

The UKAFN Newsletter

# Europe meets the United States and Canada

## Special points of interest:

- The official Launch of the UKAFN
- European and International partnership
- The IAFN 15th annual Scientific Assembly
- Mapping of SARC's and New members
- The week in the life of a Forensic Nurse Examiner
- Website update

## THE LAUNCH OF THE UNITED KINGDOM ASSOCIATION OF FORENSIC NURSES

The official launch of the UKAFN took place on 22<sup>nd</sup> March 2007 at Kings College Hospital London.

The room was bustling at the sides with attendees from as far as Sweden, Ireland and the 4 corners of the UK.

The line up of speakers was amazing, Kathy French (from the RCN), Dr. Cath White. (St Mary's Centre, Manchester) and John Yates (assistant commissioner from the Association of Chief Police Officers - ACPO). Several steering group members also spoke including Christine Donohue and Jacqui Hilder.

There was also a speech from Mavis, a former Haven service user, who shared her experience of being raped. When she had finished the room was silent and tears rolled from many an eye. This was, followed by a standing ovation. Wow! What a powerful speaker. Many listeners suggested Mavis should write and publish a book of her journey.

Our last speaker was Virginia Lynch, founding president of the International association of Forensic Nurses. Her experience as a Forensic nurse and the struggles she endured to get forensic nursing recognised as a specialist role in the United States, only supported and fuelled our determination to follow suit. To not only have forensic nursing recognised as a speciality, but to ensure it is about client care, along with maintaining excellent standards in preserving and collecting forensic evidence and developing and maintaining national standards and to produce a national accredited course for forensic nurses.

### Developments since the launch:

It is with great delight to announce since the launch of the association, the UKAFN steering group members have been invited to sit on the board or working group of the:

- Clinical Effective Committee. British association of Emergency Medicine- To produce national guidelines for the treatment and care of sexual assault victims that present to Accident & Emergency departments.
- Adult Rape and Sexual assault FME guideline Development group- This is working group includes the DH, ACOP, and the Home Office.
- The steering group are also in talks with a leading London university in developing an accredited course for Forensic and Custody nurses.- It is also support by the Council Registration of Forensic Practitioners CRFP. The RCN, Skills for Health and are presently seeking ACPO support.

The voice of the UKAFN is certainly starting to make a difference

### Inside this issue:

Photo of the UKAFN steering group	2
Europe meets the US and Canada	3
Inside Story	4
The UKAFN map Of members	5
A Week in the life of an FNE	6
Latest Home Office Stats.	8
The IAFN 15th Annual Scientific Assembly	9



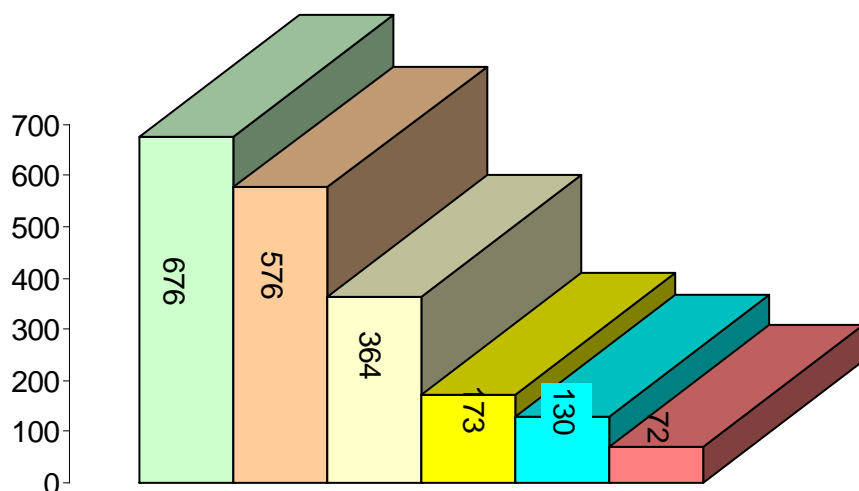
*Steering group members.*

*Back row –left to right Kylie Hobern, Adam Mcmillian, Angela Connor, Sue Fawkes, Amanda Alcock*

*Front row. Left to right. Jacqui Hilder, Anna Hulse, Lindsay Ferguson, Jo Delaforce, Christine Donohue, Annika Stenvall.*

### How the justice system handles rape cases

- Rape complaints in the sample studied, of which
- Police. No crimed
- Arrests made
- Suspect charged/cautioned
- Goes to trial
- Convictions



### Europe meets the United States and Canada



#### European Forensic Nurses join in partnership with the USA and Canada.

On the evening of Thursday 28<sup>th</sup> June 2007, in the historic backdrop setting of Brussels seven forensic nurses came together from five different countries for the first

ever meeting of European and International forensic nurses.

It was history in the making. Susan Chason the president of the International Association of Forensic Nurses (IAFN) based in America had contacted me following the official launch of the UKAFN.

The states had waited many years for forensic nursing to make a stand in the UK and similarly in Europe.

Susan invited me to join the meeting held in Brussels not only see how the IAFN could support the first sister Association in Europe, but also to meet with the General Secretary

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**It was also agreed that violence is not just a criminal justice matter**

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**The graph on page 2 is the latest Home Office Figures released on Friday 20th July 2007**



of the European Federation of Nurses Association (EFN).

The other attendees were Sheila Early, Sexual Assault Nurse Examiner (SANE) from Canada, Stacey Mitchell a forensic death investigator from Huston Texas, Piet Machielse from Holland, Giovanni Muttillio from Italy and Jonas

Lindgren the leading forensic death investigator from Sweden.

We all met on the Thursday evening to chat informally about our own individual roles, the settings in which we work and the challenges we faced as forensic nurses in raising the awareness, knowledge and skills as

examiners. The same issues had arisen nearly 25 years ago in America with the introduction of forensic nurses. Canada faced similar problems more recently. Both Susan and Sheila shared how the IAFN and nurses as individuals faced these challenges and now work side by side with clinicians and the criminal

justice units.

The evening was a great success and firm bonds were formed.

The following morning we arrived at the ENF and were sadly informed that the general secretary had to fly urgently to Poland.

However we were never going to be defeated in our task. We

grilled the EFN secretary for as much information on the EFN and its role in the EU, which is to strengthen the status and practice of the profession of nurses and interest of nurses. The EFN participates in the consultation process on the EU health strategy. They have over 1 million nurses from Na-

tional Nursing Association. Their aim is to ensure a qualitative and equitable health service in the EU by a strategic contribution to the development of an effective, competent and motivated workforce. Our conclusion was that the EFN fights for Nurses, however it does not fight for them to progress in their clinical

## The UKAFN Newsletter

ability and for this to be recognised.

It was however suggested that we contact the European Specialist Nurses Organisation (ESNO), this will be our next move.

We also agreed that it was paramount to confirm just how many forensic nurses are practicing in Europe. If you are aware of any forensic nurses outside of the UK, I would be very grateful if you could drop me a line.

It was also agreed that violence is not just a criminal justice matter it is a nursing

issue. All violence impacts on health: sexual assault, death investigation, custody nursing, domestic violence, child abuse, elder abuse and many more. Violence related crimes cost the health care system an immense amount of money.

The next meeting for us all to join again to discuss global matters will be in Italy in May 2008. We are of course keeping in constant contact by e mail and any further developments will be shared with you in the newsletter.



Picture s left top. Stacey Mitchell; piet Michielse; Jonas Lindgren; Sheila Early; Jo Delaforce; Giovanni muttillo; susan Chasson. Below; group outside the EFN.

### NEW LOOK WEBSITE:

The UKAFN website has a new webmaster and server.

Dr Tony Knight (FME) fromSussex has very kindly agreed to take over our website maintance and improvement programme. The new look is much improved and far more eye catching.

There are many new features

to the website including A message board. A members only page. Committee page. There is a employment page, which will list current vacancies in our specialist areas

http://www.ukafn.org

United Kingdom Association of Forensic Nurses  
UKAFN Home

Home About Us Resources News Events Courses Links Contacts Membership Members

**Forthcoming Courses & Events**  
Visit the Courses and Events pages for full details and further items not shown here.  
No records  
1 of 1

**Our Mission Statement**  
UKAFN is committed to:

- raising the awareness and profile of Forensic Nurses.
- working together to develop, improve and maintain a high standard in forensic collection.
- providing high quality nursing care for all individuals in a holistic manner

Membership is open to Forensic Nurses working in the field of sexual assault and custody nursing.  
Associate Membership is open to individuals who have a genuine interest in Forensic Nursing.

**Please note that your first year of membership is FREE**

**Why not visit the Membership page?**  
You will find a description of the benefits of

**Latest News**  
Visit the News page for full articles and further items.  
Under development  
The website is being built at present so you should see it evolve over the coming months.  
1 of 1

We will also be adding and updating the articles pages on a regular basis, which up till now has causes some challenges.

The UKAFN map will also have added any new SARC's and members.

The Newsletters will be available and all back copies will also be viewable.

*The UKAFN 's 1st Annual Conference will take place in Spring 2008*

*Who would you like to see there?*

*What speakers would you like?*

*Which subjects would you liked cover?*

*What can the steering group do to make this an amazing 1st International conference?*

*Please let us know by e mailing your ideas and wants. The association is about you, for you so tell us.*

*E mail  
chairperson@ukagn.org*

*The next UKAFN steering group meeting is on the 18th October 2007*





### A week in the life of Christine Donohue RN, BSc: Forensic Nurse Examiner at St Mary's Sexual Assault Referral Centre, Manchester, UK.

#### Christine's background

I first learned about the Forensic Nurse Examiner (FNE) role after attending the St Mary's Sexual Assault Referral Centre conference in January 2003. This conference introduced to the UK the idea of the Sexual Assault Nurse Examiner to perform forensic medical examinations following a pilot project at the Centre, from then on I knew this was the job for me. I had always been interested in the work of the St Mary's Centre and thought that it would be my ideal job if ever an opportunity presented itself.

In November 2003 I attended an interview for that very post and heard I had got the job as I was driving back from another conference, this time on domestic violence. It was as though I had been preparing myself for this position.

After working for six years in acute and research settings, mostly in relation to women's health, for, I had been looking for a more specialised role. I wanted a job that would be in a clinical setting, in a role in which I could make good use of my clinical and life skills. Over the years, partly due to knowing someone to me who had experienced domestic violence, I had developed an interest in abuse and its impact on health. During my years in nursing I have never been afraid of asking difficult questions and now realise that the compassion I feel for people and the counselling skills I have developed, stand me in good stead in the FNE role. The FNE role also fulfils my interest in the legal system, forensic medicine and how the two are associated.

#### Christine's week

The week for me starts at 0900 **Tuesday** morning, as I don't work Mondays. I pick up my first cup of coffee of the day and as I take my first sip, the phone rings and I know it's for me. The Force Duty Officer, who by now I am on first name terms with, informs me there are two cases pending and there are two specific requests for a forensic medical examination. He informs me there is another in the 'pipeline' but no specific request as yet. After collecting the details of both cases I prioritise who will be seen first.

Forensic considerations are made along with other issues such as: the age of the client, if an appropriate adult is available, if an interpreter is required and available, the nature of any physical injuries, if the client is intoxicated; and if there are any mental health issues, to name a few!

I want to get the first client down to the Centre as soon as possible. This gives the best chance of evidence collection as well as fulfilling the needs of the client such as getting a shower and a change of clothes and something to eat and drink. We organise an estimated time of arrival (ETA) of 10:00, sooner if the police officer can get here, and a provisional 12:30 ETA for the second case. I inform the Crisis Worker covering for the day that we have two definite cases so that she can organise her day. I have no time to waste so I make my way to the examination suite to prepare the forensic examination kit.

The first client arrives and spends time with the Crisis Worker. She is the client's advocate throughout the time the client is in the examination suite. She outlines the services and provides information that enables them to make informed choices about the services they wish to access. She will also be present for the client during the forensic examination and ensure the client has information about follow on services. I collect information from the police officer. I then speak with the client, obtain consent for the examination, collect any further details as appropriate, perform the top to toe examination, collect the relevant forensic samples, provide hormonal emergency contraception and sexually transmitted infection advice, document my findings, label all samples taken, write a brief summary of findings and eventually hand all the samples over to the police officer. The client then leaves

## Europe meets the United States and Canada

In the meantime I have contacted the Force Duty Officer and asked for the second case to be put back half an hour, giving us time to decontaminate the suite (something we do after every case). This can be an opportunity to refuel with a quick sandwich and a cup of tea before the next client arrives.

The possible third case has become a definite request which will be allocated to the forensic physician on duty in the evening as this second case may take a while, he has a number of physical injuries and requires Hepatitis B and HIV prophylaxis. The second client leaves the centre at 1630. I have organised for the client to have photographs taken by the Scenes of Crime Officer (SOCO) as soon as possible at a location agreed with the client. The examination suite is decontaminated, I collect my belongings and go home.

**Wednesday** starts more slowly. I contact the Force Duty Officer at 0905 there are no specific requests so far. They will keep me informed of any changes. I inform the Crisis Worker covering for the day. I now have time to check my emails from Friday last week onwards, as I had no chance to do that yesterday. We have a team meeting in the diary so this runs from 10:00 to 11:30. This is the opportunity for the day team to get together and share with each other what their work commitments are, and any specific issues that may affect the rest of the team. This is really useful time and allows us all to remember how busy we all are in our various roles.

By 12:00 we have a 'walk in'. This is a client without an appointment who has come to the centre seeking advice following a sexual assault two days ago. Following a discussion with one of the counsellors, the client requests a self referral examination. She is unsure about reporting to the police at this stage. At 12:30 the client is in the examination suite. The forensic examination goes ahead in exactly the same way as the police referral except that the forensic samples are stored at the St Mary's Centre should a police referral be made in the future. The client leaves at 15:00. For the rest of the afternoon I pick up where I left off from a statement of evidence I have been working on for a number of days. The Investigating Officer wants the statement by next week. This isn't the only one I have to write, I have another one pending. The one I am working on today is very detailed and therefore lengthy due to the number of physical injuries documented on body charts at the time of the examination. There is a request for an examination from the Force Duty Officer at 16:00. The doctor on call will take up this request. I leave for home at 17:00.

**Thursday** – I hit the ground running! I contact the Force Duty Officer and they have a case ready and waiting. The client arrives at 09:30. At 11:30 I am told about another client who is currently in the Accident and Emergency Department, I arrange for the client to come to the centre as soon as she is finished there. The first client I examined left the centre at 12:00. Whilst waiting for the second client I grab my lunch and finish the statement I've been working on. At 14:00 the second case arrives, she's in pain and is really tired. She manages to get through the lengthy examination and leaves at 17:00. I leave at 17:30.

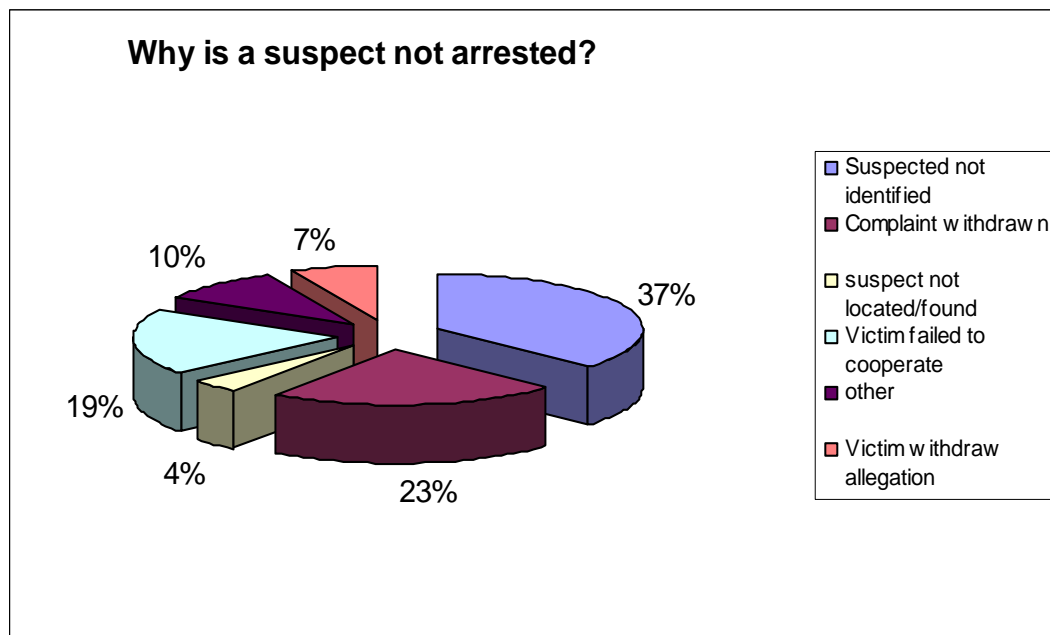
**Friday** begins with an external supervision session from 09:00 to 10:00. I access this every six weeks, in brief, its purpose is to provide an opportunity to talk openly and safely about how the work that I do impacts on me and whether there have been any particular cases or issues which have caused me concern or upset between sessions. I see this as an essential element in my professional development. It keeps me functioning at an optimum level, by recognising that the work I do can affect me as a human being in a very deep way. I come out of the session feeling as though I've done a day's work. Supervision requires some thought and reflection and my supervisor makes me work hard!

I get to work for 10:30 and there are no cases pending but I have a pile of administration to get on with. Another request for a Section Nine statement has been made and I have a letter from the Witness Care Unit in relation to client I examined six months ago. This is an initial letter informing me of the date of the plea hearing and wanting my non availability for court. I deal with these two things first and move onto my emails which I last looked at Wednesday morning.

onto my emails which I last looked at Wednesday morning. I receive a phone call from a practice nurse asking for advice about Hepatitis B prophylaxis follow up. I take a phone call from a client thinking about having a forensic medical examination.

I receive a call from the Force Duty Officer who has a request for an examination. I arrange this for an hour's time. In the meantime I am approached by one of the counsellors. A client she has seen has concerns she is pregnant. I counsel the client before the pregnancy test. The test result is negative. Other issues of sexually transmitted infection screening and family planning are addressed and we arrange follow up. This client had chosen not to report to the police. The previously arranged client arrives at 1400. This client is non-English speaking and a police interpreter is present. Working with an interpreter inevitably prolongs the process and therefore the length of time the client is in the centre. The examination complete, the client leaves at 1700.

This brings an end to a busy and varied week! Each day is different bringing its own challenges and opportunities for learning. The unpredictability of the work is challenging but also provides variety and extremely interesting choice of career. My role as a FNE is deeply fulfilling, demanding and at times is upsetting. Working within a team of staff in the Sexual Assault Referral Centre setting provides a highly supportive working environment. This support is essential in this developing role. I knew when I applied for this post I had set myself a challenge but I love the work and know I have found my niche.



**More statistics  
Released by the  
Home Office.  
20th July 2007**

**The Haven's publicity Campaign**

*This poster campaign was officially launched on the 1st June 2007. The campaign is supported by the Metropolitan Police services, the National health Service and has also been endorsed by the mayor of London.*

*The aim is to raise public awareness of the services offered by the Havens in a hope that it becomes a recognized provision embedded in the mindset of Londoners. There are a set of 4 posters*

*Sadly,  
rape is a daily  
occurrence.  
Fortunately,  
you can call us  
24 hours a day.*

Supporting a rape can sometimes seem as traumatic as the rape itself. Perhaps unable to tell so family or friends, and reluctant to go to the police, a rape victim can often feel like there's nowhere to turn.

**The Haven sees us up for smoothly that reason.**  
To provide another chance for people who've just suffered perhaps the worst trauma of their lives.

At a Haven, experienced and fully trained professionals know exactly what to do in the immediate aftermath of an attack. And their expert care, counselling and advice continue for as long as it takes in the months that follow. All conducted, of course, with appropriate confidentiality.

**No one should have to deal with rape on their own. Now they don't have to.**

**call**

CAMBERWELL 020 3299 1599  
PADDINGTON 020 7 886 1101  
WHITECHAPEL 020 7247 4787

## The UKAFN Newsletter

### Organization Address

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### NEXT ISSUE.

*Amanda Alcock Custody Nurse Manager from Hull.*

*Writes about her exciting experience following her visit to the United States, last month, to visit the Police units and sexual assault examination units.*

*Next UKAFN Newsletter*

*DECEMBER 2007*

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### The IAFN 15th Annual Scientific Assembly In Salt Lake City

The 15<sup>th</sup> Annual Scientific Assembly of the international Association of Forensic nurses will be held in Salt Lake City, Utah (October 17-20, 2007)

Piet from Holland and Jonas of Sweden, both UKAFN members are running for International member at Large, (only one will be elected) This will enable them to have input into what direction the organization will take in the future. There is presently 3 non US board members on the IAFN board.

The cost of attending the 15<sup>th</sup> Annual assembly is:

IAFN members \$450.00 approx  
£227.00

Non IAFN members \$565.00 approx  
£285.00

For further details go to [www.IAFN](http://www.IAFN)

### FACTS AND FIGURES

- Stranger assaults are still more likely to be reported than those committed by an acquaintance, partner or family member. (Crime in England and Wales 2004/05)
- Sexual assault not only affects women, but also men and children
- People who have been sexually assaulted can have many reactions including: humiliation, calmness disgust, powerlessness, numbness, disbelief, fear, guilt, blaming of oneself, isolation and unwillingness to tell others.
- 140 people were sexually assaulted in illegal mini cabs in London last year. Only use licensed mini cabs. (Project Sapphire website, 2004)
- In Scotland in the year 2003 there were 988-recorded cases of rape and attempted rape. (Scottish Executive)
- There were 60,900 sexual offences recorded by the Police in England and Wales. (British Crime Survey).
- For a variety of reasons, people do not always report crimes to the police – which means they do not get reflected in police crime figures. This is especially so with sexual offences in which only a minority of people report (British Crime Survey)
- Latest Home Office figures show that only 5% of rape cases reported to the police result in a conviction.
- A Home Office research study published in 2005 'A Gap or a Chasm? Attrition in reported rape cases' found that 80% of cases did not get beyond the investigation stage. ([www.truthaboutrape.co.uk](http://www.truthaboutrape.co.uk))
- 1 in 4 women have experienced rape or attempted rape (Painter, 1991)
- There are on average 167 reported rapes a day in the UK (RCF 2003)
- Only 1 in 5 Sexual assaults will be reported to the police (RCF 2003)
- 1 in 6 victims of sexual assault access an A & E dept. (The Haven, Camberwell, 2006)
- 81% of reported sexual assaults were tested positive for alcohol (Scott-Ham and Burton, 2005)