obtained shall only be checked against the facility staff, including those conducting the cleaning, to facilitate assessing whether the cleaning is effective and whether the cleaning staff are inadvertently transferring their DNA. It might be necessary for a check against consumable manufacturing elimination databases to exclude consumables as the source for unknown profiles.
- 9.5.4 Cleaning shall be conducted by appropriately trained staff every time the pre-assessment (waiting) room, medical examination room and bathroom areas of the facility have been used.
- 9.5.5 Cleaning shall be undertaken using cleaning equipment dedicated solely for use in each DNA clean area and using a cleaning regime validated or verified to provide effective DNA decontamination.
- 9.5.6 In the DNA clean controlled examination areas, between the examination of patients, as a minimum the following should be cleaned.
- a. Work surfaces – identify and decontaminate all surfaces that may either directly or indirectly come into contact with the patient during sample recovery activities, consumables or exhibits. These surfaces should also be cleaned before use, particularly if there is a period of non-use that could allow dust⁶³ to settle on surfaces.
 - b. Individual pieces of equipment including:
 - i. pens;
 - ii. examination couch;
 - iii. mobile examination light with magnifying lens; and

⁶² Ballantyne *et al.*, 2015.

⁶³ Farash *et al.*, 2014.

- iv. colposcope with attachments for photo-documentation.
 - c. IT equipment (graphic pads and pens, and keyboards).
- 9.5.7 On a weekly basis (assuming there has been no [gross contamination](#) with body fluid material, for example, blood) the following shall be decontaminated:
 - a. floors;
 - b. equipment such as sphygmomanometers, computers, keyboards and all exposed cables; and
 - c. all contact surfaces such as cupboards, door handles and fridges.
- 9.5.8 Deep cleaning shall be regularly scheduled and should be conducted at least every month regardless of the number of patients who have undergone a forensic medical examination at the facility. This ensures that build-up of dust deposits from ventilation/heating systems are kept to a minimum.
- 9.5.9 The whole area deep clean shall include areas not already covered by the other cleaning:
 - a. lights and vents;
 - b. walls and ceiling;
 - c. windows and blinds; and
 - d. the insides of cupboards and drawers.
- 9.5.10 Cleaning or replacement of air filters should be undertaken at a frequency recommended by the manufacturers.
- 9.5.11 For rooms that are used on an infrequent basis, i.e. less than once a week, whether new or being recommissioned after a contamination event, cleaning as detailed in sections 9.5.6 to 9.5.9 shall be undertaken prior to commencing use.
- 9.5.12 Where a spill or leak of biological material occurs, it should be removed using a cleaning regime validated to provide effective DNA decontamination. Depending on the circumstances and extent of the spillage it may be appropriate to undertake environmental monitoring of the affected area to provide assurance that all contamination has been removed.
- 9.5.13 Cleaning processes adopted shall be documented and their effectiveness verified in the hands of the end-user. It is also essential to ensure that consideration is given to the health and safety implications of using these

cleaning regimes, which shall be risk assessed and safe systems of work established prior to use.

9.5.14 An example of cleaning surfaces is as follows:

- a. spray the entire surface with a chemical that destroys DNA (for example, 1% solution of sodium hypochlorite);
- b. leave for five minutes;
- c. wipe the entire surface thoroughly (warp/weft motion) using disposable cleaning roll (or similar); and
- d. finally clean with distilled water⁶⁴ to remove cleaning agent residue.

9.6 Decontamination of Re-usable Equipment (ISO 15189 5.3.1.3; FSR-G-208)

9.6.1 Items that are not suitable for immersion in fluid without damaging them should be thoroughly cleaned using disposable cleaning roll or wipes liberally wetted with a chemical that destroys DNA, followed by cleaning with distilled water. Where equipment or items are susceptible to corrosion, then an appropriate cleaning agent that does not corrode⁶⁵ shall be used.

9.6.2 Small items thought to be contaminated that are suitable for immersion in fluid without damaging them should be submerged in a cleaning agent, scrubbed/wiped down to remove material and then rinsed in sterile distilled water.

9.7 Environmental Monitoring and Gross Contamination (ISO 15189 5.2.6; FSR-G-208; FSR-G-212)

9.7.1 The principle of EM is to undertake a programme of testing on a periodic basis:

- a. to check that particular rooms or areas are DNA clean; and
- b. to assess whether the decontamination policy for the area in question is effective and has been carried out properly.

⁶⁴ Safety testing has revealed that cleaning with hypochlorite and ethanol can produce levels of gaseous chlorine at or above the recommended exposure limits (Ballantyne *et al.*, 2015).

⁶⁵ Activ8™ contains no oxidising or corrosive ingredients and can therefore be used with confidence on all surfaces, including fabrics and carpets.

- 9.7.2 The EM sampling regime shall be proportionate to the risk; for example, equipment or areas where large amounts of biological material are inevitably present should be sampled more frequently. Components typically sampled vary according to the function of the area.
- 9.7.3 The person collecting the EM samples (for example, swabs) shall be different to the person who undertakes the cleaning. The forensic science provider undertaking the EM sample testing should be able to advise on the level of gross contamination from the results obtained. The service level/turnaround times specified in contracts with the DNA EM sample testing provider(s) should be short. This allows for any contamination issues to be identified as early as possible, so that the facility can take immediate action. It also minimises the number of cases that will require a review because they were processed through the affected area or involved the use of affected equipment.
- 9.7.4 EM samples shall take the form of a dip sample exercise and be conducted midway between each deep clean; this may be done by using monitoring forms with pre-printed sample collection sites. Initially the monitoring should be carried out monthly to build a picture of the background level of DNA across the operational work areas and a steady state of acceptable levels is maintained. Based on the results returned, the frequency of the sampling can be adjusted, and areas targeted based on risk and previous results.⁶⁶
- 9.7.5 Samples should be taken by swabbing selected areas and equipment that are in contact with operators, patients and/or the items themselves at all stages in the supply chain. The development of a training manual explaining the EM dip-sampling procedure, which includes photographs of the sites to be swabbed, is good practice. Table 1 sets the risk considerations, the frequency of monitoring and follow-up actions for unacceptable levels of DNA for various examples of equipment and areas within the facility.

⁶⁶ Forensic Science Regulator The control and avoidance of contamination in laboratory activities involving DNA evidence recovery and analysis FSR-G-208, section 8.7.

Table 1. Example of Environment Monitoring – Risk Level, Mitigation and Actions

Item	Considerations	Contamination Risk	Action for Fail (L1 ¹ or L2 ²)	Monitoring ³	Frequency
Client bed (couch)	Clean disposable cover used for every examination	Low	Re-clean	Cleaning efficiency. Monitor level for any significant increase	Quarterly
Medical trolley	No clean disposable sheet used on trolley	High	<u>Embargo</u> ⁴	Thorough decontamination – re-sample and test ⁵	Frequent. Sample prior to use for examinations and randomly select for testing
	Clean disposable sheet used on trolley	Medium/Low	Re-clean	Re-sample and test if L2 ²	Routine. Sample prior to use for examinations and randomly select for testing
Colposcope	Equipment that is close to and handled during examination of patient. Change outer gloves every time handled	High	Re-clean. Re-sample and test if L2 ²	<u>Embargo</u> ⁴ Thorough decontamination – re-sample and test ⁵	Frequent. Sample prior to use for examinations and randomly select for testing
Initial room chair	Patient wearing outer clothing and is not examined in that area	Low	Re-clean	Cleaning efficiency. Monitor level for any significant increase	Quarterly
Initial room internal door handle	Inadvertent transfer by patient. Staff hand washing and double gloving in examination room prior to examination	Medium/Low	Re-clean. Re-sample and test if L2 ²	Cleaning efficiency. Monitor level for any significant increase	Monthly to quarterly intervals as appropriate, based on previous result

Notes:

1. Forensic science provider (FSP) profile result classified as fail: re-clean and re-sample.
2. FSP profile result classified as fail: close laboratory/isolate equipment/re-clean all areas and re-sample.
3. Monitor level for any significant increase in non-staff profile elements through staff elimination database checks.
4. Immediate isolation, decontamination and sample at every use until acceptable result returned.
5. Include water swab sample control that acts as a routine water swab consumable handling check, and record result in monitoring records.

- 9.7.6 Where gross DNA contamination is identified through EM the room or equipment in which it has been identified shall be quarantined immediately and deep cleaned. Following the deep clean, EM samples shall be taken again and re-tested until the facility has reached the documented 'pass' level, and the room or equipment can be reinstated for use. This may mean closing the entire facility if gross contamination has been identified in more than one room.
- 9.7.7 Profiles obtained should only be checked against the facility staff, including those conducting the cleaning, to facilitate assessing whether:
- a. the cleaning staff are inadvertently transferring their DNA; or
 - b. the cleaning is ineffective by the level of unknown DNA sources detected.
- It might be necessary for a check against consumable manufacturing elimination databases as part of any root cause analysis.
- 9.7.8 If the repeated EM results still show an unacceptable level of gross contamination, the facility management shall either:
- a. investigate to identify the root cause and implement corrective procedures; or
 - b. utilise an external reviewer to look at the results, policies and processes.⁶⁷

10. Documentation – Recording Of Notes And Statements

10.1 Note Taking and Record Keeping (ISO 15189 4.13; ILAC G19 3.5)

- 10.1.1 Each contact with the patient by any professional shall be recorded in the set of case notes pertaining to that patient. All notes shall be clear, accurate and legible and include details of all activity that has taken place that is directly relevant to contact with the patient at the facility.
- 10.1.2 Notes should be recorded contemporaneously but where this is not possible, notes shall be made as soon as possible after the activity has taken place.

⁶⁷ In February 2014 an independent review was commissioned by Hampshire Police to assess apparent DNA contamination present in EM results of the sexual assault referral centre. This independent review resulted in the development of policies and procedures to respond to contamination levels.

- 10.1.3 All manual notes shall be made in permanent ink, signed and dated, including time if appropriate by the professional recording the notes. The name, role and professional registration/identification number of the professional shall be included and legible. If the recorder is not the practitioner undertaking the tasks then the practitioner's details are recorded and the practitioner reviews, signs and dates the notes as a true and accurate record.
- 10.1.4 For electronic notes, the name, role and professional registration/identification number and date, including time if appropriate, of the professional undertaking the tasks is recorded. These details are reviewed by the practitioner for accuracy.
- 10.1.5 Where any additions or amendments are made to the notes by any person, the amendment shall be clear, and signed and dated. If the amendment is made by someone other than original professional, the name, role and professional registration/identification number of that individual shall be recorded in the notes.
- 10.1.6 Where a correction to the notes is required, a single line shall be run through the correction so that the original note can still be read.
- 10.1.7 Where abbreviations are included in notes they shall be unambiguous and easily understood, for example, LVS for low vaginal swab.
- 10.1.8 It is important that any decision made by the professional is recorded along with the reason for making the decision. Where there is an expected course of action that is not followed, the reason for making the decision not to follow the expected course shall be detailed in the record.
- 10.1.9 Case notes shall contain sufficient details to enable a practitioner to generate a statement, if required, at a later date.
- 10.1.10 There is a range of specimen pro formas published by the Faculty of Forensic and Legal Medicine (FFLM) to assist forensic healthcare practitioners with the process of note taking and sample information.^{68,69,70} However, it is important

⁶⁸ Faculty of Forensic and Legal Medicine (2016f).

⁶⁹ Faculty of Forensic and Legal Medicine (2012).

⁷⁰ Faculty of Forensic and Legal Medicine (2010, Revised 2014).

for forensic healthcare practitioners to recognise that further information or activity may need to be recorded in the notes that is not prompted by the pro formas, for example, the batch number of consumable items such as swabs used, and barrier clothing/personal protective equipment (PPE) worn during the examination. The pro formas should be seen as a guide only and not a definitive list of information for inclusion in the patient's notes.

- 10.1.11 All notes (including permanent records such as colposcope images)⁷¹ shall be retained by the facility in a secure location that complies with data protection requirements. The notes shall be available and accessible when they are required for the purpose of second opinion, peer review, the investigation and/or any criminal justice proceedings.
- 10.1.12 Where notes are required to be removed from the facility, the reason for removal shall be documented and a record kept by the facility of the professional removing and returning the notes. It is preferable for copies, or secure electronic access (with audit tracking) to records to be used so that the potential to lose records is eliminated.

10.2 Preliminary Findings (ISO 15189 5.7.1, 5.8.1; the Codes)

- 10.2.1 Where the police request a written account of the findings immediately following the forensic medical examination, the forensic healthcare practitioner shall clearly state in writing that the written account contains preliminary findings only and that these findings shall be confirmed at a later date. The preliminary findings report shall be subject to an accuracy check and a [critical conclusion\(s\) check](#) by another competent person prior to release to the police. The police shall be made aware that they should exercise care in making decisions based on the content of the preliminary findings rather than on a full statement or report, as the preliminary findings will not include full details of the forensic medical examination. If the preliminary findings have not undergone a critical conclusion check before release this shall be stated with the preliminary findings.

⁷¹ Faculty of Forensic and Legal Medicine (2017b).

10.3 Statements and Reports (ISO 15189 5.7.1, 5.8.1; the Codes; FSR-G-200; FSR-G-225)

10.3.1 The facility shall define a process for the production of statements and reports in an agreed format and to an agreed standard. Due regard shall be taken to the disclosure obligations and the requirements set out in the Criminal Procedure Rules and Criminal Practice Directions⁷² for experts. Though duties to the court of professional witnesses and experts are similar, it shall be borne in mind that the court can deem an individual ‘an expert’ to give an opinion based on their experience and knowledge. In addition, opinion evidence may rely on the statements provided by other practitioners to base opinions upon. Legal obligations are set out FSR-I-400⁷³ and disclosure requirements in the CPS Guidance for Experts on Disclosure, Unused Material and Case Management.⁷⁴

10.3.2 All cases shall be subject to an independent peer review of all critical conclusions by a second competent individual, in a timeframe that minimises potential harm. Depending on the case, this can be:

- a. either completed in stages (please see section 10.3.4 below for more details) as the case progresses; or
- b. for the whole case as part of the peer review of the contents of the statement or report against the findings recorded and agreed.

10.3.3 The facility shall define:

- a. a process to include the timings and stages of the peer review of the case by a second competent individual; and
- b. who has a suitable level of experience and authority to perform such reviews (see 8.1).

10.3.4 Review areas shall as a minimum include:

- a. medical care, including risk assessment and subsequent management;

⁷² Available at: www.justice.gov.uk/courts/procedure-rules/criminal/rulesmenu-2015.

⁷³ Forensic Science Regulator Legal Obligations for Witnesses Providing Expert Evidence FSR-I-400.

⁷⁴ Available at: www.cps.gov.uk/legal-guidance/cps-guidance-experts-disclosure-unused-material-and-case-management.

- b. forensic sampling and documentation;
- c. follow-up decisions and management, including safeguarding; and
- d. peer review of the content and accuracy of the report or statement and whether it is fully supported by the documented case notes.⁷⁵

10.3.5 Forensic healthcare practitioners shall be appropriately trained to produce a statement that is acceptable for use within in the criminal justice process. All forensic healthcare practitioners shall be provided with ongoing support from a competent individual to assist them with statement writing.⁷⁶

11. Acknowledgements

11.1.1 This guidance has been developed and produced in consultation with representatives from the Faculty of Forensic and Legal Medicine (FFLM) of the Royal College of Physicians, the Royal College of Paediatrics and Child Health (RCPCH), the United Kingdom Association of Forensic Nurses and Paramedics (UKAFN), the College of Policing, Hampshire Constabulary, Cellmark Forensic Services, United Kingdom Accreditation Service (UKAS) and members of the Forensic Science Regulator’s medical forensics specialist group following the award to Principal Forensic Services and Lime Culture Community Interest Company to prepare the initial text.

12. Review

12.1.1 This document is subject to review at regular intervals.

12.1.2 If you have any comments please send them to the address as set out at: www.gov.uk/government/organisations/forensic-science-regulator or email: FSREnquiries@homeoffice.gov.uk.

13. References

Ballantyne, K., Salemi, R., Guarino, F., Pearson, J., Garlepp, D., Fowler, S. and van Oorschot., R. (2015) ‘DNA contamination minimisation – finding an

⁷⁵ The format for expert and non-expert technical reports is set out in Forensic Science Regulator Expert Report Guidance FSR-G-200 and Forensic Science Regulator Non-expert Technical Statement Guidance FSR-G-225 respectively.

⁷⁶ Faculty of Forensic and Legal Medicine (2018b).

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15. Abbreviations

Abbreviation	Meaning
ABE	Achieving best evidence
ASET (UKAFN)	Advanced standards in education and training
CJS	Criminal justice system
COP	College of Policing
CPS	Crown Prosecution Service
CW	Crisis worker
DNA	Deoxyribonucleic acid

Abbreviation	Meaning
ED	Emergency department
EEK	Early evidence kit
EM	Environmental monitoring
FFLM	Faculty of Forensic and Legal Medicine
FSR	Forensic Science Regulator
GMC	General Medical Council
HCPC	Health and Care Professions Council
ICIDP	Initial Crime Investigators Development Programme
ISO	International Organization for Standardization
ISVA	Independent sexual violence adviser
MedExD	Medical Examiners Elimination Database
NMC	Nursing and Midwifery Council
PAS	Publicly available specification
PPE	Personal protective equipment
QMS	Quality management system
RCPCH	Royal College of Paediatrics and Child Health
SARC	Sexual assault referral centre
SOP	Standard operating procedure
STI	Sexually transmitted infection
STO	Specialist trained officer
STODP	Specialist Trained Officer Development Programme
UKAFN	United Kingdom Association of Forensic Nurses and Paramedics
UKAS	United Kingdom Accreditation Service

Abbreviation	Meaning
UKSC	United Kingdom Supreme Court

16. Glossary

Accredit(ation): Procedure by which an authoritative body gives formal recognition that a body or person is competent to carry out specific tasks. [\[Back\]](#)

Chain of custody: Chronological documentation of the movement and location of items, from seizure until presented to court. [\[Back\]](#)

Child(ren): A child is anyone who has not yet reached their 18th birthday. [\[Back\]](#)

Competency: The ability of an individual to do a job properly. [\[Back\]](#)

Complainant: A person who makes a complaint or allegation of having been the victim of a criminal offence. See Patient. [\[Back\]](#)

Consumables: Single-use commodities used in the collection, preservation and processing of material for forensic analysis. [\[Back\]](#)

Crisis Worker: A dedicated support worker whose role is to provide immediate information, advice and advocacy to a patient of sexual violence prior to and throughout a forensic medical examination. [\[Back\]](#)

Critical Conclusions Check: another suitably qualified and competent healthcare practitioner scrutinises the report to ensure that (i) the report is internally consistent, (ii) the conclusions drawn are justifiable from the information set out in the report and (iii) the report is capable of being understood without reference to other material. See Peer Review. [\[Back\]](#)

DNA Clean Area: Area in which appropriate DNA contamination prevention measures shall be maintained at all times. [\[Back\]](#)

DNA Contamination: The introduction of DNA, or biological material containing DNA, to an exhibit, or subsample derived from an exhibit during or after its

recovery from the scene of crime or a person. In the context of the facility this could occur for any or all of the following reasons (not an exhaustive list).

- a. Poor practice⁷⁷ employed by staff using fixtures and fittings and/or collecting forensic samples.
- b. DNA contamination from anybody who has had access to the forensic waiting room and/or the medical examination room. Here key risk groups are people from whom elimination DNA profiles have not been taken and included in an elimination database, and therefore may be inadvertently associated with a crime rather than being identified as contamination. These may include visitors, contractors and people accompanying a patient into the forensic waiting room and/or the medical examination room.
- c. Insufficient use of cleaning regimes, or ineffective cleaning reagents used, as part of either cleaning DNA clean controlled areas or a subsequent deep clean.
- d. Residual DNA from the manufacture/maintenance of fixtures and fittings that have not been deep cleaned. [\[Back\]](#)

Early Evidence Kit (EEK): A dedicated kit used to collect forensic samples that are affected by both time and activities undertaken by a patient post-assault.

[\[Back\]](#)

Elimination Database: Collection of DNA profiles held in a searchable format from staff whose access/role/activities are deemed to be a potential DNA contamination risk. This may include not just the staff working within a specific facility, but also profiles from visitors to the facility, staff of manufacturers supplying consumables for DNA processing, and unsourced contamination profiles. The profiles are used to identify instances of inadvertent contamination.

[\[Back\]](#)

⁷⁷ It should be noted that even good practice does not eliminate the risk of contamination, it only helps to minimise it.

Environmental Monitoring (EM): A sampling and analytical (DNA) process for equipment, furniture and work areas that both monitors and audits the cleaning procedures and decontamination methods applied within the facility. [\[Back\]](#)

Evidence: Facts, information and samples taken to support or contradict an assertion. It also includes the absence or presence of injuries (fresh and healing), scars, and elements of the history pertaining to and provided by the patient. [\[Back\]](#)

Examination: Activity or process of observing, searching, detecting, recording, prioritising, collecting, analysing, measuring, comparing and/or interpreting. [\[Back\]](#)

Facility: The physical environment used for any medical examination and sample collection, which in part is a forensic unit. [\[Back\]](#)

Finding: Information obtained from an investigation or examination. [\[Back\]](#)

Forensic: Scientific methods, techniques and processes used to aid an investigation into a crime. [\[Back\]](#)

Forensic DNA Grade: Consumables that are compliant with the requirements set out in ISO 18385:2016 Minimizing the risk of human DNA contamination in products used to collect, store and analyse biological material for forensic purposes. [\[Back\]](#)

Forensic Healthcare Practitioner: The term is used to describe forensic physicians (both doctors and paediatricians), forensic nurses, forensic midwives and paramedics. [\[Back\]](#)

Forensic Medical Examination: Activity or process of observing, assessing, prioritising, recording, collecting samples for scientific analysis, documenting injuries and interpreting with reference to sexual assault offences. [\[Back\]](#)

Forensic Process: The joining up and interaction of various forensic plans or activities.

Forensic Science Provider: An organisation that undertakes any part of the evidence recovery, analytical process and interpretation on behalf of the police

or other criminal justice system customers. Police evidence recovery laboratories are also included. [\[Back\]](#)

Forensic Unit: A forensic unit is a legal entity or a defined part of a legal entity that performs any part of the forensic science process. [SOURCE: ILAC-G19:08/2014 Modules in a Forensic Science Process] [\[Back\]](#)

Gross Contamination: Is the transfer of DNA from a single person where a partial or complete DNA profile (these alleles are 'dependent') is obtained as a result of a single contamination event and the donor could be identified.

The term is also used in environmental monitoring (EM) sampling where a profile from multiple persons from an unidentified number of events is obtained and the donors cannot be identified. [\[Back\]](#)

Item: Object, substance or material that is collected or sampled as part of the forensic process. [\[Back\]](#)

Non-Police-Referral: The term used to describe a patient who has not reported a sexual offence to the police and is referred to support services, including a forensic medical examination, by professionals, for example, doctors, counsellors, independent sexual violence advisers (ISVAs). [\[Back\]](#)

Patient: In the context of this document, a patient is an individual subjected to or suspected of being subjected to sexual assault. [\[Back\]](#)

Peer Review: Evaluation of the work of other competent practitioners in the same field to assess that there is sufficient basis for the conclusions and/or opinions, and the implications for the disclosure of unused material in criminal investigations. See Critical Conclusions Check. [\[Back\]](#)

Personal Protective Equipment (PPE): Items, for example, clothing and gloves, which are used to prevent skin and mucous membrane exposure when in contact with blood and body fluid on or from any patient. PPE is also worn to protect the practitioner from contact with harmful chemicals, for example, during decontamination and to minimise the chance that the wearer causes inadvertent DNA contamination. [\[Back\]](#)

Police-Referral: The term frequently used to describe a patient who has reported a sexual offence to the police and is seeking/offered additional support services including a forensic medical examination. [\[Back\]](#)

Quality Management System (QMS): A management system to direct and control an organisation with regard to quality. [\[Back\]](#)

Report: Communication method of the forensic findings. These include but are not limited to:

- a. streamlined forensic reports (SFRs);
- b. section 9 statements (Criminal Justice Act 1967);
- c. interim reports. [\[Back\]](#)

Self-Referral: The term frequently used to describe a patient who has not reported a sexual offence to the police or other professional and is seeking/accessing support services including forensic medical examination.

[\[Back\]](#)

Standard: A standard is an agreed way of doing something that is to a level of quality or attainment. [\[Back\]](#)

Statement: A statement is one form of a report. It is formatted to comply with the provisions of s9 Criminal Justice Act 1967. [\[Back\]](#)

17. Annex A: Guidance On The Professional Roles Associated With The Facility

17.1 Professional Providing Service Within the Facility

Crisis worker (however named)

- 17.1.1 The primary role of the crisis worker (CW) (or professional fulfilling the role, such as a paediatric nurse) is to provide immediate support to the patient and significant others where relevant (for example, family members where the patient is a child) prior to and throughout the examination process.
- 17.1.2 The CW acts as an advocate for the patient, providing information to the patient to enable them to make informed choices about what will happen to them at the facility.
- 17.1.3 The CW may be required to assist in the recovery of forensic science related evidence by:
- a. advising and providing the early evidence kit (EEK) where appropriate;
 - b. recovering clothing from patients; and
 - c. assisting with the packaging and labelling of forensic samples collected.
- 17.1.4 The CW may be involved in the cleaning of those areas of the facility where the collection of forensic samples is undertaken.
- 17.1.5 The CW shall be competent to:
- a. provide information and initial crisis support to the patient (and/or their significant others);
 - b. communicate and engage with the patient (and/or their significant others);
 - c. advocate on behalf of the patient (and/or their significant others);
 - d. carry out an initial assessment to identify the needs of and risks to the patient of sexual violence;
 - e. provide and give guidance on the use of the EEK;
 - f. assist in the collection and labelling of forensic samples (if appropriate); and
 - g. clean the medical examination and DNA clean areas of the facility to the accepted standard (if appropriate).

- 17.1.6 Organisations employing CWs shall ensure that the CW is trained to an appropriate standard that is maintained in order to meet the competencies to undertake the role. Such training shall include the following role and responsibilities (to include boundaries and safe practice):
- a. communicating and working effectively with the patient and third parties;
 - b. assessing need, risk and safety;
 - c. providing advocacy on behalf of the patient;
 - d. having a general forensic awareness, including an overview of the forensic medical examination;
 - e. giving guidance on how to use the EEK;
 - f. assisting with the collection, packaging and storage of forensic samples;
 - g. cleaning the forensic areas of the facility.
- 17.1.7 Competency assessment shall take place after training, followed by ongoing assessment through regular clinical and management supervision. The organisation shall ensure that the CW accesses and undertakes continuous professional development.

Forensic Nurses, Midwives and Paramedics

- 17.1.8 The Nursing and Midwifery Council (NMC) sets the general professional standards for nurses working in the UK. The Health and Care Professions Council (HCPC) sets out the general standards for paramedics working in the UK. For the individual nurse providing care, the NMC is clear that the nurse shall recognise and work within their competence.⁷⁸ The HCPC also includes that healthcare professionals should recognise and work within their competence.⁷⁹
- 17.1.9 Healthcare professionals who work in a forensic setting undertake various roles, therefore competencies will vary depending on the role undertaken. For example, some nurses will be purely supportive, others will be performing forensic examinations independently, thereby working at an advanced level as

⁷⁸ Nursing and Midwifery Council (2015).

⁷⁹ Health and Care Professions Council (2016).

defined by the Department of Health,⁸⁰ NMC⁸¹ and the Royal College of Nursing⁸².

- 17.1.10 Nurses (including midwives) and/or paramedics who undertake forensic medical examinations independently shall hold relevant qualifications and competence to meet the requisite standard of practice. This includes the expectations of what the forensic nurses/midwives/paramedics should achieve in relation to training, mentoring and supervision, and accesses and undertakes continuous professional development.
- 17.1.11 The Faculty of Forensic and Legal Medicine (FFLM) provides advice for obtaining qualifications in clinical forensic medicine,⁸³ and quality standards for nurses of patients who have been subjected to sexual offences.⁸⁴ The United Kingdom Association of Forensic Nurses (UKAFN)⁸⁵ has developed advanced standards in education and training for nurses in the sexual assault setting.

Forensic physician

- 17.1.12 The General Medical Council (GMC) sets the competencies for doctors working in the UK. For the individual doctor providing care, the GMC is clear that the doctor shall recognise and work within the limits of their competence.⁸⁶
- 17.1.13 The forensic physician provides the medical and forensic examination for the patient. The FFLM has provided advice on qualifications⁸⁷ and the forensic physician shall be trained to an appropriate standard to ensure that they are able to meet the competencies to undertake the role to conduct a medical and forensic examination. Forensic physicians should meet the quality standards in forensic medicine⁸⁸ set out by the FFLM in relation to training, mentoring and

⁸⁰ Department of Health (2010).

⁸¹ Nursing and Midwifery Council (2005).

⁸² Royal College of Nursing (2018) Standards for Advanced Level Nursing Practice.

⁸³ Faculty of Forensic and Legal Medicine (2018c).

⁸⁴ Faculty of Forensic and Legal Medicine (2019).

⁸⁵ UK Association of Forensic Nurses (2018). Course details are available at: <http://ukafn.org/aset/>

⁸⁶ General Medical Council (2013).

⁸⁷ Faculty of Forensic and Legal Medicine (2018c).

⁸⁸ Faculty of Forensic and Legal Medicine (2016a).

supervision, and accesses and undertakes continuous professional development.

Paediatrician

- 17.1.14 The role of the paediatrician is to provide for a child patient either:
- a. the medical element of a forensic medical examination, which will include a comprehensive assessment of the physical and emotional development of the child or young person; or
 - b. both the medical and forensic elements of the forensic medical examination, which will also include a comprehensive assessment of the physical and emotional development of the child or young person.
- 17.1.15 The role of the paediatrician in the forensic examination of a child patient will depend upon the competency of the paediatrician. The FFLM and the Royal College of Paediatrics and Child Health (RCPCH) Guidelines on Paediatric Forensic Examination in Relation to Possible Child Sexual Abuse⁸⁹ states:
- “A single doctor examination may take place provided the doctor concerned has the necessary knowledge, skills and experience for the particular case. When a single doctor does not have all the necessary knowledge, skills and experience for a particular paediatric forensic examination two doctors with complementary skills should conduct a joint examination. Usually such examinations involve a paediatrician and a forensic medical practitioner. However, it may be necessary to involve another medical professional such as a genito-urinary physician or family planning doctor, if the case demands it.”
- 17.1.16 Paediatricians should meet the quality standards in forensic medicine⁹⁰ set out by the FFLM in relation to training, mentoring and supervision, and have access to and undertakes continuous professional development. The RCPCH has guidance regarding numbers of examinations and maintenance of competence.⁹¹ The RCPCH and the FFLM have produced a service

⁸⁹ Faculty of Forensic and Legal Medicine and Royal College of Paediatrics and Child Health (2012).

⁹⁰ Faculty of Forensic and Legal Medicine (2016a).

⁹¹ Royal College of Paediatrics and Child Health (2017).

specification for the clinical evaluation of children and young people who may have been sexually abused.⁹²

Cleaner Specialising in DNA Decontamination

- 17.1.17 A person with responsibility for the decontamination cleaning of the forensic areas of the facility. The cleaner shall be deemed competent to:
- a. conduct the DNA decontamination cleaning to the required standard as defined in section 9.5 of this guidance; and
 - b. utilise the cleaning agents in a manner compliant with relevant health and safety requirements.

- 17.1.18 The decontamination cleaner shall be trained to an appropriate standard to ensure that they are able to meet the competencies to undertake the role. Such training shall include the following in relation to cleaning:
- a. instruction and practical demonstration in the effective use of cleaning reagents, cleaning equipment and personal protective equipment (PPE) (barrier clothing);
 - b. instruction and practical demonstration in effective cleaning techniques to remove any potential contamination within the facility;
 - c. a basic understanding of the scientific principles for DNA decontamination procedures;
 - d. maintenance and accurate recording of the cleaning logs; and
 - e. environmental sampling if appropriate.

Person with Responsibility for Quality Management (ISO 15189 4.1.2.7)

- 17.1.19 The named person with overall responsibility for ensuring the facility's compliance shall establish, implement and maintain an appropriate quality management system, in conformity with ISO 15189:2012.
- 17.1.20 The named person and those who undertake these tasks shall be competent in:
- a. implementing and maintaining a quality management system;

⁹² RCPCH and FFLM (2015).

- b. reporting on the functioning and effectiveness of the quality management system; and
- c. co-ordinating awareness of the needs and requirements of users.

17.1.21 These personnel shall be trained to an appropriate standard to ensure that they are able to meet the competencies to undertake the role. Such training shall include the following:

- a. a comprehensive understanding of the essential elements and functionality of a quality management system;
- b. how to implement a quality management system and ensure that it is properly maintained;
- c. an understanding of the staff roles and responsibilities required for the effective operation of the quality management system; and
- d. auditing the quality management system.

17.2 Professional Providing Initial Contact/First Response Internal and External

17.2.1 The first professional responding to a phone call or personal contact from the patient, for example:

- a. staff at the facility;
- b. the police;
- c. a social worker, if the patient is a child or young person;
- d. health professionals (such as GPs, emergency department [ED] staff, sexual health staff); and
- e. staff at another agency, such as rape support services.

17.2.2 The first professional at the facility shall be competent to:

- a. provide relevant information and immediate support to the patient (and/or their significant others);
- b. communicate and engage with the patient (and/or their significant others);
- c. carry out an initial assessment to identify the immediate needs of and risks to the patient; and

- d. provide information regarding the preservation and prevention of loss of forensic science related evidence until the patient receives appropriate practical support.

17.2.3 The professional providing initial contact/first response shall be trained to an appropriate standard to ensure that they are able to meet the competencies to provide initial response to patients. Such training shall include the following:

- a. communicating and working effectively with the patient and third parties, including assessing age, disability, language;
- b. assessing the patient's immediate needs, risk and safety, including emergency medical provision;
- c. having a general forensic awareness, including forensic science related evidence preservation, for example, not laundering clothes, urine samples if an early evidence kit (EEK) is not immediately available; and
- d. being aware of the options available to patients for forensic medical examination, including timescales and police/self-referrals.

17.3 Police Personnel

First Response Police Officer

17.3.1 The first response police officer is the professional who responds to the patient following the response from the call handler/initial contact person. The first response police officer shall be competent to:

- a. provide information and support to the patient (and/or their significant others);
- b. communicate and engage with the patient (and/or their significant others);
- c. carry out an initial assessment to identify the immediate needs of and risks to the patient;
- d. provide information regarding the preservation and prevention of loss of forensic science related evidence;
- e. provide an overview of the forensic medical examination; and
- f. gather initial forensic science related evidence, including the EEK and clothing.

17.3.2 The first response police officer shall be trained to an appropriate standard to ensure that they are able to meet the competencies to provide an appropriate initial response to patients. Such training shall include the following:

- a. developing communication skills to work effectively with the patient and third parties, including assessing age, disability, language;
- b. how to assess the patient's immediate needs, risk and safety, including emergency medical provision;
- c. how to use the EEK;
- d. how to preserve, package and label forensic samples;
- e. being aware of the options available to patients for forensic medical examination, including timescales; and
- f. having an overview of the forensic medical examination.

Specialist Trained Officer

17.3.3 The specialist trained officer (STO) is the police officer who takes responsibility for the patient following the first response police officer or call handler/initial contact response, in the event that a first response police officer has not been dispatched. The STO shall be competent to:

- a. provide information and initial crisis support to the patient (and/or their significant others);
- b. communicate and engage with the patient (and/or their significant others);
- c. carry out an initial assessment to identify the needs of and risks to the patient;
- d. assist in the collection and labelling of forensic samples;
- e. provide information regarding the preservation and prevention of loss of forensic science related evidence;
- f. provide an overview of the forensic medical examination; and
- g. gather initial forensic science related evidence, including from the EEK, and clothing.

17.3.4 The STO shall be trained to an appropriate standard to ensure that they are able to meet the competencies to undertake the role. Such training shall include the following in relation to the forensic medical examination:

- a. the STO's role and responsibilities;
- b. communication and working effectively with the patient and third parties;
- c. assessment of need, risk and safety;
- d. general forensic awareness including an overview of the forensic medical examination;
- e. use of the EEK;
- f. assisting with the collection, packaging and storage of forensic samples;
- g. preserving, packaging and labelling forensic samples; and
- h. the options available to patients for forensic medical examination, including timescales.

17.3.5 The STO Development Programme (STODP) developed by the College of Policing (COP) is an example of good practice in relation to training STOs.

Investigation Officer

17.3.6 The investigation officer is a detective at detective constable (DC) or detective sergeant (DS) level who has competencies in:

- a. forensic knowledge;
- b. strategy setting in relation to sexual offences; and
- c. management and practical knowledge of the forensic science related evidence collection at a scene and subsequent forensic medical examination.

17.3.7 The investigation officer may be part of a joint investigation team or a member of a dedicated team dealing with adult sexual offences and or child protection cases. In terms of training the investigation officer, the Initial Crime Investigators Development Programme (ICIDP) as defined by the COP is recommended as good practice. The investigation officer shall be competent to:

- a. conduct an evaluation of the material gathered during the initial response to develop an investigation strategy;
- b. ensure that the material is retained and recorded in line with current legislation and policy;

- c. develop and maintain investigative strategies, identifying and prioritising lines of enquiry to maximise the gathering of forensic information that could assist with the forensic medical examination;
- d. deal with patients who have been subjected to sexual assault in an ethical and effective manner, recognising their needs with respect to race, diversity and human rights; and
- e. be trained to an appropriate standard to ensure that they are able to meet the competencies to undertake the role.

17.3.8 Such training shall include the following in relation to the forensic medical examination:

- a. ensuring the source and provenance of different types of potential forensic material recovered during the forensic medical examination and/or following the use of an EEK;
- b. ensuring the forensic medical examination is incorporated within any wider forensic strategy that is developed as part of the investigation;
- c. understanding the role and responsibilities of the STO, crisis worker, forensic healthcare practitioner, paediatrician, forensic authoriser and local forensic science provider;
- d. planning and communication with the appropriate staff at the sexual assault referral centre (SARC) regarding when and how possible forensic science related evidence may be retrieved from the patient, including contingencies where the care of the patient may affect forensic science related evidence recovery; and
- e. collating information about the forensic medical examination and retrieval of forensic science related evidence, including the security of forensic samples and any subsequent access to the samples.

Authority for Forensic Science Submission

17.3.9 This is a person with a crime scene, forensic science or investigative police background who has up-to-date knowledge in relation to forensic science, and associated evidence-based sampling time frames. This person shall understand forensic strategy setting and have knowledge of contractual forensic

arrangements with the forensic science provider(s). In respect of the forensic medical examination, this person shall be competent to:

- a. explore and identify all potential forensic opportunities from the evidence collected at the forensic medical examination and any samples obtained from the use of an EEK;
- b. formulate a forensic strategy in all sexual offence cases in order for the relevant samples to be collected at the forensic medical examination; and
- c. establish the facts from the witness accounts and consider the best items for forensic submission in consultation with the investigating officer and the forensic science provider.

17.3.10 The forensic submissions authoriser shall be trained to an appropriate standard to ensure that they are able to meet the competencies to undertake the role. Such training shall include the following in relation to the forensic medical examination:

- a. ensuring the source and provenance of different types of potential forensic material recovered during the forensic medical examination and/or following the use of an EEK;
- b. ensuring the forensic medical examination is incorporated within any wider forensic strategy that is developed as part of the investigation;
- c. understanding the role and responsibilities of the STO, crisis worker, forensic healthcare practitioner, paediatrician, forensic authoriser and local forensic science provider;
- d. planning and communicating the forensic strategy requirements from the point of first submission to any subsequent phased submissions with the local forensic science provider; and
- e. having an understanding of the forensic science results in relation to sexual offences and the ability to challenge results where appropriate with the forensic science provider.

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