Forensic Science Regulator

Guidance: Forensic medical examination of sexual offence complainants

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2. Background

2.1.1 There were over 200,000 reports to police in England and Wales to December 2024; of these > 71,000 (35%) were allegations of rape. Fewer than 20% (17-18%) of such crimes are reported to police, so that means > 1 million sexual assaults and > 350,000 rapes go unreported [1].

2.1.2 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 medical examination:

a. to address their concerns;
b. minimise trauma; and
c. aid and support their recovery.

2.1.3 At the same time, the collection of evidence and its interpretation can provide patients with the option to assist in any criminal investigation. The evidence collected in the form of information, items and findings (observations), may aid a criminal prosecution, prevent further sexual violence or assist with the exoneration of the innocent.

2.1.4 The provision of dedicated services for the health and well-being of patients and delivery of justice has considerable benefits [2]. Such services provide patients with the opportunity for high-quality care alongside forensic medical examination and the possible collection of samples, or other evidence, e.g. documentation of physical findings, including injury. 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).

2.1.5 The medical and therapeutic needs of the patient may be prioritised over the requirement to collect material with forensic relevance, however the aim of a

SARC service is to provide both elements simultaneously should that be possible

2.1.6 Whilst the need to provide high-quality medical care is of primary importance, essential consideration is also given to the requirements for achieving best quality evidence, which includes but is not limited to high-quality samples for scientific analysis. The documentation of physical findings, including the presence of injury, or its absence may be of significant evidential importance. Defined standards are necessary for all stages of the patient's 'journey' immediately before, during and after the forensic medical examination. These ensure there is confidence in the relevance of any medical findings documented during the examination, and in any subsequent scientific results from the samples taken during the examination. The patient's care pathway varies, based on the individual case and local variation of service delivery. However, this should not detract from achieving the best health and justice outcomes for the patient.

2.1.7 The compliance with 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 the appropriate standard is being met.

2.1.8 The Forensic Science Regulator's Code sets the quality requirements for the collection of and analysing biological evidence material as described in FSA BIO-100.The Code has precedence over accreditation to ISO standards in England and Wales so the collection of evidence must comply with the Code and maintain accreditation with the ISO 15189 standard. All practitioners should provide evidence of compliance with the Code and with accreditation. This means that to be compliant practitioners shall:

a. meet the requirements detailed in the Code
b. include the Code on their accreditation schedule.

2.1.9 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 including e.g. images and diagrams [3], reports and the statement(s) generated;
g. quality management; and
h. continuous improvement, review, and audit.

2.1.10 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, or other findings, and the interpretation, which may be related to the alleged offence.

3. Scope

3.1.1 This guidance should be used to assist with meeting the requirements set out in the Forensic Science Regulator's Code [4], including section 91. 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 [5]. Compliance with the Code, for the forensic medical examination services relating to alleged sexual assault, comes into force from 02 October 2025.

3.1.2 The guidance is aimed at providers and forensic healthcare practitioner (FHP)s. 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.

3.1.3 The remit of the Forensic Science Regulator (FSR) covers obtaining samples for scientific analysis and the interpretation and opinion provided from observations in criminal investigations and does not cover clinical/medical practices for health and wellbeing purposes; any reference to medical practice is included for context, as forensic medical examination and the medical care of patients overlap.

3.1.4 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.

3.1.5 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.

3.1.6 The use of ad hoc locations such as mobile units, emergency departments and care homes are excluded from accreditation; however, contamination controls for the examination and recovery are expected to be practiced. Although not subject to accreditation, such out-of-SARC (the facility) examinations require disclosure, compliance declaration and the mitigations to address the risks involved, such as contamination.

3.1.7 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 subsequent activities within the facility including the production of reports. 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.

3.1.8 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. However, the FHP shall be competent to address the interpretation of physical findings and the relation to the allegation of concern.

3.1.9 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 worker (CW)s, 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.

4. Terms and definitions

4.1.1 The terms and definitions set out in the Code, including section 91, and the glossary section apply to this document. Those in ILAC G19:06/2022 [6] apply where there is no corresponding definition set out in the Code or guidance.

4.1.2 As in the Code, in this guidance FHP is used to refer to forensic physicians (including paediatricians), forensic nurses, forensic midwives and paramedics. The term 'professional' is used to refer to other relevant roles such as CW, and police investigators.

4.1.3 The word 'shall' has been used in this document where there is a corresponding requirement in the Code [4], ISO 15189:2022 [5] or ILAC G19:06/2022 [6]; the word 'should' has been used to indicate generally accepted practice where the reason for not complying, or any deviation, shall be recorded. This differs in the General Medical Council (GMC) publication, Good medical practice, where '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 FHP's control which affect

whether or how guidance can be followed [7]. The word 'may' has been used for recommendations. Recommendations have been used to indicate what ideal practice is when it is practicable.

4.1.4 The ISO 15189 standard provides the standards framework for the forensic medical examination of patients, as a laboratory standard it is not an ideal fit, so interpretation and adjustments is informed by a number of documents, these include ILAC - G19 [6], the FSR Code [4] and this guidance document where clauses from the standard are specified. This makes the application of the standard relatable to the BIO-100 forensic science activity, for example, 'SARC facility' is used for 'laboratory' , sometimes 'patient' is used for 'sample' and the testing relates to the examination of the patient which can include recovery of forensic samples, recording information and reporting.

4.1.5 To aid the interpretation of ISO 15189 standard for SARC units the following is a guide:

a. 'Sample' means sample and patient depending on the context in clauses 6.35, 7.2.5, 7.2.6.1-2, 7.2.7.1, 7.2.7.3 and 7.2.4.4.
b. 'Sample' means sample in clauses 7.2.3, 7.2.4.1 and 7.2.4.2
c. 'Test' means sample in clauses 7.4.1.6, 7.4.1.7 and 7.4.2.

5. Structural and governance requirements

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

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

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

5.2.1 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 which cover all aspects of the services, including all personnel working therein.

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

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

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

5.3.1 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.

5.3.2 The management system shall include:

a. Responsibilities (see section 5.2)
b. Objectives and policies (see section 5.4)
c. Document control (see section 5.5
d. Improvement and corrective action systems (see section 5.6)
e. Evaluation and audits (see section 5.7)
f. Management reviews (see section 5.8)

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

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

5.4.1 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 forensic medical examinations which fulfil their intended purpose; and

d. comply with the standards and good practice to which the facility operates.

5.5 Control of management system documents (ISO 15189:2022 sec 8.3, 7.3.6, Code sec 33)

5.5.1 The facility shall control the documents which 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 which document the intentions and direction of the facility, as formally expressed by its senior management.
b. Standard Operating Procedures (SOPs) which 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.

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

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;
d. unintended use of obsolete documents is prevented; and
e. relevant documents are archived to identify what was accepted/standard practice at a particular time in the past.

5.6 Continual iimprovement process (ISO 15189:2022, sec 8.5, 8.6, 8.7)

5.6.1 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 which identify the sources for corrective, preventative and improvement actions.

5.6.2 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.

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

5.6.4 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.

5.6.5 Non-conformities (non-fulfilment 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.

5.6.6 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.

5.6.7 Following investigation, the issue could require escalation to the Forensic Science Regulator; examples are provided in section 8.1.7 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.

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

5.7.1 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 FHP competency in both practical work and in report writing.

5.7.2 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, the FHPs 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.

5.7.3 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.

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

5.8.1 Regular management reviews shall be conducted by the facility to ensure the performance of the unit and the procedures are followed, and continue to be, effective from a quality perspective. These should be discussed and highlighted as part of the induction of new and updating existing FHPs, CW and other staff affected by such changes

5.8.2 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. Fulfilment 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 activities 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 personnel) 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).

5.8.3 A report of the management review shall be generated which 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.

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

6. Technical requirements

6.1 Personnel: training and competence (ISO 15189:2022 sec 6.2, 6.7; ILAC G19 sec 3.3, Code sec 22.1,22.2, 91.4)

6.1.1 The facility shall ensure all personnel working within the facility, both internal and external are competent to perform the activities 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.

6.1.2 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.

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

6.1.4 FHPs and other personnel /staff who have reason to access DNA clean areas at the facility, e.g. the forensic medical examination room shall have contamination awareness training [8], such as issues relating to contamination risks and their avoidance in specific processes, e.g., the use of personal items, [9] and contamination control methods [10] should be an integral part of training.

6.1.5 FHPs should be deemed competent to conduct examinations [11], this may vary in training, experience for the examination required and would include those who are:

a. Trained and competent under direct supervision (examinations observed)
b. Trained and competent under indirect supervision (examinations not observed, supervisor available)
c. Trained and competent to work independently.

6.1.6 The FFLM has produced a resource list of the evidence base that underpins the recommendations for the collection of forensic specimens from complainants and suspects which FHPs shall be familiar with [12].

6.1.7 The facility shall ensure that all practitioners who report factual evidence based on sound principles and methods that are valid and be clear where factual reporting ends, and where evidence of opinion begins (Code section 22.2).

Where reporting requires interpretations and expressions of opinions, for example, injuries and signs of abuse, then FHPs shall be competent to present such evidence. The following table provides a guide to examples of the different types of interpretation of which some will be fact or opinion based.

Interpretation Type	Examples
Factual	This includes information provided at the time of examination and direct observations which are communicated as the assumptions on which the case examination strategy and subsequent interpretation is based on; examples include: a. Medical history taken into consideration as well when noting findings (technical explanations). b. What elements of the forensic medical examination was conducted (based on strategy). c. Collection of samples/recording (imaging and (observations) d. What was found or not found i.e. injuries, body fluids etc. (observations)
Categorical: Opinion	This is an opinion that falls short of being factual, the alternative explanation(s) is so unlikely that the expert can confidently justify discounting them; examples include: a. Exclusions (e.g. ligature mark vs self-harm). b. Mark which is not an injury (e.g. congenital defects, hyperpigmentation).
Investigative: Questions that the examination seeks to answer	Usually, one version of events or none as patient unable to tell or remember incident. The interpretation of findings may provide answers in relation to aspects of proposed version or versions of events, such as what happened, when or where did it occur. Examples include: What happened? a. Fluid (e.g. blood/not blood (caution needed if opining on non-blood). b. Collection of samples/recording (imaging and observations) for preliminary reporting. Where did it occur? a. Recovery of foreign material/debris of unknown source (e.g. hairs, vegetation). When did it happen? a. State of injuries (healing of injuries/timings).

Interpretation Type	Examples
Evaluative: Formation of propositions	Where the interpretation of findings is clinically suggestive of a mechanism this is a 'proposition'. Examples include: a. Genital injuries – a finding of a genital injury is suggestive of trauma (proposition) The most common cause of penetrative trauma is sexual penetration, however accidental impalement or penetrating accident have been described. b. Penetrating trauma may occur in consenting and non-consenting intercourse (if age-appropriate). c. Likelihood to other factors taken into account i.e. medical information, condition etc. For Paediatric (up to 18 years) cases, the recommended clinical terminology for interpretation of findings (benchmarked to the Istanbul Protocol on signs of torture) is provided in the RCPCH/FFLM the physical signs of child sexual abuse [13].

6.1.8 For the purposes of this guidance, it is assumed all relevant training, processes and reporting to meet the requisite legal, e.g. legislation, health and safety; medical, i.e. clinical and therapeutic aspects of the service; and safeguarding requirements are already in place.

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

General

6.2.1 Accommodation at the facility shall meet the needs of all its end users (the Code, sec 91.5.3). 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.

6.2.2 The Faculty of Forensic & Legal Medicine (FFLM) has produced guidance on equipment for forensic medical examination (FME) rooms [14].

6.2.3 The Department of Health and Social Care has published Building Notes (HBN Series) [15] 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 [16]);
b. sexual and reproductive health clinics (Building Note 12-01 [17]);
c. sanitary bathroom (Building Note 00-02 [18]);
d. sterile environments (Building Note 13 [19]); and
e. hospital accommodation for children (Building Note 23 [20]).

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

Layout

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

6.2.6 As required by the Code, section 91.5.5, 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.

6.2.7 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.

6.2.8 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 companions who may be conversing and interacting whilst not wearing personal protective equipment (PPE). It can be designated as a DNA clean area, if its use is controlled such that those entering (other than the patient) are wearing PPE and actions to mitigate against DNA contamination are undertaken.
b. A dedicated forensic medical examination room which, as required by the Code (section 91.5.6) shall be a designated DNA clean area – this is

where the FME shall take place and forensic samples shall be collected. The room should have access to the bathroom/toilet facility.

c. A dedicated clean bathroom/toilet facility, where relevant 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 [9], section 7.3.

6.2.9 A dedicated area for putting on PPE which should be separate from the area where examinations are undertaken, ideally a separate lobby or room. Only FHPs and CWs should use this area for putting on PPE if it adjoins the medical examination room.

Structure

6.2.10 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. CW, paediatrician, FHP, interpreter, companion/parent/carer, trainee).

6.2.11 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 [9].

Environment, furnishings and equipment

6.2.12 The facility shall ensure the examinations rooms are appropriate for the examinations undertaken (the Code, section 23). 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 which 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 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 controls which are easily cleanable or protected by removable flexible covers which can be cleaned or replaced, (for example, keyboard, specialist medical video-camera covers). Equipment with flat surfaces and smooth clean lines is preferable (for example, touch screens);
d. Equipment for paediatric distraction and calming here such as projectors or bubble lights. This may also be essential in adults with learning disabilities, autism and other sensory special needs.
e. A disposable curtain which shields the examination couch. The frequency of curtain replacement should be subject to a risk assessment and will depend on the number of forensic medical examinations conducted in the room [21]. 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.
f. A designated hand-wash basin within the examination room with taps which can be operated without being touched by hand.
g. A medical examination couch with height and position adjustments to allow for ease of movement. The couch shall have disposable forensic DNA grade (FDG) covering, which is changed between each examination, in addition to the cleaning of the couch.
h. Wipeable wall clocks, height charts and weighing scales.

i. A specialist medical video-camera for all examinations as appropriate, to record relevant injuries and findings.
j. An approved sharps box and clinical and domestic waste receptacles, with appropriate disposal provisions arranged;
k. Optional equipment to enable photo-documentation for general injuries and/or general observations.

6.2.13 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 91.5.6) 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 91.5.4).

DNA decontamination

6.2.14 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 [9].

Exhibit packaging

6.2.15 Exhibit packaging is required to preserve material recovered for subsequent forensic testing or analysis. It is an important principle 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 sampling kit modules to ensure comprehensive forensic sample collection as recommended by the FFLM [11]. The kits shall be FDG grade where DNA analysis is expected.

6.2.16 The packaging of all items should be labelled so that it allows for the chain of custody to be tracked. As a minimum, labelling [22] should include:

a. A unique identifier (for example, barcode or a combination of date/case number/operator/consecutive numbering), this is normally used as the exhibit number;

b. Description of the sample/item.

c. The name of the patient the sample, as appropriate, was collected from; recommended details include:

i. i) for a police referral: name, unique SARC ID or name and date of birth

ii. ii) for a non-police referral: unique SARC ID and date of birth.

d. The date, and time when critical, (see FFLM recommendations on Collection of Specimens [11]) when the item was collected.

e. The name or identifier of the person who collected the item.

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

General principles

6.3.1 All professionals working at the facility who come into contact with patients shall have the relevant training, knowledge, skills and attitudes to be competent to work with patients of the relevant age-group for the patient, (see section 6.1.1).

6.3.2 FHPs should have a clear understanding of the different ways in which patients who have been subjected to sexual assault may present following an assault. FHPs shall act impartially and ethically, and a non-judgemental approach should be adopted in every case.

6.3.3 It is recognised some patients will be unable to make an immediate decision about whether they wish to report the assault to the police, fewer than around 20% of reports are made more than a year after the assault [1], or be involved in the criminal justice process. It is essential they have accurate information about the choices available and be supported to have control over what happens next. Pressure from others to report to police, even if made with the best of intentions, may discourage the future involvement of the patients in any subsequent court proceedings. The patient shall be provided with information about the self-referral route which could support them to decide to report an assault at a later date. The FHPs should adopt a trauma-informed approach when providing advice and care to patients. [23].

6.3.4 It is also recognised that not all patients have made allegations. There may be grounds for concern regarding possible sexual offense in the absence of first-person account/allegation, or where the nature/extent of the offense may be unknown, for example in children or those with significant learning difficulties. In such cases, the time interval from last event may be unknown. Examination should proceed on the basis of most recent possible contact, and in the best interests of the patient, where appropriate consent is obtained.

6.3.5 It is essential the acute medical (both physical and mental) health 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.

6.3.6 While the time frame of the assault will be an important factor in determining when a forensic medical examination should take place, each case should be properly considered, with the needs of the patient being the paramount consideration. A non-recent medical is looking for injuries, so is still a forensic medical, just less urgent than those looking for DNA/trace evidence and/or acute injury.

Often, patients who have been subjected to a sexual assault have washed, showered, eaten or taken other actions prior to engaging with the facility, which may affect the recovery of forensic material. These activities and actions shall be recorded on the

forensic medical examination paperwork, to assist the development of a forensic strategy and interpretation by the forensic scientist. (see section 6.5). If the patient is concerned about these actions, they should be reassured that this is normal.

6.3.7 Gathering information about the assault can be a difficult process for patients who have been subjected to sexual violence. The information-gathering process shall be sensitive and respectful to the patients, in a trauma-informed way, minimising repetition of questions relating to the assault [23].

6.3.8 The forensic medical examination should be a thorough process which may 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.

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

6.3.9 The FHPs shall ensure patients are always given the correct information and advice regarding a forensic medical examination and the options available to them (the Code, section 91.6.1).

6.3.10 The Code (section 91.6.2) requires that the patient shall be provided with accurate information about the facility. This may include:

a. the services which 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.

6.3.11 As required by the Code, section 91.6.3, FHPs 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 which relate to the sexual assault; and
d. the importance of the recovery and preservation of such material, the documentation and interpretation of medical findings of forensic relevance.

6.3.12 As required by the Code section 91.6.3 in relation to the collection of forensic samples, the FHPs 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. defaecating;
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.

6.3.13 In particular, where the patient reports vaginal or anal assault, samples shall be taken following documented procedures (the Code, sec 91.6.1) and in accordance with the FFLM recommendations [11], subject to the patient's consent. 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.

6.3.14 The FHPs at the facility providing the initial contact to the patient will need to explain 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 it. This also applies to sanitary products, underwear liners or nappies being worn or discarded, but available for evidence collection.

Decision to undertake an examination

6.3.15 Recovery of material with potential forensic relevance and documentation of physical findings, including injuries, or their absence, as well as an evaluation of the therapeutic needs of the patient shall be considered when deciding on the appropriate time-frame for conducting a forensic medical examination as part of the examination strategy (code section 17).

6.3.16 The decision to undertake a forensic medical examination shall only be made by a trained and competent FHP (the Code, sec 91.7.2). Therefore, the FHP shall be consulted as soon as possible after the patient's presentation or disclosure where there is any question about whether a forensic medical examination is required immediately, or at all. The decision about whether, where and when to carry out the examination should be made, taking into account the medical needs of the patient and acute mental health concerns. In addition, the FHP should consider the flowcharts for pre-pubertal and post-pubertal complainants provided by the FFLM in the Guide to Establishing Urgency of Sexual Offence Examination [24], the Recommendations for the Collection of Specimens from Complainants and Suspects [11].

6.3.17 For children, the decision to undertake a forensic medical examination shall be made by multiagency agreement at strategy discussion in accordance with the statutory guidance Working Together to Safeguard Children [25]. Where there are grounds for concern, there should be a presumption towards examination, subject to valid informed consent. The strategy discussion shall include an appropriately trained and competent FHP, with specific competences in relation to the age-group of the child.

6.3.18 Where children disclose sexual offences, or there is a concern a sexual offence may have occurred, there should be a holistic strategy discussion, involving the FHP, police, children's social care, to address the child's safety, medical care and forensic strategy, where appropriate. The FHP shall be aware of the shorter time frames within which DNA type evidence might be retrieved and how quickly injuries in a child may heal. The FHP should have the expertise to advise the strategy meeting on timescales, but the strategy team collectively makes the decision to offer a forensic medical examination. (the Code, section 91.7.3).

6.3.19 Where it is necessary for the patient to be taken to an emergency department from, or prior to reaching, the facility (for acute physical or mental health needs), the FHP shall advise on if, where, and when an FME shall take place. (the Code, section 91.7.4). Attending the hospital will depend on discussion with the responsible clinician/consultant to avoid compromising the patient's care. It is generally accepted, in these circumstances forensic integrity may be compromised, however, the needs of the patient come before gathering material with forensic relevance [26]. In these cases, FHPs should work alongside other healthcare providers, for example, a patient requiring an examination under anaesthetic, (EUA), and/or surgical repair of an injury; or provide advice to those who are treating the patient.

6.3.20 Any forensic samples shall be collected using approved forensic kits, FDG, where required for DNA retrieval. Hospital swabs are not suitable for forensic purposes and shall not be utilised. FHPs should be aware, if asked, blood and urine samples taken at hospitals, although not necessarily containing appropriate preservative, may still provide useful evidence, in the absence of any more suitable specimens, (the Code, section 91.7.5). In these circumstances, the FHP should advise the police to seek advice from their forensic science provider.

Attendance of the forensic healthcare practitioner

6.3.21 Local policy will dictate who has the responsibility for requesting the attendance of the FHP and the expected time frames for attendance at the facility.

6.3.22 The provider of the forensic medical workforce should ensure they are able to provide a timely response to reflect the clinical and forensic needs of patients. There should be advice from a competent FHP available 24 hours a day and 7 days/week, and timely arrangements made which best meet the needs of the patient [24] [27].

6.3.23 Risks of cross-contamination and processes to minimise shall be considered by the attending FHP (Code section 91.11), see FSR-GUI-0017 [9], section 7 for more details.

6.3.24 The communication of where and when PPE is donned when interacting with the patient should be determined in advance, for example, either this introductory conversation needs to take place outside the forensic waiting room with the CW in normal wear, then CW changes, or someone else meets the patient and shows them into forensic waiting area where CW already is in PPE to have that conversation. Once in PPE, the FHP should remain in DNA clean areas otherwise the PPE should be changed on re-entering the DNA clean area.

Arrival of the patient

6.3.25 On the patient's arrival at the facility, a CW or equivalent should meet the patient (and of any companions . 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.

The patient's companion shall not enter any of the DNA clean rooms for recent (acute) cases where the retrieval of trace/DNA evidence is expected unless accompanying the patient as per the patient's choice or are the parent/carer of a child or it is non-recent (non-acute) incident. The companion shall be advised to wear PPE, and this shall be documented, along with any requirement for an elimination DNA sample

6.3.26 The CW should provide immediate support to the patient, companion, parent or carer, by explaining:

a. their role as a chaperone and in supporting and advocating for the patient throughout their time at the facility;
b. the options available, including the opportunity to have a forensic medical examination, and 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, including identifying and addressing the patient's expectations; and
d. how the medical examination will be conducted.

6.3.27 Although the CW may be repeating what has already been explained 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.

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

6.4 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

6.4.1 Once the CW has completed their discussion with the patient/parent/carer, the FHP shall introduce themselves, if they have not already done so. The FHP shall explain what is proposed and check they are willing to continue with the FME.

6.4.2 Where specialised equipment, such as a specialist medical video-camera [28], [29] is to be used during the examination, this may need a more detailed explanation from the FHP, including its purpose and function and how it will be used during the examination, and the subsequent secure management of the images.

6.4.3 In order to obtain consent the FHP 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

6.4.4 The FHP shall obtain informed consent [30] [31] [26]from the patient or the child's parent/carer 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. for children under 18 years old, consent should be obtained for a child protection medical report with interpretation of anatomical findings and analysis of safeguarding risk to be shared with children's social care; and
g. where applicable, separate, specific consent to the use of their anonymised photographs/videos/digital images/medical notes for teaching or research purposes [26];

For self-referrals:

h. 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, if available, or to proceed with a police complaint, before destruction [32]; and
i. For self-referrals who do not want to progress to a police complaint, permission to share anonymised information and/or process samples anonymously (if such a service is available),

6.4.5 The patient (or the person with parental responsibility, in the case of children without Gillick Competence) should understand the purpose of the examination and be able to give consent freely.

The patient (or the person with parental responsibility, in the case of children without Gillick Competence) should be aware 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.

6.4.6 Guidance and requirements for obtaining consent are provided by the FFLM [26], the General Medical Council (GMC) [31], the Nursing and Midwifery

Council (NMC) [33], and the Health and Care Professions Council (HCPC) [34], in accordance with the Mental Capacity Act 2005 [35].

6.4.7 It is the responsibility of the FHP to seek informed consent from the patient. Where there is concern 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 [26] . 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).

6.4.8 When the patient is a child, reference should be made to the GMC [36] [37], the Royal College of Paediatrics and Child Health (RCPCH) [38] and the RCPCH & FFLM [39] guidance documents for obtaining valid consent. Consent for a forensic medical examination should be obtained from one of the following:

a. parent/carer with parental responsibility;
b. the child, if they are of sufficient age and understanding (as assessed by the FHP, seeking advice from other professionals e.g., paediatricians), if appropriate;
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

6.4.9 Where a patient, whether adult or child has reported the assault to the police, the FHP should take an initial account of the assault from the police. This may include information from other professionals, e.g. social worker.

6.4.10 Although an Achieving Best Evidence (ABE) interview (or video recorded interview, VRI) may be required by the police, it should not take precedence over a timely forensic medical examination.

6.4.11 The FHP may confirm and document 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.

6.4.12 If the patient has not reported the assault to the police and has self-referred to the facility, the FHP (where appropriate) will take the account directly from the patient after consent has been given.

Medical/social history

6.4.13 The FHP (where appropriate) shall document relevant information (the Code, sec 91.6.1c) 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 should be taken [40]. This may be from a parent, caregiver or from the child themself – depending on the age and capacity of the child., The child should be given the opportunity to talk to the FHP independently of carers [36].

6.4.14 Care should be taken to ensure the 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 the important information is routinely asked by FHPs, where the patient is an adult, [41] or a child [42].

6.4.15 The FHP 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

6.4.16 Safeguarding is an important aspect of the holistic assessment of the patient. Consideration of safeguarding issues needs to be addressed in all cases particularly if the patient:

a. is a child (under 18 years);
b. is a carer for children; or
c. is a carer for an adult at risk.
d. or is an adult at risk.

6.4.17 Where the patient is under the age of 18 years, a forensic medical examination is a specialist form of child protection medical assessment. A child protection medical report should be produced, which includes expert interpretation of the physical findings and analysis of the safeguarding risks, in all cases. This includes older children who present as self-referrals, where applicable, and where there is no police/criminal justice action.

6.4.18 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

6.4.19 FHPs should ensure 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 the examination.

6.4.20 The facility shall have procedures in place for examination activities undertaken including the relevant skills for working with patients (the Code 91.6.1a), 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.

6.4.21 Where interpreters are necessary, except in a medical emergency, family members shall not be used, and the gender preference of the patient should be taken into account. Where interpreters are required, in person, the patient shall choose where they are positioned during the examination. If necessary, an on-line/telephone interpreting service may be an alternative choice, provided by the police (for a police referral) or the facility (for a non-police referral).

6.4.22 As required by the Code, section 91.10.2, 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 DNA clean areas they accessed and whether they wore full or partial PPE in the DNA clean controlled areas, should be recorded. If an

elimination sample was not 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. The level of PPE and elimination sample information can vary and should be based on risk assessment of whether the examination is acute, i.e. recent requiring sample recovery or non-acute where no forensic samples are taken. Please refer to section 8.6 in FSR-GUI-0017 [9] for more details regarding DNA elimination samples.

Roles and responsibilities of those conducting the examination

6.4.23 Where more than one person is conducting the examination, for example, in the case of a child where a paediatrician and another FHP might be present, their respective roles and responsibilities [40] within the examination shall be documented (the Code section 91.8.1).

Removal of clothing (the Code, section 91.9)

6.4.24 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.

6.4.25 Where damage to clothing is detected, the FHP 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 FHP 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. Ideally, 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.

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

6.4.27 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.

6.4.28 The patient should be asked to remove clothes, one item at a time, trying to maintain the orientation in which 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).

6.4.29 The professional or FHP collecting and subsequently packaging the clothing should wear gloves, ideally two pairs of gloves (doubled gloved) and hold an exhibit bag open for the patient to place the item inside. The gloves / 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 as the patient's exhibit could be a police investigator, sexual offence liaison officer (SOLO) / sexual offences investigative trained officer (SOIT)/specially trained officer (STO), or a CW or a FHP.

6.4.30 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 which were worn at the time of the incident, then these may be packaged together to reduce handling.

6.4.31 The description of the clothing shall be documented (the Code, sec29.2.7) 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 minimal delay (see FSR-GUI-0017 [9], sec8).

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

6.5.1 The FHP shall consider the medical, psychological and safeguarding needs of the patient, alongside the collection of information which could potentially be used to support an investigation or subsequent court case relating to the

assault. It is important the forensic medical examination is carried out methodically to ensure all relevant information relating to the assault is sought.

6.5.2 With regard to the collection of forensic samples, FHPs, 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, also for safeguarding risk assessment, age-group, known gang affiliations).

6.5.3 There is a FFLM pro forma designed to assist FHPs in the assessment of adult male and female patients [41]. The FFLM has also designed a similar form for children [42]. Organisations can use their own pro forma provided it meets the FFLM content as the minimum requirement.

6.5.4 Where the patient is a child or young person the paediatric forensic medical examination should include a comprehensive assessment as described in the paediatric proforma published by the FFLM [42]. 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 which is known. The forensic medical assessment provides an opportunity to consider, identify and make onward referral 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 [43] and 2004 [44]. This assessment shall also inform the planning of any ongoing investigation or

treatment required by the child, and appropriate explanation and reassurance for the child and family.

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

6.5.6 The FHPs should thoroughly examine the patient, based on the consent provided, from top to toe and check for any injuries, areas of pain or soreness. It is essential the FHP notes any medical signs which may impact on a differential diagnosis, either positive (present) or negative (absent). The FHP shall ask the patient how and when any findings may have occurred and relevant information shall be documented (the Code, sec 91.10.1).

The location of injuries and the relationship between multiple injuries should be documented such as using body diagrams. The FHP should consider photographing injuries, requesting additional specialist photography or provide advice, particularly where there may be detail in the injury which may assist the investigation, such as a footwear pattern within stamping or kicking injuries or teeth marks from biting injuries. The FFLM has published guidance on photography [29] and injuries caused by teeth [45].

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

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

6.6.2 Where the FFLM recommendations provide the order of sampling for a particular site, for example, the vagina, this should be followed [46]. 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.

6.6.3 During the collection of the samples, the FHP shall take steps to minimise contamination (the Code section 91.12). For further information regarding contamination prevention see section 7 of FSR-GUI-0017 [9].

The facility shall have clear procedures in place for minimum PPE worn (6.4.29), packaging, labelling, and sealing items/exhibits since this is critical for their admissibility during criminal proceedings (the Code, section 29.2.3). 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.

6.6.4 It shall be the responsibility of the person who obtains the sample to ensure each sample is appropriately labelled as detailed in the FFLM guidelines on the labelling of samples [22]. This should be done at the first practical opportunity, and before items are stored. In the event a CW, SOIT/SOLO/STO, police investigator or scenes of crime officer (SOCO), also known as crime scene investigator (CSI), is requested to assist with the labelling process, the responsibility to ensure the samples are correctly labelled remains with the FHP.

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

6.6.6 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).

6.6.7 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 moistening the swab; if the nozzle makes contact with any contaminated surface then the water ampoule should be discarded.

6.6.8 A chain of custody is required for all forensic samples. Similarly a chain of evidence (custody) process is required for sexually transmitted infection (STI) samples [47] where they may be relevant to the forensic case, agreed between the facility and a local medical microbiology/virology laboratory.

Transfer of samples

6.6.9 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.

6.6.10 Where the patient has not reported the assault to the police the FHP 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 29.2.8).

It is important the transit time between collection and storage of samples shall be minimised wherever possible. Samples shall be packaged to avoid potential degradation. For example, for self- referrals should off-site storage be required, samples shall be transported in a timely fashion in suitable insulated carrying containers to keep the samples cold during transportation (the Code, section 29.4.2).

Storage of samples (Code, sec 33.1.9 and 33.1.10; ISO 15189, sec 6.3.3 and 7.4.2)

6.6.11 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) . Traceability for the stored samples shall be maintained to include those who have had access, when and why to specific samples held.

6.6.12 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].

6.6.13 The facility shall follow sample storage policies to ensure:

a. optimal storage conditions are adopted for all samples collected as part of the forensic medical examination; and

b. the bio-hazards for handling and storing samples containing human tissue, including body fluids, e.g. blood, urine are understood and comply with local and national infection control procedures.

6.6.14 Where samples are held in cold storage at the facility, a system shall be in place to ensure 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 so that appropriate action can be taken expeditiously.

6.6.15 The facility should ensure policies are in place to address evidence storage in cases where the patient is undecided about reporting to the police. It is important there is adequate space and provision to store samples taken from patients who self-refer.

6.6.16 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 essential the patient is informed at the time of the forensic medical examination 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.

6.6.17 In the event 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 shall be provided with suitable information regarding the retention and destruction policy.

Sample management (Code, sec 91.11.3, ISO 15189, sec 7.4.2)

6.6.18 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 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.

6.6.19 The FHP 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

6.6.20 Where the referral is a self- or non-police-referral, the samples should be placed in storage at a facility by the FHP 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 to ensure the sample can be located and retrieved.

Images (Code, sec 91.11.4)

6.6.21 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.

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

6.6.23 It is the responsibility of the facility to ensure any images taken by FHPs at the facility adhere to the following process:

a. The images are taken by FHPs 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.

6.6.24 Should images of intimate areas be required, these should be taken by the FHP during the forensic medical examination. These images along with descriptions and body diagrams may be used for second opinions and/or peer review. Imaging should be routinely used, subject to the appropriate consents, in all children under 18 years, and in adults who have not been voluntarily sexually active; it should be considered in all cases where there are injuries seen or suspected, the FHP shall record this in the documentation (ISO 15189, sec 7.2.4.1). The FFLM has published guidelines on photography [29] and intimate images [48].

6.6.25 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 [28].

6.7 Ensuring the quality of examination procedures (ISO 15189:2022, sec 7.3.7; the Code, sec 23.3, 91.11)

6.7.1 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 which minimise the possibility of contamination from the moment a patient arrives at the facility to undertake a forensic medical examination until completion of the examination.
b. Record keeping for the use of locks/security seals to rooms in the forensic area of the facility, e.g. 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. Staff at the facility understand the scientific basis for both preventative and decontamination procedures and are competent in conducting practical cleaning regimes and associated record keeping.

e. Staff at the facility understand the difference between a deep clean, cleaning requirements for DNA clean controlled areas, and a general clean.

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

6.8.1 As required by the Code (section 91.14) at the point the FHP decides to undertake a forensic medical examination resulting in the collection of items/exhibits, the FHP shall wear personal protective equipment (PPE), details of the PPE to be worn and the recommended sequence of putting on for both cleaning and examination activities can be found in FSR-GUI-0017, section 8.5.4 [9].

6.8.2 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 FHP considers the use of a face mask to be distressing and it is subsequently not worn, this should be recorded in the examination case notes with the reasons. However, the FHP's DNA profile shall be available for contamination elimination purposes, as required in section 91.12.6 of the Code. Further guidance on this can be found in section 8.6 of FSR-GUI-0017 [9].

6.8.3 Hand hygiene is an essential part of the examination procedure. Hands should be decontaminated by washing with liquid soap using good hand washing technique [49] before donning gloves and following their removal. If taking blood sample for alcohol analysis, then avoid using alcohol hand rub.

7. Documentation – recording of notes and statements

7.1 Note taking and record keeping (ISO 15189:2022, sec 8.4; ILAC G19, sec 3.5, Code 19.2)

7.1.1 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 which is directly relevant to contact with the patient at the facility, along with dates and times [50].

7.1.2 Notes may be handwritten (in black ink) or electronic and should be recorded contemporaneously or at the first practical opportunity. The name, role and regulatory number of the FHP undertaking the examination shall be recorded, along with the date and the time. Other documentation may be made by the crisis worker and the same principles should apply.

If the FHP undertaking the examination is not recording the notes, then they FHP shall 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. Local SOPs shall address when there are two FHPs undertaking the examination, who is responsible for what aspect of it and similarly, how trainees are supervised.

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

7.1.4 It is important forensic medical-related decision made by the FHP is recorded along with the reason for it. 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.

7.1.5 Case notes shall contain sufficient details to enable a FHP to provide a preliminary findings report, which includes an interpretation of the findings and generate a statement, if required (code section 19.2).

There is a range of specimen proformas published by the FFLM to assist FHPs with the process of note taking and sample information [51], [42], [41]. However, it is important for FHPs to recognise additional information or activity, not included in 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 proformas should be seen as a guide only and not a definitive list of information for inclusion in the patient's notes.

7.1.6 All notes (including records such as images taken using a specialist medical video-camera and off-site storage) shall be retained by the facility in a secure location which complies with data protection requirements [52]. 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. Processes should be in place for the transfer and/or access to records following change of service provision and/or where FHP is no longer employed by the facility.

7.1.7 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 FHP removing and returning the notes.

7.2 Preliminary findings (ISO 15189:2022 sec 7.4.1 and 7.4.1.6k; the Code sections 20 and 91.14.4; ILAC G19 4.9)

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

7.2.1 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 informed and understand 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.

7.3 Statements and reports (ISO 15189:2022, sec 7.4.1; the Code sec, 20 and 31 and ILAC G19, sec 4.9)

7.3.1 The facility shall define a process for the production of statements and reports to meet the requirements of the criminal justice system. The FHP shall comply with the relevant sections of the Criminal Procedure Rules and Criminal Practice Directions [53] 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.

Some guidance on the format for expert and non-expert technical reports can be found in the Expert Report Guidance [54] and the Non-expert Technical Statement Guidance [55] respectively.

7.3.2 All cases shall be subject to an independent peer review (Code section 20.3) 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 7.3.4 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.

7.3.3 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.

7.3.4 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.

7.3.5 FHPs shall be appropriately trained to produce a statement which is acceptable for use within the criminal justice process. All FHPs shall be provided with ongoing support from a competent individual to assist them with statement writing [56] [57].

7.3.6 From 02 October 2025 a declaration of compliance or non-compliance to the Code [4] shall be made on all statements and reports relating to FSA-BIO-100 for the forensic medical examination of complainants [58].

8. Acknowledgements

8.1.1 This guidance has been updated by the Office of the Forensic Science Regulator, the Faculty of Forensic & Legal Medicine, The Havens, St. Mary's, and reviewed by the Forensic Science Regulator's Medical Forensics Specialist Group.

9. Modification

9.1.1 This is the second issue of this document.

9.1.2 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 it is a guidance document. Combined with the issue number this ensures each document is uniquely identified.

9.1.3 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-#-####.

9.1.4 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.

10. Review

10.1.1 This document is subject to review at regular intervals.

10.1.2 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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13. Abbreviations

Abbreviation	Meaning
ABE	Achieving best evidence
ASET (UKAFN)	Advanced standards in education and training
CJS	Criminal justice system
COP	College of Policing
CPS	Crown Prosecution Service
CW	Crisis worker
DNA	Deoxyribonucleic acid
ED	Emergency department
EEK	Early evidence kit
EM	Environmental monitoring
FDG	Forensic DNA Grade
FFLM	Faculty of Forensic & Legal Medicine
FHP	Forensic healthcare practitioner
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/advocate
MedExD	Medical Examiners Elimination Database
NMC	Nursing and Midwifery Council
PAS	Publicly available specification
PPE	Personal protective equipment

Abbreviation	Meaning
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
SOIT	Sexual offences investigative trained officer
STO	Specially trained officer
STI	Sexually transmitted infection
UKAFNP	United Kingdom Association of Forensic Nurses and Paramedics
UKAS	United Kingdom Accreditation Service
UKSC	United Kingdom Supreme Court
VRI	Video Recorded Interview

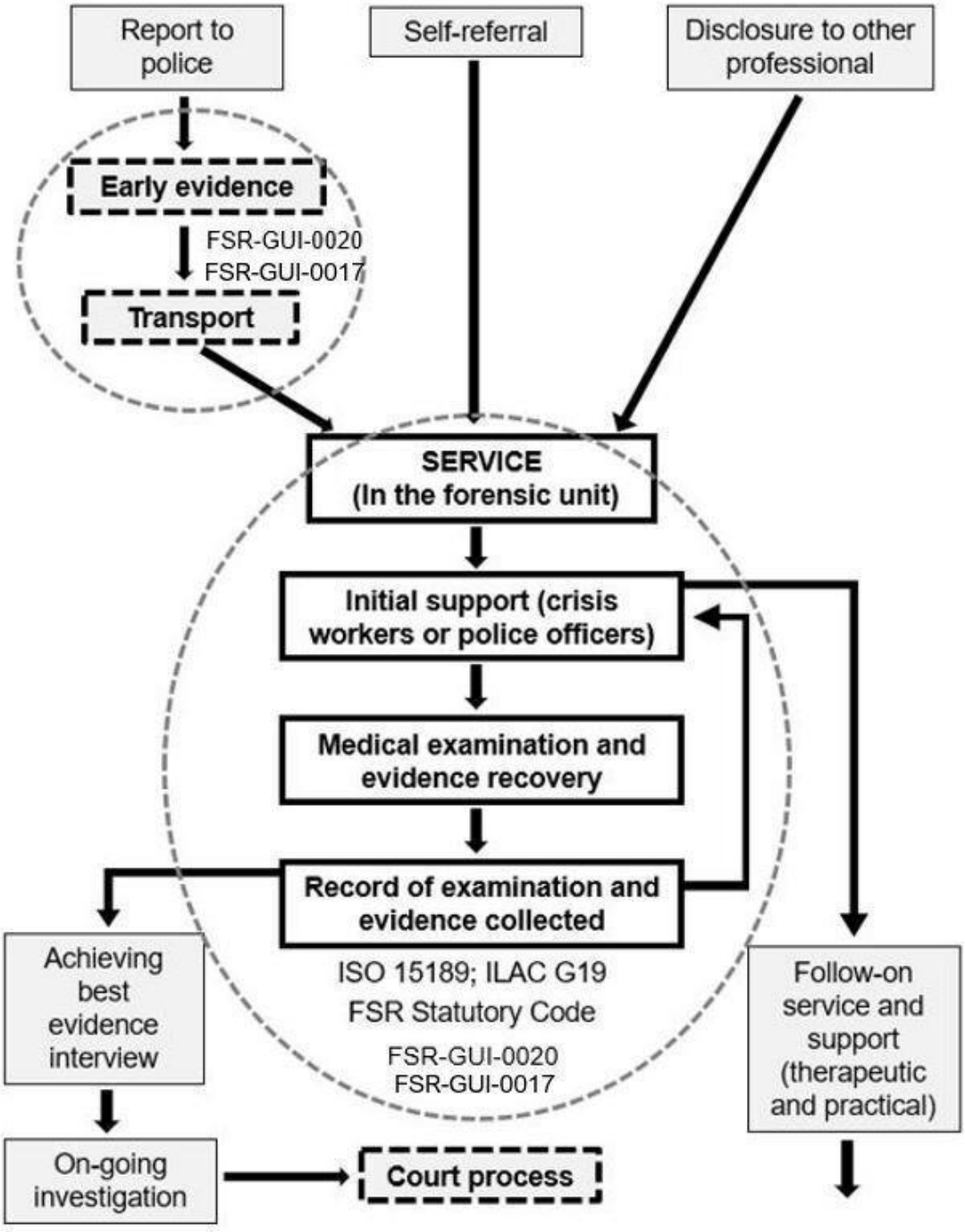
14. Glossary

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 which 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.
Forensic healthcare professional/practitioner (FHP)	The term used to describe forensic physicians (including paediatricians), forensic nurse examiners, forensic midwife examiners and forensic paramedics.
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/advocates (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.

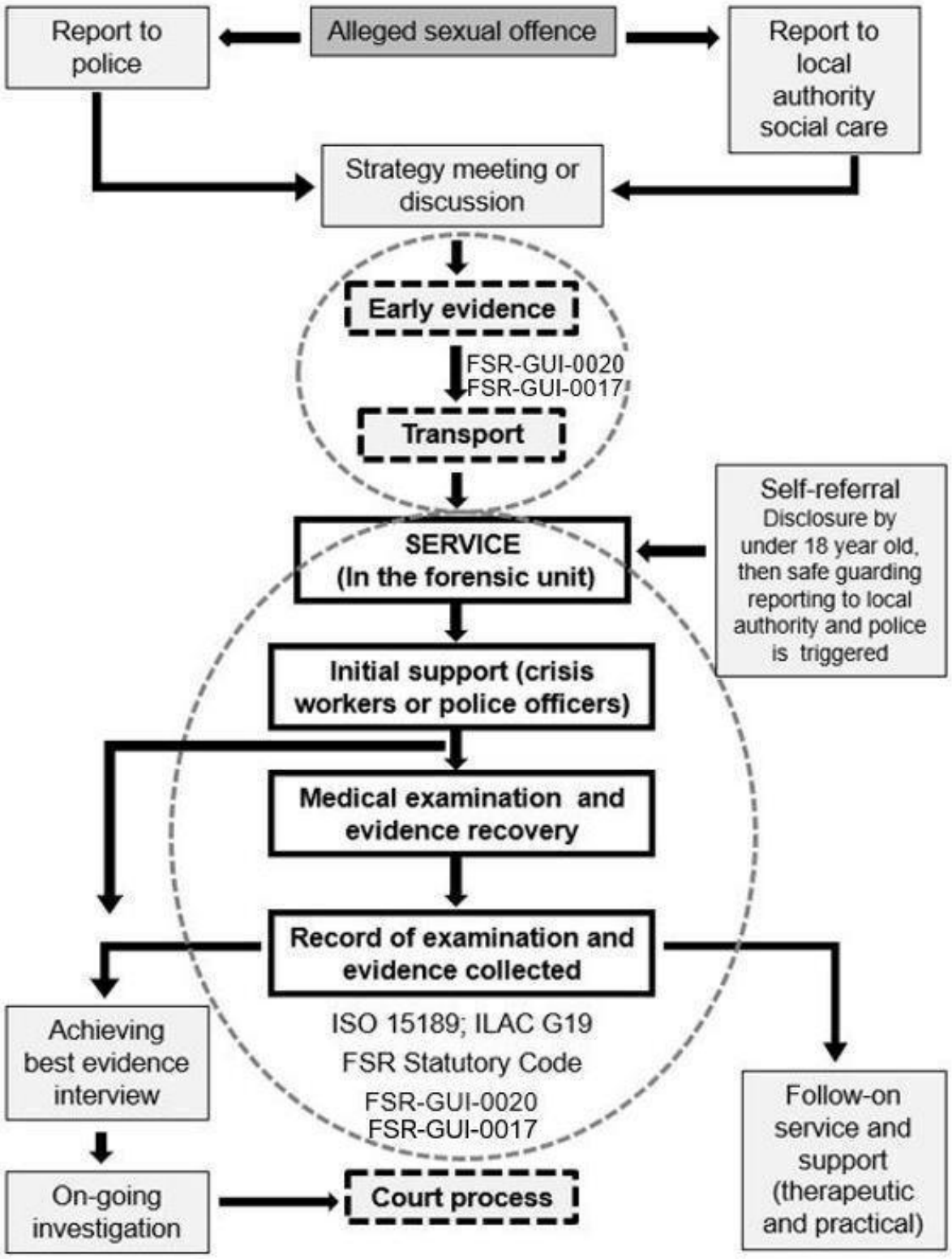
15. Annex A: patient pathways

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).

16. Annex B: self-assessment readiness guide

16.1 About this self-assessment

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

16.1.2 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 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.

16.1.3 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.

16.2 Self–assessment completion

16.2.1 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.

16.2.2 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 which clearly shows the lines of management/reporting (e.g., responsibility, clinical governance structures and legal responsibilities) which 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 which 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 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 which is separated 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 which 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 the 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 expiry 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 are designated 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, special medical video-cameras and equipment controls are easily cleanable or protected by removable flexible covers which 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. The couch is cleaned, and the 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	**Furnishings and equipment used for the examination**	**Assessment**	**Evidence**
5.11	Equipment records and unique identifiers per key item are used. For example, which special medical video-camera wascamera was used is noted.		
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 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 at the facility are the same for both patients who self-refer and those who are referred 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 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 in which patients which patients of sexual assault may present following an assault. A non-judgemental approach is adopted in every case.		

6	Examination methods and procedures	Assessment	Evidence
6.3	FHPs at the facility ensure patients (and their companions) are always given the correct information and advice regarding a forensic medical examination and the options available to them.		
6.4	FHPs 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 which 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	FHPs at the facility are aware the samples 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 an FHP. 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 which identifies who has the responsibility for requesting the attendance of the FHP and/or paediatrician, and the expected time frames for attendance at the facility.		
6.7	The provider of the forensic medical workforce ensures they are able to 'provide a timely response' 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 which shall ensure the FHP available for sexual offence forensic medical examinations is not also used for custody medicine during the same time period. Code section 23.3.7,91.12.		

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 FHPs.		
6.10	A crisis worker (or equivalent) is available to meet the patient (and their companion), accompany them to the pre-examination waiting area of the facility and provide immediate support.		
6.11	The crisis worker is able to ensure a urine sample or oral sample is taken using the early evidence kit and confirm that any non-intimate skin swabs are taken, where appropriate		
6.12	The FHP 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 FHPs 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 to which they had access, 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. Similarly, a chain of custody/continuity/evidence for sexually transmitted infection (STI) samples is required 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 shall be the responsibility of the FHP 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 the 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 the 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 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 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 there has been no loss or alteration of evidence prior to criminal proceedings.		
7.10	FHPs or paediatricians (where appropriate) are appropriately trained and familiar in how to operate the equipment required to capture a permanent record/image.		
7.11	Imaging records taken by FHPs 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 which minimise the possibility of contamination; • record keeping for the use of locks/security seals for rooms in the forensic area; • steps which have been taken to identify contamination; • the FHPs understand the scientific basis for preventative and decontamination procedures; • the FHPs are competent in conducting cleaning and the associated record keeping; and • an audit plan is in place.		

8	Ensuring the quality of the examination procedure	Assessment	Evidence
8.2	To undertake a medical examination, the FHPs 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	FHPs 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 which will undertake the DNA profiling for elimination purposes; and • sharing agreement of DNA profile information (between FHPs, 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 individuals 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 [9]).		
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 which 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	Records, notes and statements	Assessment	Evidence
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	FHPs are appropriately trained to produce a statement which is acceptable for use within in the criminal justice process.		
9.10	All FHPs are provided with ongoing support from an appropriately experienced forensic physician to assist them with statement writing.		

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

17.1 Forensic healthcare practitioners and professionals providing service within the facility

Crisis worker (however named)

17.1.1 The primary role of the crisis worker (CW) (or professional fulfilling the role, such as a paediatric nurse) is to provide immediate support to the patient and companions where relevant (for example, family members where the patient is a child) prior to and throughout the examination process.

17.1.2 The CW acts as 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.

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.

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

17.1.4 The CW should be competent to:

a. provide information and initial crisis support to the patient (and/or their companions);
b. communicate and engage with the patient (and/or their significant others);
c. advocate on behalf of the patient (and/or their significant others);
d. carry out an initial assessment to identify the needs of and risks to the patient of sexual violence;
e. provide and give guidance on the use of the EEK;

f. assist in the collection and labelling of forensic samples (if appropriate); and
g. clean the medical examination and DNA clean areas of the facility to the accepted standard (if appropriate).

17.1.5 Organisations employing CWs should ensure the CW is trained to an appropriate standard which is maintained, (see 16.1.7), 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.

17.1.6 Competency assessment should take place after training, followed by ongoing assessment through regular clinical and management supervision. The organisation should ensure CW has access to and undertakes continuous professional development. There are relevant National Occupational Standards (NOS) [59] for CW to use regarding giving advice and their role

Forensic nurses, midwives and paramedics

17.1.7 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 the nurse should recognise and work within their competence [60]. The HCPC also requires healthcare professionals should recognise and work within their competence [61].

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 [62], and the Royal College of Nursing [63], [64] and Nursing and Midwifery Council [65].

17.1.8 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.

17.1.9 The FFLM provides advice for obtaining qualifications in clinical forensic medicine [66], the content of introductory training, and quality standards for nurses of patients who have been subjected to sexual offences [67]. The United Kingdom Association of Forensic Nurses has developed advanced standards in education and training for nurses in the sexual assault setting [68].

Forensic physician

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 they are able to meet the competencies to undertake the role to conduct a medical and forensic examination [66].

17.1.10 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 [27].

Paediatrician

17.1.11 The role of the paediatrician is to provide for a child patient either:

a. the medical element of a forensic medical examination, which will include a comprehensive assessment of the physical and emotional development of the child or young person; or
b. both the medical and forensic elements of the forensic medical examination, which will also include a comprehensive assessment of the physical and emotional development of the child or young person.

17.1.12 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) [39].

17.1.13 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 [27]. The RCPCH has published guidance regarding numbers of examinations and maintenance of competence [13]. 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 [39].

Cleaner specialising in DNA decontamination

17.1.14 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 [9] and
b. utilise the cleaning agents in a manner compliant with relevant health and safety requirements.

17.1.15 The decontamination cleaner should be trained to an appropriate standard to ensure 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)

17.1.16 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.

17.1.17 Those involved in quality management should be trained to an appropriate standard to ensure 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 it is properly maintained;
c. an understanding of the staff roles and responsibilities required for the effective operation of the quality management system; and
d. auditing the quality management system.

17.2 Professional providing initial contact/first response at the facility

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

a. Call handler;
b. FHP
c. CW;

17.2.2 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 companions 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.

17.2.3 The professional providing initial contact/first response should be trained to an appropriate standard to ensure 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.

17.3 Police personnel

First response police officer

17.3.1 The first response police officer is the professional who responds to the patient following the 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 companions, 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.

17.3.2 The first response police officer should be trained to an appropriate standard to ensure 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.

17.3.3 The College of Policing provides a course which supports police officers providing initial response, the rape and serious sexual assault (RASSO) first responder programme [69], and has published a briefing note for police first responders [70].

Sexual Offences Trained Officer

17.3.4 The SOIT/SOLO/STO is the police officer who acts as a conduit between the complainant and the investigating officer. The SOIT/SOLO/STO should be competent to:

a. provide information and initial crisis support to the patient (and/or their companion(s));
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.

17.3.5 The SOIT/SOLO/STO should be trained to an appropriate standard to ensure 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 SOIT/SOLO/STO's role and responsibilities;
b. communication and working effectively with the patient and third parties;
c. assessment of need, risk and safety;
d. general forensic awareness including an overview of the forensic medical examination;
e. use of the EEK;
f. collection, packaging and storage of forensic samples;
g. preserving, packaging and labelling forensic samples; and
h. the options available to patients for forensic medical examination, including timescales.

17.3.6 The College of Policing expects SOIT/SOLO/STO s to be trained at Professionalising Investigations Programme (PIP) level 1 and provides a course for SOIT/SOLO/STO s, the Sexual Offences Officer Learning Programme.

Investigating officer

17.3.7 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.

17.3.8 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 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 which 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

17.3.9 The investigating officer should be trained to an appropriate standard to ensure 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 which is developed as part of the investigation;
c. understanding the role and responsibilities of the SOIT/SOLO/STO, crisis worker, FHP, paediatrician, forensic submissions 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

17.3.10 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.

17.3.11 The forensic submissions authoriser should be trained to an appropriate standard to ensure 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 SOIT/SOLO/STO, crisis worker, FHP, 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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