Forensic Science Regulator

Guidance: Forensic medical examination of sexual offence complainants

FSR-GUI-0020

Issue 1

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Contents

1. Background

1.1.1 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.

1.1.2 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.

1.1.3 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 examination 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 from:

a. wrongful conviction(s);
b. wrongful acquittal(s); or
c. obstructing or delaying investigation(s).

1.1.4 The medical and therapeutic needs of the patient may override the requirement to collect material with forensic relevance.

1.1.5 Whilst the need to provide high-quality medical care is of primary importance, it is essential that consideration is given to the requirements for achieving 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.

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

1.1.7 Safeguarding issues, safety plans specifically relating to children and vulnerable adults at risk, and social issues are very important. However, these fall outside the FSR's remit and are therefore not part of this guidance. This guidance covers the following areas as they relate to forensic medical examination of patients:

a. training and ongoing competence of personnel;
b. accommodation and environmental conditions;
c. equipment used for the examination;
d. examination process;
e. handling, storage, and transport of forensic samples;
f. the notes, other records (e.g. images, diagrams etc.), reports and the statement(s) generated;
g. quality management; and
h. continuous improvement, review, and audit.

1.1.8 This guidance 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 intimate and non-intimate 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, related to the alleged offence.

2. Scope

2.1.1 This guidance should be used to assist with meeting the requirements set out in the Forensic Science Regulator's Code [1], including section 102. The Code requires forensic units carrying out FSA – BIO 100, to achieve accreditation to the international standard ISO 15189:2022 Medical laboratories – Requirements for quality and competence [2], for the forensic medical examination services relating to alleged sexual assault, within 24 months from the Code coming into force.

2.1.2 The guidance is aimed at providers and forensic healthcare practitioners. The guidance was developed by multiple stakeholders and sets out good practice to be followed wherever possible to provide confidence through a consistent and quality service delivered across multiple providers.

2.1.3 The remit of the Forensic Science Regulator (FSR) 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 overlap.

2.1.4 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.

2.1.5 This guidance covers the facility where a forensic medical examination and the collection of evidence from a patient takes place. The patient may be referred by the police or present as a self-referral. The most frequently used type of facilities in England and Wales are known as sexual assault referral centres (SARCs). Other facilities exist within police premises, such as patient examination suites or sympathy suites, and within National Health Service premises. For the purpose of the Code, wherever they are located these facilities 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.

2.1.6 The use of ad hoc locations such as emergency departments and care homes are not included; however, contamination controls for the examination and recovery are expected.

2.1.7 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 samples or early evidence kits (EEKs) is included, as these may be used at the facility.

2.1.8 The figures in annex A, figure 1 (for adults) and figure 2 (for children), outline where the facility's practices and procedures occur within the patient's 'journey' from the incident to court. These figures identify where the various standards and guidance apply. Therapeutic interventions, such as medical evaluation and treatment, suicide risk and mental health assessments, and follow-up care are usually part of the service provision of the facility but are outside the scope of this guidance. These clinical aspects are quality assured in other ways within the clinical governance.

2.1.9 As a result of the commissioning and funding arrangements in England and Wales the forensic medical provider will, in many cases, be different to the provider of crisis workers, other professionals and core administrative personnel. This guidance applies to all personnel involved in performing and supporting the medical examination and managing the facility, regardless of the commissioning arrangements or funding structure.

3. Terms and definitions

3.1.1 The terms and definitions set out in the Code, including section 102, and the glossary section apply to this document. Those in ILAC G19:06/2022 [3] apply where there is no corresponding definition set out in the Code or guidance.

3.1.2 As in the Code, in this guidance forensic healthcare practitioner is used to refer to forensic physicians (e.g., paediatricians), forensic nurses, forensic midwives and paramedics. The term 'professional' is used to refer to other relevant roles such as crisis workers, and police investigators.

3.1.3 The word ‘shall’ has been used in this document where there is a corresponding requirement in the Code [1], ISO 15189:2022 [2] or ILAC G19:06/2022 [3]; the word ‘should’ has been used to indicate generally accepted practice where the reason for not complying, or any deviation, shall be recorded. 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 forensic healthcare practitioner’s control which affect whether or how guidance can be followed [4]. The word ‘may’ has been used for recommendations. Recommendations have been used to indicate what ideal practice is when it is practicable.

4. Structural and governance requirements

4.1 Legal entity (ISO 15189:2022, section 5.1)

4.1.1 The legal entity taking overall responsibility and accountability for quality at the facility shall be defined.

4.2 Organisation and management responsibility (ISO 15189:2022 sections 5.2 and 5.4)

4.2.1 The organisation and management responsibility of the facility shall be defined and documented. This could be through an organisation chart, which makes clear the lines of responsibility, clinical governance structures and legal responsibilities that cover all aspects of the services, including all personnel working therein.

4.2.2 The role and responsibilities for all personnel working within the facility shall be defined and documented to manage resources, training, competency, and service provision.

4.2.3 The facility manager shall have the competence, authority and responsibility for all aspects of the services provided.

4.3 Management system (ISO 15189:2022, section 5.4.2 and 8.1)

4.3.1 A management system, such as a quality management system, (QMS), which directs and controls the quality of services at the facility by all providers, shall be established, documented and maintained.

4.3.2 The management system shall include:

a. Responsibilities (see section 4.2)

b. Objectives and polices (see section 4.4)

c. Document control (see section 4.5)

d. Improvement and corrective action systems (see section 4.6)

e. Evaluation and audits (see section 4.7)

f. Management reviews (see section 4.8)

4.3.3 The facility shall have a member of personnel with responsibility for ensuring the QMS functions correctly.

4.4 Objectives and policies (ISO 15189:2022, sections 5.5, 8.2, 8.2.1)

4.4.1 The facility shall establish, document, and maintain objectives and policies, including quality objectives. Management system documents can be, but are not required to be, contained in a quality manual. Objectives and policies shall be established and maintained to:

a. meet the needs and requirements of its patients and users;
b. commit to good professional practice;
c. provide examinations that fulfil their intended purpose; and
d. comply with the standards and good practice to which the facility operates.

4.5 Control of management system documents (ISO 15189:2022 sec 8.3, 7.3.6, Code sec 42)

4.5.1 The facility shall control the documents that relate to fulfilment of the services provided. These documents may be policies, procedures, instructions, and

relevant forms and sit below the quality manual in the hierarchy of required documentation. Controlled documents may include:

a. Policies that document the intentions and direction of the facility, as formally expressed by its senior management.
b. Standard Operating Procedures (SOPs) that outline the practical way to translate the policies into action.
c. Day-to-day work instructions which 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 which provide evidence that a procedure and/or related instructions have been carried out.

4.5.2 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.

4.6 Continual improvement process (ISO 15189:2022, sec 8.5, 8.6, 8.7)

4.6.1 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.

4.6.2 Corrective, preventative and improvement actions may be identified though evaluation and audits, trials and customer feedback, peer review and checking of outputs, self-assessment (see annex B) and suggestions from personnel.

4.6.3 Regardless of how the action was identified, all shall be documented into an improvement, corrective, or preventative process for subsequent assessment and action.

4.6.4 Improvement and preventative actions shall be classified and prioritised on the basis of a risk assessment and those taken forward allocated to an appropriate owner to be resolved by an agreed target date and included as part of the management review.

4.6.5 Non-conformities (non fulifilment of a requirement) shall be responded to and action taken to control and correct the non-conformity. The facility shall determine the cause(s) of the non-conformity and evaluate the need for corrective action to reduce the likelihood of recurrence.

4.6.6 Non-conformities shall be brought to the attention of the appropriate facility manager and records kept, including the actions taken and the effectiveness of any corrective action.

4.6.7 Following investigation, the issue could require escalation to the Forensic Science Regulator; examples are provided in section 23.1.4 of the Code. Concerns about quality issues can also be raised using the anonymous reporting tool, details can be found at https://forms.theiline.co.uk/forensic-science-regulator%E2%80%99s-anonymous-reporting-line.

4.7 Evaluation and audits (ISO 15189:2022, sec 5.5(d), 8.6, 8.8)

4.7.1 The facility shall have an ongoing audit programme. The audit programme cycle should include:

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

4.7.2 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 forensic healthcare practitioners are up to date with their training and competency records.
b. External independent assessment by auditors from other facilities or by UKAS are carried out if, for example, the facility is seeking accreditation or is accredited to ISO 15189:2022.

4.7.3 Audits provide an important mechanism for detecting and investigating quality issues or non-conformities a mechanism for continuous improvement and provide a major input into the management review.

4.8 Management review (ISO 15189:2022, sec 8.9)

4.8.1 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 forensic healthcare practitioners.

4.8.2 As a minimum the management review should be conducted annually. However, initially these should be undertaken more frequently as the review process beds in and the frequency becomes appropriate to the maturity of the quality management system. Inputs to the review shall include the following:

a. Actions from previous reviews;
b. Fulilment of objectives and suitability of policies and procedures, such as post-implementation review of changes to procedures and practice;
c. Assessments of evaluations and audits. These may include reports of assessments of outside bodies, internal audits of the quality management system and of the examination procedures;
d. Patient survey, complaints, or feedback.
e. Quality assurance;
f. A review of the status and effectiveness of preventative, corrective and improvement actions;
g. Performance of any external providers;
h. Review of activites carried out at the facility, including any inter-facility comparison programmes and point of care testing;
i. Other relevant factors such as significant changes in organisation and management, personnel (including the induction of new personnels) and other resources or processes; and new quality incidents (i.e., occasions where a mistake has occurred, or quality procedures have not been adhered to).

4.8.3 A report of the management review shall be generated that includes the following:

a. The effectiveness of the management system and its processes - a summary of the successes and failures since the last review and future quality objectives and priorities;
b. Improvement actions and provision of required resources - 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. training and competency; and
    vi. financial requirements.

4.8.4 Conclusions and actions from the management review should be readily available (in electronic or paper form) and shall be shared with forensic healthcare practitioners within the facility.

5. Technical requirements

5.1 Personnel: training and competence (ISO 15189:2022 sec 6.2, 6.7; ILAC G19 sec 3.3)

5.1.1 The facitility shall ensure that all personnel working within the facility, both internal and external are competent to perform the activies they are responsible for providing. This requires:

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.

5.1.2 The facility shall ensure that competence is documented and maintained and provide access to continuing professional development.

5.1.3 The guidance and requirements apply to all personnel working and/or providing services (ISO 15189, section 6.7) within the facility. Information and guidance

for practitioner and professional roles and others is provided in annex C of this guidance.

5.1.4 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.

5.2 Accommodation and environmental conditions (ISO 15189:2022 sec 6.3; ILAC G19 sec 3.11)

General

5.2.1 Accommodation at the facility shall meet the needs of all its end users (the Code, sec 102.5.3). It should be accessible to the community it serves with policies and procedures in place to ensure security for the service users and personnel. For example, consideration should be given to the style of decor and availability of toys where the facility is being accessed by child patients.

5.2.2 The Department of Health and Social Care has published Building Notes (HBN Series) [5] which 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 (Building Note 12 [6]);

b. sexual and reproductive health clinics (Building Note 12-01 [7]);

c. sanitary bathroom (Building Note 00-02 [8]);

d. sterile environments (Building Note 13 [9]); and

e. hospital accommodation for children (Building Note 23 [10]).

5.2.3 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

5.2.4 There should be an entrance for access to the facility by the patient and their companions which is separate to public traffic.

5.2.5 As required by the Code, section 102.5.5, 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.

5.2.6 The layout of the rooms and corridors should enable the workflow to progress through the SARC in one direction, to minimise cross contamination and control designated DNA clean rooms or areas.

5.2.7 The forensic area of the facility should include the following:

a. A pre-examination waiting room which 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. Patients and visitors should change into PPE in the waiting room if the designated gowning up room is adjoining the medical examination room and/or is used to store consumables and PPE.

b. A dedicated forensic medical examination room which, as required by the Code (section 102.5.6) shall be a designated DNA clean area – this is where the forensic medical examination will take place and forensic samples are collected. The room should have access to the bathroom/toilet facility directly and/or via a corridor;

c. A dedicated bathroom/toilet facility, where early evidence collection can be conducted. An area where the patient can shower post-examination should be provided which may be within this dedicated bathroom or located elsewhere within the facility. If the bathroom is linked to the medical examination room, the bathroom is also considered to be a DNA clean area for cleaning and environmental monitoring (EM) purposes. Further requirements on Environmental Monitoring can be found in FSR-GUI-0017, section 6.4; and

d. A dedicated gowning up area for putting on PPE that should be seperate from the area where examinations are undertaken, ideally a separate lobby or room. Only forensic healthcare practitioners should use this area for putting on PPE if adjoins the medical examination room.

Structure

5.2.8 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 (e.g. crisis worker, paediatrician, forensic medical clinician, interpreter, companion, trainee forensic healthcare practitioner).

5.2.9 Further requirements for forensic medical facilities can be found in the FSR's guidance document on DNA contamination controls – forensic medical examinations, FSR-GUI-0017.

Environment, furnishings and equipment

5.2.10 The facility shall ensure that the examinations rooms are appropriate for the examinations undertaken (the Code, section 29.1.2). Controls shall be in place to prevent adverse influences on examinations, such as from contamination, cross contamination, or poor functionality including use of:

a. Workbench surfaces, storage cupboards, seating and examination couches that are easy to clean and resistant to disinfectants and cleaning reagents;
b. Flooring in areas where a patient undresses and where they are then subsequently forensically examined, should be is impervious to any liquid substance (i.e., water and/or bodily fluid) with any joins in the floor sealed;
c. Computer keyboards, specialist medical video cameras and equipment controlsthat are easily cleanable or protected by removable flexible covers that can be cleaned or replaced (for example, keyboard, specialist medical

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

d. A disposable curtain which shields the examination couch. The frequency of curtain replacement will depend on the number of forensic medical examinations conducted in the room and 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 should be replaced immediately. A record of the date and reason for changing the curtain should be kept;
e. A designated hand-wash basin within the room where the patient is being examined with taps that can be operated without being touched by hand;
f. A medical examination couch with height and position adjustments to allow for ease of movement. The couch should have disposable covering, which is changed between each examination;
g. Wipable wall clocks, height charts and weighing scales;
h. A specialist medical video-camera for all child examinations and for adults as appropriate to record relevant injuries and findings;
i. An approved sharps box and clinical and domestic waste receptacles, with appropriate disposal provisions arranged;
j. Equipment to enable photo documentation for general injuries and/or general observations.

5.2.11 The areas of the facility (the pre-examination waiting area, examination room and the dedicated bathroom/toilet facility) shall always be secure and access controlled (the Code section 102.5.6) and entry into and exit from the forensic medical examination room shall be recorded including the date, time and name, activity/role (the Code, section 102.5.4).

DNA decontamination

5.2.12 Cleanliness of the forensic medical 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. Further requirements for DNA contamination can be found in the FSR's guidance document on DNA contamination controls – forensic medical examinations, FSR-GUI-0017.

Exhibit packaging

5.2.13 Exhibit packaging is required to preserve material recovered for subsequent forensic testing or analysis. 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;
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 as recommended by the FFLM [11].

5.2.14 The packaging of all items should be labelled so that it allows for the chain of custody to be tracked. As a minimum, labelling should include:

a. A unique identifier (for example, barcode or a combination of date/case number/operator/consecutive numbering);
b. Description of the item;
c. The name of the person and/or location from which the item was collected;
d. The date, and time when critical, (see FFLM recommendations on Collection of Specimens [11]) that the item was collected; and
e. The name or identifier of the person who collected the item.

5.3 Examination methods and procedures (ISO 15189:2022 sec 6.2.1b, 6.7.1 7.2.2, 7.3)

General principles

5.3.1 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 (see section 5.1.1).

5.3.2 Forensic healthcare practitioners should have a clear understanding of the different ways that patients who have been subjected to sexual assault may behave following an assault. Forensic healthcare practitioners shall act impartially and ethically, and a non-judgemental approach should be adopted in every case.

5.3.3 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, forensic healthcare practitioners should adopt a trauma informed approach when providing advice and care to patients. The patient shall be provided with information about the self-referral route that could allow them to decide to report an assault at a later date.

5.3.4 It is an important principle that acute medical needs take precedence over evidential needs. Therefore, the initial response to acute injury, the need for trauma care, and the safety needs of the patient will take priority over the collection of material for subsequent forensic testing or analysis.

5.3.5 While the time frame of the assault will be an important factor in determining whether a forensic medical examination should take place, each case should be properly considered, with the needs of the patient being the paramount consideration.

5.3.6 It is common for patients who have been subjected to sexual assault to have showered, eaten or taken other self-protective actions prior to engaging with the facility, which may affect the recovery of forensic material. No judgement should be made regarding these activities and the actions taken by the patient should

be recorded on the forensic medical examination paperwork (see section 5.5 in this guidance for more details).

5.3.7 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 and they may be uncomfortable discussing personal matters. The information-gathering process should be as respectful to the patients as possible and minimise repetition of questions relating to the assault.

5.3.8 It is important to note that the forensic medical examination should be a thorough process which can take a considerable length of time as dictated by the needs of the patient. All forensic opportunities should be considered, not just DNA, for example documenting any injuries noted.

Prior to the patient's arrival at the facility – initial contact

5.3.9 It is important that forensic healthcare practitioners 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 (the Code, section 102.6.1).

5.3.10 Where possible the facility should seek to work in partnership with other relevant services (such as the police, social workers, health professionals and other support organisations). The Code (section 102.6.2) requires that the patient shall be provided with accurate information about the facility. This may include:

a. the services that can be provided at the facility; and
b. the importance of the recovery of material for subsequent forensic testing or analysis if they provide the initial contact/first response to the patients.

5.3.11 As required by the Code, section 102.6.3, forensic medical practitioners 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 material with forensic relevance .

5.3.12 As required by the Code section 102.6.3 in relation to the collection of forensic samples, the forensic healthcare practitioners providing the initial contact/first response to the patient shall be able to sensitively and without judgement, explain the impact activities taken after the incident may have had on the collection of forensic material. These activities may include:

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

5.3.13 In particular where the patient reports vaginal or anal assault, samples shall be taken following documented procedures (the Code, sec 102.6.1) and in accordance with the FFLM guidance [11]. Where the assault is suspected of being drug/alcohol facilitated, then an appropriate urine, blood or hair sample should be taken from the patient. 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 should explain to the patient how they could collect a sample of their urine in a clean receptacle. At the earliest opportunity, this sample should be transferred to the EEK collection vessel and date time of the original sampling and the transfer of the sample recorded.

5.3.14 The forensic healthcare practitioners 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

5.3.15 Forensic samples are only one consideration in deciding upon the merits of undertaking a forensic medical examination. Opportunities to recover other material with forensic relevance, such as the presence of injuries and their sequelae, as well as an evaluation of therapeutic issues for the patient should be considered. The time frames for conducting a forensic medical examination will vary on a case-by-case basis.

5.3.16 The decision to undertake a forensic medical examination shall be made by the forensic healthcare practitioner (the Code, sec 102.7.2). Therefore, the practitioner shall be consulted at the earliest opportunity where there is any question about whether a forensic medical examination is required immediately, or at all. 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 [12], the Recommendations for the Collection of Specimens from Complainants and Suspects [11], and the medical needs of the patient (for example, HIV post-exposure prophylaxis, emergency contraception).

5.3.17 Where children disclose sexual offences, or there is a concern that a sexual offence may have occurred, the need for, and timing of, a forensic medical examination could be particularly pertinent. It is not for the police officers/investigators and/or social workers to make decisions about whether children disclosing sexual abuse should be examined or at what time. In these circumstances the forensic healthcare practitioner and/or paediatrician should be involved in any strategy meetings and consulted for advice on the recovery

of material for subsequent forensic testing or analysis (the Code, section 102.7.3).

5.3.18 Where it is necessary for the patient to be taken to an emergency department from, or prior to reaching, 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 (the Code, section 102.7.4). Attending the hospital will depend on discussion with the responsible clinician consultant to avoid compromising the patient's care. It is generally accepted that in these circumstances forensic integrity may be compromised, however, the needs of the patient come before the gathering of material with forensic relevance [13]. In these cases forensic healthcare practitioners should work alongside other healthcare providers or provide advice to those who are treating the patient.

5.3.19 Any forensic samples shall be collected using recognised forensic sample kit modules. 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 (the Code, section 102.7.5).

Attendance of the forensic healthcare practitioner

5.3.20 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.

5.3.21 The provider of the forensic medical workforce should ensure that they are able to provide a timely response to reflect the clinical and forensic needs of patients, for example within two hours, or as agreed for a particular case FFLM [14].

5.3.22 Risks of cross-contamination should be considered by the attending forensic healthcare practitioner, see FSR-GUI-0017, section 6 for more details.

Arrival of the patient

5.3.23 On the patient's arrival at the facility, a crisis worker (CW) or equivalent should meet the patient (and their supporters). The CW should 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.

5.3.24 Patient supporters will not enter any of the DNA clean rooms unless accompanying the patient as per the patients wish, supports will be advised to wear PPE.

5.3.25 The CW should provide immediate support to the patient by explaining to them:

a. their role as a chaperone and 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, 5.3.11and how the CW will be present to support 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.

5.3.26 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.

5.3.27 Where a urine sample has not already been collected, the CW should ensure that a urine sample is collected where appropriate, using the FFLM [11] recommended urine collection kit.

5.4 Medical examination and evidence collection (ISO 15189:2022 7.2.2, 7.2.3, 7.2.4, 7.3; ILAC G19 4.3.3)

Preliminary matters

5.4.1 When the CW is satisfied that the patient is ready for the forensic medical examination to take place, the forensic healthcare practitioner will introduce themselves to the patient (and their family if the patient is a child), and shall explain what is proposed and check that they are willing to continue with the medical examination.

5.4.2 Where specialised equipment, such as a specialist medical video camera [15], [16] is to be used during the examination, this may need a more detailed explanation from the forensic healthcare practitioner, including its purpose and function and how it will be used during the examination.

5.4.3 In order to obtain consent the forensic healthcare practitioner shall provide the appropriate information to the patient explaining 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

5.4.4 The forensic healthcare practitioner shall obtain informed consent [17] from the patient for the examination, including:

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) retaining and storing their samples, 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 [18]; and
h. (For self-referrals who do not want to progress to a police complaint) permission to process samples anonymously (if available) before sample destruction.

5.4.5 The patient should understand the purpose of the examination and be able to give consent freely.

5.4.6 The patient should be aware that they have 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, this should be recorded along with any reasons given.

5.4.7 Guidance and requirements for obtaining consent are provided by the FFLM [13], the General Medical Council (GMC) [19], the Nursing and Midwifery Council (NMC) [20], and the Health and Care Professions Council (HCPC) [21], in accordance with the Mental Capacity Act 2005 [22].

5.4.8 It is the responsibility of the forensic healthcare practitioner to seek informed consent from the patient. Where there is concern that a patient, aged 16 years or older, may lack the capacity to consent, the Mental Capacity Act (2005) requires certain actions to be taken to support the patient. Ultimately any decisions made should be in the patient's best interests. Records of the decisions made shall be such that the basis of the decision can be reviewed by another competent healthcare practitioner (ILAC G19 sec 3.5).

5.4.9 Where the patient is a child, reference should be made to the GMC [23], the Royal College of Paediatrics and Child Health (RCPCH) [24] and the FFLM [25] guidance documents for obtaining valid consent. Consent for a forensic medical examination should be obtained from one of the following:

a. parents/carers with parental responsibility;
b. the child, if they are of sufficient age and understanding (as assessed by the forensic healthcare practitioner with advice from other professionals e.g., paediatricians);
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, and where applicable, from the Court of Protection.

First account

5.4.10 Where an adult patient has already reported the assault to the police, the forensic healthcare practitioner should 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 forensic healthcare practitioner will need to take the initial account.

5.4.11 If the patient is a child the initial account may be provided by a social worker or a police investigator.

5.4.12 The Police may need to collect information from the patient as part of their investigation. However, an Achieving Best Evidence (ABE) interview (or video recorded interview, VRI) should not take precedence where a timely forensic medical examination is required.

5.4.13 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 may not be appropriate with a young child or an adult or child with other vulnerabilities, such as learning difficulties.

5.4.14 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

5.4.15 The forensic healthcare practitioner (where appropriate) shall document relevant information (the Code, sec 102.6.1c) including taking 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 medical evidence. Where the patient is a child, a full paediatric history will be taken. This may be from a parent, caregiver or from the child themself – depending on the age and capacity of the child. In line with current practice, the child should be given the opportunity to talk to the forensic healthcare practitioner independently of carers.

5.4.16 Care should be taken to ensure that questions are pertinent to the purpose of the medical examination and any subsequent findings. The FFLM has produced

proforma which can be utilised to ensure that important information is routinely asked by forensic healthcare practitioners, FFLM [26] and paediatricians, FFLM [27].

5.4.17 The forensic healthcare practitioner should 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

5.4.18 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.
d. or is an adult at risk.

5.4.19 The circumstances of the case may also indicate wider safeguarding issues, e.g. risks to other children or vulnerable adults.

Addressing practical and emotional needs

5.4.20 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, addressing urgent or essential issues (for example, for the treatment of serious injuries, crisis intervention and support, translation, and interpretation) before commencing with the examination.

5.4.21 The facility shall have procedures in place for examination activities undertaken including the relevant skills for working with patients (the Code 102.6.1a), such as being 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.

5.4.22 Where interpreters are necessary, family members should not be used, and the gender preference of the patient should be taken into account. Where

interpreters are in attendance as opposed to online resources, they should be present prior to the patient arriving and there should be space for them in the examination room to interpret for the patient.

Record of attendees

5.4.23 As required by the Code, section 102.10.2, a record of all persons in attendance at any time during the forensic medical examination shall be made. The full 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 in the DNA clean controlled areas should be recorded. If an elimination sample wasn't taken at the time of attendance, then the contact details will allow for an elimination DNA sample to be requested at a later date for contamination elimination purposes. Please refer to section 7.6 inFSR-GUI-0017 for more details regarding DNA elimination samples.

Roles and responsibilities of those conducting the examination

5.4.24 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, their respective roles and responsibilities within the examination shall be documented (the Code section 102.8.1).

Removal of clothing (the Code, section 102.9)

5.4.25 If the patient attends wearing the clothing worn at the time of the incident, or soon afterwards, it may contain important evidence 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.

5.4.26 Where damage to clothing is detected, the forensic healthcare practitioner should 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 should not be cut through on removal of the clothing. This is particularly

important if the patient is receiving emergency medical treatment by other medical personnel such as in an emergency department.

5.4.27 The patient should be provided with a private area within the DNA clean area to remove their clothing, behind a curtain or screen.

5.4.28 Consideration should be given to the use of a disposable sheet, placed onto the floor to act as a barrier, to collect foreign material dislodged from clothing during undressing. Care should be taken to avoid any evidence transfer. The patient should be asked to remove footwear first and these should be individually packaged if they are likely to yield relevant evidence, for example, debris from an outdoor scene location.

5.4.29 The patient should be asked to remove clothes, one item at a time, trying to maintain the orientation that the garment was worn during removal. The patient should be asked to draw attention to any damage noted during undressing, as it may be appropriate to photograph this before the item is removed (for example, damaged tights).

5.4.30 The professional or forensic healthcare practitioner collecting and subsequently packaging the clothing should wear two pairs of gloves (doubled gloved) and hold an exhibit bag open for the patient to place the item inside. The outer gloves do not need to be changed unless the clothing is handled. Where the patient is a self-referral or a non-police-referral, the professional collecting the clothing may be a CW. Where the patient is a police-referral, the professional collecting the clothing could be a police investigator, sexual offence liaison officer (SOLO), or a CW or it may be a forensic healthcare practitioner.

5.4.31 No more than one item should be placed in each exhibit bag; for example, each sock or shoe should be packaged individually. However, if the patient brings a package of clothes that were worn at the time of the incident, then these may be packaged together to reduce handling.

5.4.32 The description of the clothing shall be documented (the Code, sec 35.2.8), and recorded on the exhibit label and on the forensic medical examination exhibit collection documentation, this should include any staining/soiling present. 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 should be frozen or dried with a minimum delay (see FSR-GUI-0016, sec 7).

5.5 The examination process (ISO 15189:2022 7.3; ILAC G19 4.7)

5.5.1 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 is carried out methodically to ensure that all relevant information relating to the assault is sought.

5.5.2 With regard to the collection of forensic samples, forensic healthcare practitioners, as part of the forensic medical examination, should 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).

5.5.3 There is a FFLM pro forma designed to assist forensic healthcare practitioners in the assessment of adult male and female patients [26]. The FFLM has also designed a similar form for children [27]. Organisations can use their own pro forma provided that it meets the FFLM content as the minimum requirement.

5.5.4 Where the patient is a child or young person the paediatric forensic medical examination should include a comprehensive assessment as described in the paedeatric proforma published by the FFLM [27]. 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 [28] and 2004 [29]. 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.

5.5.5 Forensic healthcare practitioners should seek to collect as much evidence (samples, injuries, trace evidence) from the patient as possible, guided by the scope of the informed consent.

5.5.6 The forensic healthcare practitioners should 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 occurred and relevant information shall be documented (the Code, sec 102.10.1). The location of injuries and the relationship between multiple injuries should be documented such as using body diagrams. The forensic healthcare practitioner should consider requesting photography of the injuries particularly where there may be detail in the injury that would assist the investigation, such as a footwear pattern within stamping or kicking injuries. There is an FFLM guidance document on photography [16].

5.6 Sample collection and handling (ISO 15189:2022 6.3.5, 7.2.3 - 7.2.7, 7.4.2; ILAC G19 4.3.3)

5.6.1 Collection of appropriate samples should have regard to the medical history and the first account of the assault. The FFLM has produced recommendations for the collection of samples [11]. While the FFLM recommendations for the ideal time frames within which to collect samples, it is important to note that sample collection will vary on a case-by-case basis.

5.6.2 Where the FFLM 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.

5.6.3 During the collection of the samples, the forensic healthcare practitioner shall take steps to minimise contamination(the Code section 102.12). For further information regarding contamination prevention see section 6 of FSR-GUI-0017.

5.6.4 The facility shall have clear procedures in place for packaging, labelling, and sealing items/exhibits since this is critical for their admissibility during criminal proceedings (the Code, section 35.2.3). Exhibit bags should be sealed at the open end using adhesive tape if self-seal bags are not utilised, before they are transported for storage either within the facility or at an agreed alternative storage facility.

5.6.5 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 [30]. This should be done at the first practical opportunity, and before items are stored. In the event that a CW, SOLO, 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 the samples are correctly labelled remains with the forensic healthcare practitioner.

5.6.6 Handling of the forensic samples shall be restricted to those persons necessary, who are involved and recorded in the chain of custody.

5.6.7 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 ‘moist’ and ‘dry’ and utilising the letters ‘A’ (for the first sample) and ‘B’ (for the second sample).

5.6.8 If required to use moistened swabs for sampling, then clean gloves should be worn to open the water ampoule and the initial drops of water discarded as a means to flush the nozzle before wetting the swab; if the nozzle makes contact with any contaminated surface then the water ampoule should be discarded.

5.6.9 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

5.6.10 Where the patient has reported the assault to the police, it should be the responsibility of a police investigator to transfer items/exhibits (excluding STI samples) from the facility to the designated storage site used by the police, or directly to the relevant forensic unit. This shall be documented appropriately to demonstrate the chain of custody.

5.6.11 Where the patient has not reported the assault to the police the forensic healthcare practitioner or CW should transfer evidence from the examination room to the appropriate storage location. This shall be documented appropriately to demonstrate the chain of custody (the Code, section 35.2.9).

5.6.12 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 and where appropriate shall be transported in a timely fashion in suitable insulated carrying containers to keep the samples cold during transportation (the Code, section 35.4.2).

Storage of samples (Code, sec 42.1.9 and 42.1.10; ISO 15189, sec 6.3.3 and 7.4.2)

5.6.13 Samples collected before or during the forensic medical examinations stored at the facility shall be stored in secure locations with access restricted to authorised nominated personnel (for police, non-police (self) referrals).

5.6.14 All forensic medical samples shall be properly stored until required for forensic medical examination in the laboratory. Detailed information on the required storage conditions is given in the FFLM recommendations [11].

5.6.15 The facility shall follow sample storage policies 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.

5.6.16 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.

5.6.17 The facility should 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.

5.6.18 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 for which 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.

5.6.19 In the event that the patient does not pursue a police complaint within the agreed time limit, if they choose to provide consent to analyse the samples anonymously, then where this service is offered these should be provided to the police to process anonymously (real name withheld and name not recorded on the exhibit labels or associated documentation). Otherwise, the samples shall be destroyed in a safe and timely manner. The patient should be furnished with suitable information regarding the retention and destruction policy.

Sample management (Code, sec 102.11.3, ISO 15189, sec 7.4.2)

5.6.20 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 transfer of DNA.

5.6.21 The forensic healthcare practitioner should take 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 or placed into storage. This handover shall be documented and a record retained. The documentation shall continue with each transfer of the evidence. Where the referral is a police-referral the samples should be handed:

a. to authorised police personnel for transport to a designated storage site used by the police; or
b. directly to the forensic unit for analysis

5.6.22 Where the referral is a self- or non-police-referral, the samples should be placed in storage at a facility by the forensic healthcare practitioner or handed to a CW. It is the responsibility of the facility's management team to maintain the integrity of the samples during storage. Any movement or transfer of samples shall be documented and a record retained so that the sample can be located and retrieved.

Images (Code, sec 102.11.4)

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

a. allow for image scaling; and
b. demonstrate the features of interest clearly.

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

5.6.25 It is the responsibility of the facility to ensure that any images taken by forensic healthcare practitioners at the facility adhere to the following process:

a. The images are taken by forensic healthcare practitioners who:

i. understand 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, protecting the anonymity of the patient if necessary; and

c. The existence and location of the images are recorded by the facility and acknowledged in the patient's medical records.

5.6.26 Images of intimate areas should be taken by the forensic healthcare practitioner. These images may be used for second opinions and/or peer review. Where the patient is a child and a permanent record is not obtained, the forensic healthcare practitioner shall record this in the documentation (ISO 15189, sec 7.2.4.1). The FFLM has published guidelines on photography [16].

5.6.27 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 [15].

5.7 Ensuring the quality of examination procedures (ISO 15189:2022, sec 7.3.7; the Code, sec 29.3)

5.7.1 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 have been taken to identify contamination (or the possibility of contamination occurring) including environmental monitoring (EM).

d. Forensic healthcare practitioners 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. Forensic healthcare practitioners engaged at the facility understand the difference between a deep clean, cleaning requirements for DNA clean controlled areas, and a general clean.

5.8 Use of personal protective equipment (ISO 15189:2022 6.3.4, 6.3.5, 6.4.5(d))

5.8.1 As required by the Code (section 102.14) at the point the forensic healthcare practitioner decides to undertake a forensic medical examination resulting in the collection of items/exhibits, the forensic healthcare practitioner shall wear personal protective equipment (PPE), details of the PPE to be worn and the sequence of putting on can be found in FSR-GUI-0017, section 8.4.**Error! Reference source not found.**

5.8.2 PPE includes a face mask, the purpose of which is to reduce the risk of DNA contamination and this should be explained to the patient. If the patient objects or where the forensic healthcare practitioner considers the use of a face mask to be distressing and the face mask is subsequently not worn, this should 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, as required in section 102.12.6 of the Code. Further guidance on this can be found in section 8.5 of FSR-GUI-0017.

5.8.3 Hand hygiene is an essential part of the examination procedure. Hands should be decontaminated by washing with liquid soap using good hand washing technique before donning gloves and following their removal.

6. Documentation – recording of notes and statements

6.1 Note taking and record keeping (ISO 15189:2022, sec 8.4; ILAC G19, sec 3.5)

6.1.1 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 is directly relevant to contact with the patient at the facility.

6.1.2 Notes may be handwritten (in black ink) or electronic and should be recorded contemporaneously or at the first practical opportunity. The name, role, and professional registration/identification number and date, including time if appropriate, of the professional undertaking the examination shall be recorded.

6.1.3 If the forensic healthcare practitioner undertaking the examination is not recording the notes, then the forensic healthcare practitioner will need to review, sign and date the notes as a true and accurate record. Where any additions or amendments are made to the notes, the original entry shall be clear and the amendment shall be 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.

6.1.4 Where abbreviations are included in notes they should be unambiguous and easily understood, for example, LVS for low vaginal swab.

6.1.5 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 which is not followed, the reason for making the decision not to follow the expected course shall be detailed in the record.

6.1.6 Case notes shall contain sufficient details to enable a forensic healthcare practitioner to generate a statement, if required, at a later date.

6.1.7 There is a range of specimen pro formas published by the FFLM to assist forensic healthcare practitioners with the process of note taking and sample information [31], [27], [26]. However, it is important for forensic healthcare practitioners to recognise that additional information or activity, not required by the pro forma, may need to be recorded in the notes for example, the batch number of consumable items such as swabs used, and 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.

6.1.8 All notes (including permanent records such as images taken using a specialist medical video-camera) shall be retained by the facility in a secure location which complies with data protection requirements [32]. 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.

6.1.9 The location of case records shall be defined, where notes are required to be removed from the facility, a record shall be kept documenting the reason for removal, and the forensic healthcare practitioner removing and returning the notes.

6.2 Preliminary findings (ISO 15189:2022 sec 7.4.1 and 7.4.1.6k; the Code sections 26 and 102.14.4; ILAC G19 4.9)

6.2.1 Where the police request a written account of the findings immediately following the forensic medical examination, the forensic healthcare practitioner should clearly state in writing that the written account contains preliminary findings only and that these findings should be confirmed at a later date.

6.2.2 The preliminary findings report should be subject to an accuracy check and a critical finding(s) check by another competent person prior to release to the commissioning party. If the preliminary findings have not undergone a critical finding(s) check before release this shall be stated with the preliminary findings. The police should 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.

6.3 Statements and reports (ISO 15189:2022, sec 7.4.1; the Code sec, 26.5 and 37.1 and ILAC G19, sec 4.9)

6.3.1 The facility shall define a process for the production of statements and reports to meet the requirements of the criminal justice system. The forensic healthcare practitioner shall comply with the relevant sections of the Criminal Procedure Rules and Criminal Practice Directions [33] for experts, as 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 on which to base opinions upon.

6.3.2 All cases shall be subject to an independent peer review of all critical findings by a second competent individual, in a time frame which minimises potential harm. Depending on the case, this can be:

a. either completed in stages (please see section 6.3.46.3.4 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.

6.3.3 The facility shall define procedures for peer review, including:

a. 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.

6.3.4 As a minimum, review areas should include:

a. medical care, including risk assessment and subsequent management;
b. forensic sampling and documentation, including images and diagrams;
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 and intimate images, if taken.

6.3.5 Forensic healthcare practitioners shall be appropriately trained to produce a statement which 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 [34].

7. Acknowledgements

7.1.1 This guidance has been adapted from the previous, non-statutory guidance (FSR-G-212, Guidance for the Assessment, Collection and Recording of Forensic Science Related Evidence in Sexual Assault Examinations) and

reviewed by the Forensic Science Regulator's Medical Forensics Specialist Group.

8. Modification

8.1.1 This is the first issue of this document.

8.1.2 The Regulator uses an identification system for all documents. In the normal sequence of documents this identifier is of the form 'FSR-###-####' where (a) (the first three '#') indicates letters to describe the type of document and (b) the second four '#' indicates a numerical code to identify the document. For example, this document is FSR-GUI-0020, and the 'GUI' indicates that it is a guidance document. Combined with the issue number this ensures that each document is uniquely identified.

8.1.3 If it is necessary to publish a modified version of a document (for example, a version in a different language), then the modified version will have an additional letter at the end of the unique identifier. The identifier thus becoming FSR-#-####.

8.1.4 In all cases the normal document bearing the identifier FSR-#-### is to be taken as the definitive version. In the event of any discrepancy between the normal version and a modified version then the text of the normal version shall prevail.

9. Review

9.1.1 This document is subject to review at regular intervals.

9.1.2 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@forensicscienceregulator.gov.uk.

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12. Abbreviations

Abbreviation	Meaning
ABE	Achieving best evidence
ASET (UKAFN)	Advanced standards in education and training

Abbreviation	Meaning
CJS	Criminal justice system
COP	College of Policing
CPS	Crown Prosecution Service
CW	Crisis worker
DNA	Deoxyribonucleic acid
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
SOLO	Sexual Offence Liaison Officer

Abbreviation	Meaning
STI	Sexually transmitted infection
UKAFN	United Kingdom Association of Forensic Nurses and Paramedics
UKAS	United Kingdom Accreditation Service
UKSC	United Kingdom Supreme Court
VRI	Video Recorded Interview

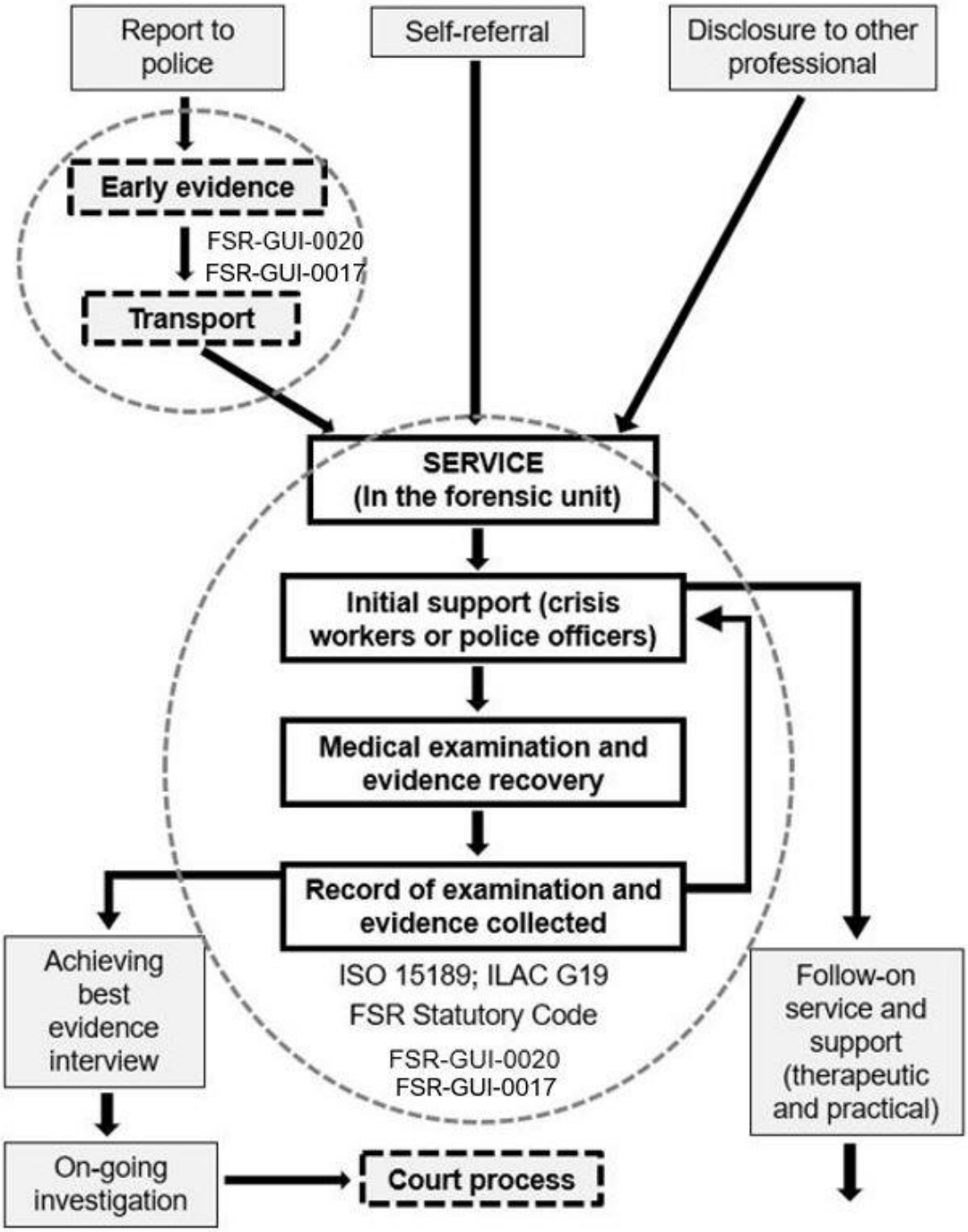
13. Glossary

Chain of custody	Chronological documentation of the movement and location of items.
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.
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.
Facility	The physical environment used for any medical examination and sample collection, which in part is a forensic unit.
Forensic	Scientific methods, techniques and processes used to aid an investigation into a crime.
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).
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.
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.

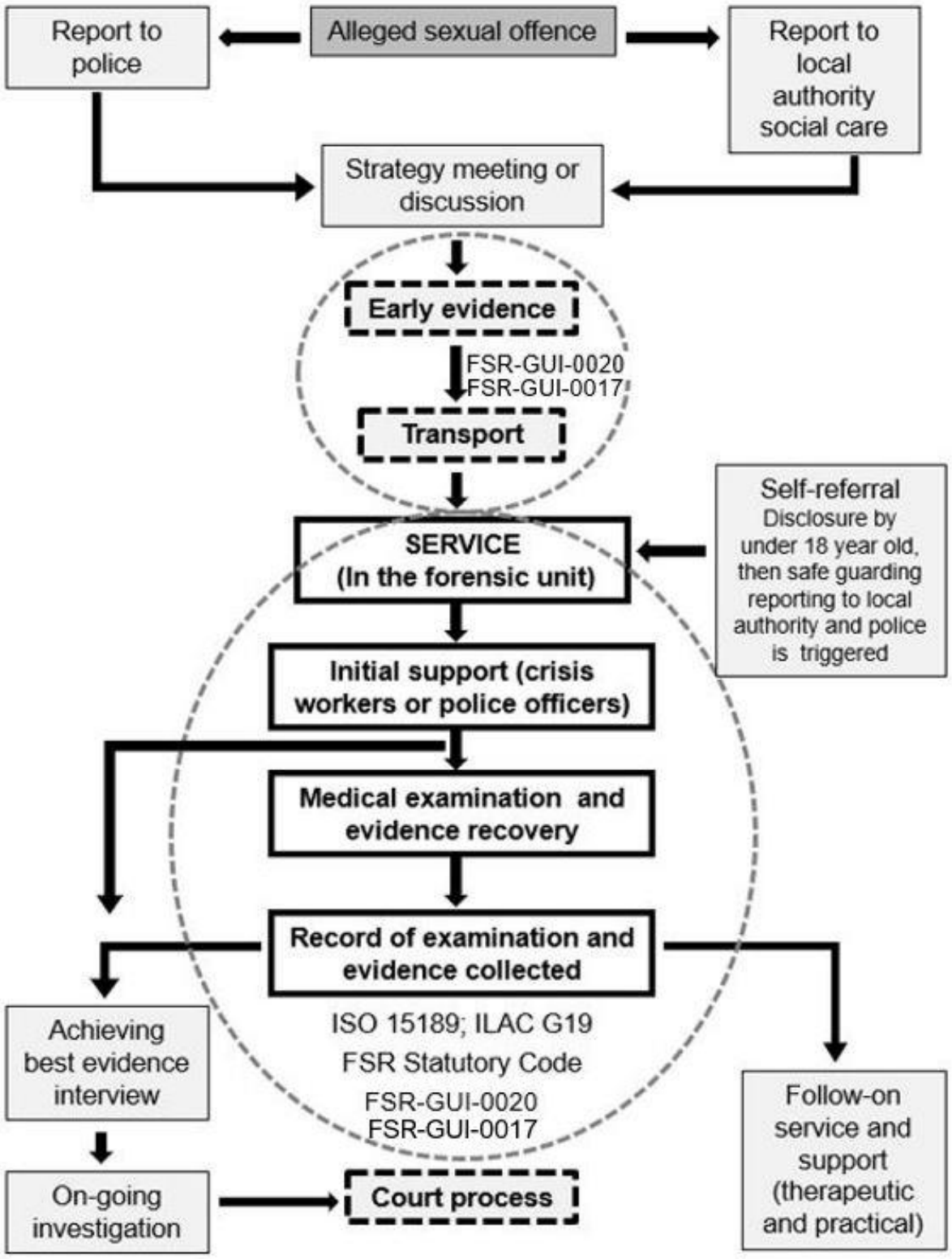
14. Annex A: patient pathways

Figure 1. Adult patient's journey from allegation to court via the facility.



The standards and guidances apply at the stages in bold text within the facility (solid lines) and outside the control of the facility (dashed lines).

Figure 2. Child patient's journey from allegation / disclosure / professional concern of abuse to court via the facility.



The standards and guidances apply at the stages in bold text within the facility (solid lines) and outside the control of the facility (dashed lines).

15. Annex B: self-assessment readiness guide

15.1 About this self-assessment

15.1.1 This self-assessment contains an overview of the standards that a facility should achieve in order to meet the Code relating to the forensic medical examination of sexual assault patients.

15.1.2 The purpose of the self-assessment is to give an indication of the areas where a facility may need to improve, or where it is doing well. It is important to note that this self-assessment template does not provide information about 'how' to demonstrate compliance with the standard, as some of this level of information is contained within this guidance.

15.1.3 This self-assessment is divided into two categories: Management Requirements and Technical Requirements. The requirements contained in each of these are there to provide a general overview as to how your facility is performing in each area.

15.2 Self–assessment completion

15.2.1 Against each requirement there are four possible assessment options. These indicate where a facility currently stands on any particular requirement.

a. Fully met – Every aspect of the standard has been met or exceeded. A facility can evidence this by both documented and practical examples where applicable.
b. Partially met – Some or most of the standard has been met and can be evidenced. This option should be selected if a facility undertakes activities to meet the standard but cannot evidence it, or has not effectively communicated with employees about it.
c. Not met **–** None or very little of the standard has been met. This option should be selected if activities, procedures or systems are still under development or have not been implemented.
d. Not applicable **–** The standard covers an area which does not relate to a facility due to the nature of its activities, location, or other practical reason.

15.2.2 Against each requirement evidence to support the assessment score is recorded, this could include SOPs, completed forms, logs, audits, activity witnessing and demonstrations.

Part A. Management requirements

1	**Organisation and management responsibility**	**Assessment**	**Evidence**
1.1	The organisation and management responsibility of the facility is defined and documented.		
1.2	The facility has an organogram/organisation chart or similar that clearly shows the lines of management/reporting (e.g., responsibility, clinical governance structures and legal responsibilities) that cover all aspects of the facility, including the personnel working therein.		
1.3	The facility is managed by a person or persons with the competence and delegated responsibility for all aspects of the services provided.		
1.4	Policies on business continuity, independence, impartiality, integrity, and confidentiality are in place at the facility.		
2	**Quality management system**	**Assessment**	**Evidence**
2.1	A quality management system (QMS) is in place that directs and controls the activities for all providers of services at the facility with regard to quality.		
2.2	The QMS for the facility includes all of the elements listed below: • procedures, instruction and forms; • document control system; • non-conformance process; • continual improvement process; • risk evaluation and audit; • management review; • customer feedback and complaints process; • provision of goods and services (contracts and service-level agreements).		

2	Quality management system	Assessment	Evidence
2.3	A quality manager (however named) has been appointed to ensure that the QMS functions correctly.		

Part B. Technical requirements

3	Training and ongoing competence of personnel	Assessment	Evidence
3.1	All professionals working within the facility have undergone training in both theoretical and practical aspects of forensic science according to the roles within which they are working. These would include sampling, packaging and contamination controls.		
3.2	All professionals working within the facility have been assessed for competency in the theoretical and practical aspects of forensic science according to their roles. Records are kept showing how competency was achieved and is maintained.		
3.3	Each individual has access to continuing professional development to maintain ongoing competency.		
3.4	Records of individuals' continuing professional development are maintained and retained.		
3.5	All professionals working within the facility have the required background checks/clearances.		
4	**Accommodation and environmental conditions**	**Assessment**	**Evidence**
4.1	Accommodation at the facility is age-appropriate and accessible to the communities it serves, including service deliverers.		
4.2	Accommodation at the facility has adequate security for the service, users and staff (e.g., security camera at facility entrance/alarm system linked to local police response). There is an entrance for use by the patient and their companions which is separate and not open to the public.		

4	Accommodation and environmental conditions	Assessment	Evidence
4.3	The forensic areas of the facility include a pre-examination waiting room (a separate waiting area for patients who may undergo a forensic medical examination), which is cleaned to DNA standards. There is a policy regarding its use and whether it can be designated and maintained as a DNA clean area.		
4.4	The forensic area of the facility includes a dedicated forensic medical examination room, of sufficient size and appropriate layout, which is the designated DNA clean area.		
4.5	The forensic area of the facility includes a dedicated bathroom/toilet facility, cleaned to DNA standards, accessed from the medical examination room or DNA cleaned corridor, where early evidence collection can be conducted, and an area is provided where the patient can shower post-examination.		
4.6	There is 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 areas.		
4.7	The forensic area of the facility is secure at all times with controlled entry into and exit from the designated forensic medical examination room. Records of all personnel (date, time and activity/role) entering the room are maintained.		
4.8	Air movement within and between rooms is managed with measures taken to minimise the risk of contamination from environmental background DNA.		
4.9	Air flow within and between designated forensic areas of the facility is kept to a level that minimises the risk of trace evidence being transferred from the patient to the room environment and vice versa.		
4.10	The layout of the rooms and corridors enables the patient and workflow to progress through the facility in one direction preventing the patient from revisiting any designated DNA clean rooms or areas.		
4.11	The style and finish of fixtures and fittings, such as air-conditioning, ceilings, lighting and working space allow for effective repeat cleaning.		

5	Furnishings and equipment used for the examination	Assessment	Evidence
5.1	Workbench surfaces, storage cupboards, seating and examination couches are impervious to water, easy to clean and resistant to disinfectants and cleaning reagents.		
5.2	Batch numbers, expiry dates and the maker of the reagent are displayed on the packaging of reagents/consumables. Batch/lot information and expiration dates are recorded.		
5.3	Consumables are stored in a secure main store cupboard or room and transferred in small numbers into the medical examination room storage area. Those used for sampling are free from detectable levels of human DNA or forensic DNA grade.		
5.4	In areas where a patient undresses and where they are subsequently forensically examined, floor surfaces are impervious and any joins in the floor are sealed.		
5.5	Computer keyboards, colposcopes and equipment controls are easily cleanable or protected by removable flexible covers that can be cleaned or replaced (e.g., specialist medical video camera arm and head covers).		
5.6	Where a curtain shields the examination couch, the curtain is disposable.		
5.7	Guidance is provided on the frequency of curtain replacement and a record is kept of the date and reason for changing the curtain.		
5.8	There is a designated hand-wash basin in the forensic medical examination room. The taps are capable of being operated without being touched by hand.		
5.9	The medical examination couch has height and position adjustments to allow for ease of movement. Disposable covering is changed between each examination.		
5.10	There is a labelled storage area for keeping consumables used for the forensic medical examination and packaging of samples, which is kept suitably clean and protected from contamination.		

5.11	Equipment records and unique identifiers per key item are used. For example, which colposcope was used is noted.		
5	**Furnishings and equipment used for the examination**	**Assessment**	**Evidence**
5.12	There is an approved sharps box and clinical and domestic waste receptacles; appropriate disposal provisions are in place.		
5.13	A general forensic clean of the waiting room, forensic medical examination room and bathroom is undertaken prior to and/or after each examination. Additionally, an up-to-date cleaning protocol is held with a cleaning log, recording the cleaner, date, time and areas cleaned.		
5.14	Deep cleaning of the forensic medical examination room is undertaken in accordance with the cleaning procedure.		
5.15	The forensic medical examination room is sealed after each clean and the door labelled.		
5.16	The cleaning products and spillage kits used, and the manner of application, have been demonstrated to be effective in removing detectable levels of DNA.		
5.17	The application of the cleaning product is carried out according to the manufacturer's guidelines and in a manner compliant with health and safety requirements.		
5.18	Standards used for the collection of evidence are the same for both patients who self-refer to the facility and those who are referred to the facility by the police.		
5.19	Where appropriate (e.g., specialist medical video camera) records are kept of equipment calibrations, cleaning, maintenance and/or service records.		
6	**Examination methods and procedures**	**Assessment**	**Evidence**
6.1	All healthcare professionals working at the facility who come into contact with patients of sexual violence have the relevant skills, knowledge and competency to work with patients in the immediate aftermath of an alleged sexual assault.		
6.2	Facility personnel have a clear understanding of the different ways that patients of sexual assault may		

	behave following an assault. A non-judgemental approach is adopted in every case.		
6	**Examination methods and procedures**	**Assessment**	**Evidence**
6.3	Forensic healthcare practitioners at the facility ensure that patients (and their accompanying person) are always given the correct information and advice regarding a forensic medical examination and the options available to them.		
6.4	Forensic healthcare practitioners at the facility are able to provide basic information to patients and their accompanying person about: • options to attend the facility and the opportunity to undertake a forensic medical examination; • options to report the sexual offence to the police if they so choose; • potential medical concerns of the patient that relate to the alleged sexual assault; • the importance of body fluids and the recovery of such forensic evidence; • the provision of early evidence samples; • the impact different actions may have on the collection of evidence; and • the value of clothing in providing evidence.		
6.5	Forensic healthcare practitioners at the facility are aware that thesamples collected will vary on a case-by-case basis taking into account ideal time frames. The decision whether or when to carry out a forensic medical examination is made in consultation with a forensic healthcarepractitioner. The collection of forensic samples is only one aspect and consideration is always given to other forensic evidence, such as interpretation of injuries and the therapeutic needs of the patient.		
6.6	The facility has a policy in place that identifies who has the responsibility for requesting the attendance of the forensic healthcare practitioner and/or paediatrician, and the expected time frames for attendance at the facility.		
6.7	The provider of the forensic medical workforce ensures that they are able to ‘provide a timely response’ (within two hours, or as agreed for a particular case, specifically if a child is involved) to reflect the clinical and forensic needs of the patient.		

6.8	Separate rotas are in place to ensure that the forensic healthcare practitioner available for sexual offence forensic medical examinations is not also used for custody medicine during the same time period.		
6	**Examination methods and procedures**	**Assessment**	**Evidence**
6.9	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 are examined in separate suites and by different forensic healthcare practitioners.		
6.10	A crisis worker (or equivalent) is available to meet the patient (and their accompanying person), accompany them to the pre-examination waiting area of the facility and provide immediate support.		
6.11	The crisis worker is able to ensure that a urine sample or oral sample is taken using the early evidence kit and that non-intimate skin swabs are taken where appropriate		
6.12	The forensic healthcare practitioner or paediatrician (where appropriate) uses the medical history, together with the first account, to guide the examination, evidence collection and support any subsequent forensic laboratory examination and findings.		
6.13	Where more than one person conducts the examination, all forensic healthcarepractitioners have agreed roles and responsibilities before the examination commences and this is documented.		
6.14	A record of all persons in attendance at any time during the forensic medical examination is made. The name and contact details for each visitor, including non-facility professionals in attendance, are recorded, including details of the areas they accessed, together with information about what PPE (if any) was worn in DNA controlled areas.		

7	Collection, storage and transport of forensic samples	Assessment	Evidence
7.1	The facility has clear policies for uniquely labelling, sealing and storing samples to provide a clearly documented chain of continuity for all forensic samples and for sexually transmitted infection (STI) samples where they may be relevant to the forensic case.		
7.2	Where the patient has reported the alleged assault to the police, it is the responsibility of a police officer to transfer evidence from the facility to the appropriate laboratory or other designated storage site used by the police. This is recorded appropriately to demonstrate the chain of custody.		
7.3	Where the patient has not reported the alleged assault to the police, it should be the responsibility of the forensic healthcare practitioner or crisis worker to transfer evidence from the examination room to the storage room(s) within the facility. This is recorded appropriately to demonstrate the chain of custody.		
7.4	Samples collected before or during the forensic medical examinations are stored in secure locations at the facility with access restricted to authorised nominated personnel (for self- and non-police referrals).		
7.5	The facility follows sample storage policies agreed with the police and the relevant forensic unit to ensure that optimal storage conditions for all samples collected as part of the forensic medical examination are maintained. A policy on storage timescale requirements and a destruction timeline is also in place and agreed.		
7.6	Where samples are held in cold storage at the facility, a system is in place to ensure that samples are always kept at a specified temperature, which includes maintaining temperature monitoring logs and use of alarms to notify failure of the equipment.		
7.7	The facility has ensured that policies are in place to address evidence storage in cases where the patient is undecided about reporting to the police.		
7.8	There is adequate space and provision at the facility to store samples taken from patients who self-refer.		

7	**Collection, storage and transport of forensic samples**	**Assessment**	**Evidence**
7.9	The sample collection, labelling, transfer and storage of evidence collected as part of the forensic medical examination is documented to ensure that there has been no loss or alteration of evidence prior to criminal proceedings.		
7.10	Forensic healthcare practitioners or paediatricians (where appropriate) are appropriately trained and familiar with how to operate the equipment required to capture a permanent record/image.		
7.11	Imaging records taken by forensic healthcare practitioners or paediatricians (where appropriate) are stored securely by the facility.		
7.12	The facility has a defined system for the secure storage of records, which protects the anonymity of the patient.		
7.13	Procedures are in place to enable the disclosure of notes and images where a request is made in court proceedings.		
8	**Ensuring the quality of the examination procedure**	**Assessment**	**Evidence**
8.1	System wide auditing the quality of forensic medical examination procedures to include the following: • adherence to procedures that minimise the possibility of contamination; • record keeping for the use of locks/security seals for rooms in the forensic area; • steps that have been taken to identify contamination; • that forensic healthcare practitioners understand the scientific basis for preventative and decontamination procedures; • that forensic healthcare practitioners are competent in conducting cleaning and the associated record keeping; and • that an audit plan is in place.		

8	Ensuring the quality of the examination procedure	Assessment	Evidence
8.2	To undertake a medical examination, the forensic healthcare practitioners wear barrier clothing/personnel protective equipment (PPE) as defined below: • disposable barrier clothing such as scrubs or aprons and disposable sleeve covers; • face mask; and • non-latex gloves (available in a range of sizes). In addition, it is preferable to wear the following: • mob caps; • shoe covers. Where it is considered inappropriate to wear a face mask (or other PPE item), this is recorded with the reasons.		
8.3	Forensic healthcare practitioners know the correct order in which to put on barrier clothing/PPE and change it after every forensic medical examination, cleaning, or maintenance task.		
8.4	The facility has processes in place to address: • agreement/consents for DNA elimination sample donation and use of profile information; • security and access of information at a local/national level; • secure and recorded transfer of samples in accordance with guidance provided by the forensic unit that will undertake the DNA profiling for elimination purposes; and • sharing agreement of DNA profile information (between forensic healthcare practitioners, facility management, forensic medical provider, police investigator).		
8.5	All personnel working within the facility have provided a DNA elimination sample prior to entering any part of the forensic area of the facility.		
8.6	DNA elimination samples are taken taking account of the requirements and guidance in the FSR's DNA contamination detection – the management and use of staff elimination databases.		
8.7	A record is kept of: • which room is used for each examination; • the date and times of the examination; and • the names of all persons who enter the examination room during the examination,		

	including interpreters and any person who supports the patient.		
8.8	Cleaning of the facility is carried out and recorded on a cleaning log for audit purposes.		
8.9	Cleaning is conducted by appropriately trained practitoners every time the forensic waiting, examination and bathroom areas of the facility have been used.		
8.10	Cleaning is 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.		
8.11	Deep cleaning is regularly scheduled and conducted generally once a month but depending on use and monitoring results (see FSR-GUI-0017).		
8.12	The environmental monitoring sampling (EMS) scheduling plan is in place (appropriate frequency established through trend analysis) and sampling is conducted midway between each deep clean.		
8.13	When contamination is identified, depending on the risk rating, the equipment or room is immediately deep cleaned, and EM swabs are taken. Use of the room or equipment is determined by risk, and the criteria to be reinstated are clearly defined.		
9	**Records, notes and statements**	**Assessment**	**Evidence**
9.1	Each contact with the patient by any professional is clearly, accurately, and legibly recorded in the set of case notes pertaining to that patient.		
9.2	Notes are recorded contemporaneously or, where this is not possible, notes are made as soon as possible after the activity has taken place. Batch numbers of consumables, reagents, equipment, PPE, and who used/wore them, are recorded.		
9.3	All notes (including permanent records such as intimate images) are retained by the facility in a secure location that complies with data protection requirements.		
9.4	The notes are available and accessible if they are required for the purpose of the investigation, peer review, second opinion and any court proceedings.		
9.5	Where notes are required to be removed from the facility, the reason for removal is documented. A record is kept by the facility of the professional		

	removing and returning the notes within an agreed timescale.		
9.6	The facility has defined a process for the production of statements and reports in an agreed format and to an agreed standard. There is a policy regarding quality assurance of statements/reports.		
9.7	Where preliminary findings are provided, these are recorded in writing with appropriate caveats.		
9.8	The facility has defined a process for a critical conclusion check of the report/statement by a second competent individual.		
9.9	Forensic healthcare practitioners are appropriately trained to produce a statement that is acceptable for use within in the criminal justice process.		
9.10	All forensic healthcare practitioners are provided with ongoing support from an appropriately experienced forensic physician to assist them with statement writing.		

16. Annex C: guidance on the forensic healthcare practitioner and professional roles associated with the facility

16.1 Forensic healthcare practitioners and professionals providing service within the facility

Crisis worker (however named)

16.1.1 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.

16.1.2 The CW acts as a chaperone and 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.

16.1.3 The CW may be required to assist in the following, these are not deemed to be forensic science activities as specified by the Code:

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.

16.1.4 The CW may be involved in the cleaning of those areas of the facility where the collection of forensic samples is undertaken.

16.1.5 The CW should 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).

16.1.6 Organisations employing CWs should 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 should 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.

16.1.7 Competency assessment should take place after training, followed by ongoing assessment through regular clinical and management supervision. The organisation should ensure that the CW accesses and undertakes continuous professional development. There are relevant National Occupational Standards (NOS) [35] for crisis workers to use regarding giving advice and their role

Forensic nurses, midwives and paramedics

16.1.8 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 should recognise and work within their competence [36]. The HCPC also requires that healthcare professionals should recognise and work within their competence [37].

16.1.9 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 medical examinations independently, thereby working at an advanced level as defined by the Department of Health [38], and the Royal College of Nursing [39], [40].

16.1.10 Nurses (including midwives) and/or paramedics who undertake forensic medical examinations independently should 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.

16.1.11 The FFLM provides advice for obtaining qualifications in clinical forensic medicine [41], the content of introductory training, and quality standards for nurses of patients who have been subjected to sexual offences [42]. The United Kingdom Association of Forensic Nurses has developed advanced standards in education and training for nurses in the sexual assault setting [43].

Forensic physician

16.1.12 The forensic physician provides the medical and forensic examination for the patient. The FFLM has provided advice on qualifications and the forensic physician should 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 [41]. Forensic physicians should meet the quality standards in forensic medicine set out by the FFLM in relation to training, mentoring and supervision, and undertake continuous professional development [14].

Paediatrician

16.1.13 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.

16.1.14 The role of the paediatrician in the forensic medical examination of a child patient will depend upon the competency of the paediatrician, as stated in guidelines set out by the FFLM and the Royal College of Paediatrics and Child Health (RCPCH) [25].

16.1.15 Paediatricians should meet the quality standards in forensic medicine set out by the FFLM in relation to training, mentoring and supervision, and undertake continuous professional development [14]. The RCPCH has published guidance regarding numbers of examinations and maintenance of competence [44]. The RCPCH and the FFLM have produced a service specification for the clinical evaluation of children and young people who may have been sexually abused [25].

Cleaner specialising in DNA decontamination

16.1.16 A person with responsibility for the decontamination cleaning of the forensic areas of the facility. The cleaner should be deemed competent to:

a. conduct the DNA decontamination cleaning to the required standard as defined in FSR-GUI-0017 and
b. utilise the cleaning agents in a manner compliant with relevant health and safety requirements.

16.1.17 The decontamination cleaner should be trained to an appropriate standard to ensure that they are able to meet the competencies to undertake the role. Such training should 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);
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 5.4.2)

16.1.18 The named person with overall responsibility for ensuring the facility's compliance should establish, implement, and maintain an appropriate management system, in conformity with ISO 15189:2022. This will require competence in:

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

16.1.19 Those involved in quality management should be trained to an appropriate standard to ensure that they are able to meet the competencies to undertake the role. Such training should 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.

16.2 Professional providing initial contact/first response, internal and external

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

a. A forensic healthcare practitioner at the facility;
b. a social worker, if the patient is a child or young person;
c. health professionals (such as GPs, emergency department practitioners, sexual health practitioners); and
d. Personnel at another agency, such as rape support services.

16.2.2 The professional providing response should be competent to:

a. provide immediate support to the patient;
b. provide relevant information and to the patient (and their significant others if appropriate);
c. communicate and engage with the patient (and their supporters if appropriate);
d. carry out an initial assessment to identify the immediate needs of and risks to the patient; and
e. provide information regarding the preservation and prevention of loss of potential forensic material until the patient receives appropriate practical support.

16.2.3 The professional providing initial contact/first response should be trained to an appropriate standard to ensure that they are able to meet the competencies to provide initial response to patients. Such training should 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, risks and safety, including emergency medical provision;
c. having a general forensic awareness, including preservation of material with forensic relevance, 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.

16.3 Police personnel

First response police officer

16.3.1 The first response police officer is the professional who responds to the patient following the call from the handler/initial contact person. The first response police officer should 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 supporters, if appropriate);

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 potential forensic material;
e. provide an overview of the forensic medical examination; and
f. recover initial material for subsequent forensic testing or analysis, which may include an EEK and clothing.

16.3.2 The first response police officer should 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 should include the following:

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

16.3.3 The College of Policing provides a course that supports police officers providing initial response, the rape and serious sexual assault (RASSO) first responder programme [45], and has published a briefing note for police first responders [46].

Sexual Offences Liaison Officer

16.3.4 The sexual offences liaison officer (SOLO) is the police officer who acts as a conduit between the compliant and the investigating officer. The SOLO should 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 potential forensic material;
f. provide an overview of the forensic medical examination; and
g. recover initial material for subsequent forensic testing or analysis including from the EEK, and clothing.

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

a. the SOLO'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. 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.

16.3.6 The College of Policing expects SOLOs to be trained at Professionalising Investigations Programme (PIP) level 1 and provides a course for SOLOs, the Sexual Offences Liaison Officer Learning Programme.

Investigating officer

16.3.7 The investigating 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 collection of material with forensic relevance at a scene and subsequent forensic medical examination.

16.3.8 The investigating 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. The College of Policing expects investigators to be trained at Professionalising Investigations Programme (PIP) level 2 and to have attended the Specialist Sexual Assault Investigations Programme (SSADIP). The investigating officer should 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

16.3.9 The investigating officer should be trained to an appropriate standard to ensure that they are able to meet the competencies to undertake the role. Such training should 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 SOLO, crisis worker, forensic healthcare practitioner, paediatrician, forensic authoriser and relevant forensic units;
d. planning and communication with the appropriate staff at the sexual assault referral centre regarding when and how potential forensic material

may be retrieved from the patient, including contingencies where the care of the patient may affect recovery of forensic material; and

e. collating information about the forensic medical examination and retrieval of material with forensic relevance, including the security of forensic samples and any subsequent access to the samples.

Authority for forensic science submission

16.3.10 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 should understand forensic strategy setting and have knowledge of contractual forensic arrangements with relevant forensic units. In respect of the forensic medical examination, this person should 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 unit.

16.3.11 The forensic submissions authoriser should be trained to an appropriate standard to ensure that they are able to meet the competencies to undertake the role. Such training should include the following in relation to 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 which is developed as part of the investigation;
c. understanding the role and responsibilities of the SOLO, crisis worker, forensic healthcare practitioner, paediatrician, forensic authoriser and relevant forensic unit;

d. planning and communicating the forensic strategy requirements from the point of first submission to any subsequent phased submissions with the relevant forensic unit; 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 relevant forensic unit.

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