Delayed/Anonymous Reporting Issues

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Sexual assault victims have a number of important and far reaching decisions that must be made soon after the assault. During this time of likely significant trauma, turmoil, fear, shock, and disbelief, they must decide if they are going to disclose the assault, if they are going to report to law enforcement, and if they are going to get medical attention. It is unlikely that without additional information from trained professionals they will fully understand the true implications of these decisions. This paper will discuss the labels different tribes and communities use to describe and document these decisions and the implications of the labels. It will also discuss the impact of VAWA 2005 and make recommendations about the information the professional advocates and SANE/SAFEs need to provide victims so they can make informed choices.

One of the first choices the victim must make is deciding whether or not to seek medical attention including having a medical evidentiary examination. Unfortunately, in some communities this decision was and may still be tied to making a formal law enforcement report. This is unfortunate because many victims are unable or unwilling to make a decision about talking to law enforcement in the immediate aftermath of a sexual assault. Especially in tribal communities fear of retribution is significant and not an unrealistic fear. Pressuring these victims to report may actually discourage their future involvement in the criminal justice process (USDOJ, 2004). During the initial crisis response period victims are most likely to be fearful of the assailant, it is in the weeks and months following when recovery begins and they are in a safe location with trusted

relatives and friends that the fear turns to anger and they are more likely to want to report the crime and hold their assailant accountable (Frazier & Ledray, 2011). It is essential that the patient's choice to seek medical attention, including an evidentiary exam and evidence collection , remains a separate decision from talking with law enforcement and participating in the criminal prosecution.

In some communities law enforcement has historically insisted on "authorizing the exam". Unfortunately, this decision was inconsistent and based on limited or biased information. If the law enforcement or tribal police officer did not believe the victim was "really raped" or if the victim was intoxicated, or did not want to report or cooperate with prosecution, the exam would not be "authorized". This was both a control and payment issue. If the patient went to a non-HIS hospital for care and the exam was not "authorized" by law enforcement, that meant SANE or hospital would not be paid for completing the exam and in jurisdictions where law enforcement held the evidence collection kits, it meant the SANE/medical staff would not be given a kit to use to collect evidence. This sometimes also meant the SANE and advocate were not even called to the hospital to see the patient. This clearly significantly limited the care these patients were provided and put law enforcement in a position to determine the medical response to these patients.

This was unfortunate, as an early study found 38% of patients who came to the hospital after a sexual assault were initially uncertain if they wanted to report to law enforcement. However, when the SANE and advocate were automatically activated, and the patient was allowed to have an evidentiary exam completed and evidence collected 12% of those who did not initially want to report allowed the SANE to call law

enforcement to the hospital and an additional 23% made a report to law enforcement within 30 days after the exam. Only 3% were certain they did not want to report and declined the evidentiary exam (Ledray & Kraft, 2001).

Another study linked reporting to law enforcement to receiving medical attention in a positive way. The National Crime Victim Survey (NCVS) found that between 1992-2000, 39% of attempted rapes and 17% of completed sexual assaults resulted in physical injury to the victim. Only 34% of attempted rapes and fewer still, 26% of sexual assaults were reported to law enforcement. However 53% of the victims who reported to law enforcement received medical attention compared to only 18% of those who did not report to law enforcement (Rennison, 2002). We can conclude from this data that one way to facilitate victims the getting medical care they need for injuries and to prevent sexually transmitted disease and pregnancy is to encourage reporting to law enforcement. In areas with SARTs law enforcement is educated to bring the victims to the medical facility immediately for the forensic medical exam.

VAWA 2005 Reauthorization Impact

The VAWA 2005 Reauthorization recognized the importance of having trained professional advocates and SANE/SAFEs respond and of allowing the patient to make the decision about having a sexual assault evidentiary exam, including forensic evidence collection without charge and without also needing to immediately decide to report to law enforcement and cooperating with prosecution. As a result, one of the VAWA 2005 forensic compliance mandates was to ensure victims of sexual assault had access to a forensic medical examination without requiring them to talk to or cooperate with law enforcement or participate in the criminal justice system (VAWA 42 USCA S. 3796gg-4

(d) (1). The goal was to encourage patients to come to a medical facility as soon after the assault for medical care and evidence collection. This was important because the evidence that can be collected on the patient's body is more likely to be found the shorter the time between the assault and evidence collection. This is a primary reason forensic exams are only performed for a limited time after the sexual assault. Initially most communities limited forensic medical exams to 72 hours after an assault (ACEP, 1999; DOJ, 2004; Ledray, 1999; Littel, 2001). With advances in DNA recovery this time frame has been extended to 96, or 120 hours after the assault and in some communities even longer (Delfin, F., Madrid, B., Tan, M., & De Ungria, 2005; Ledray, 2006; Ledray, 2010; Ledray & O'Brien, 2011). The Indian Health Service (IHS) has no specific time limits for evidence collection but recommends that when the need for evidence collection is in question the potential benefits and limitations should be discussed with the patient (IHM, 2011).

As a result, since January 5, 2009, when VAWA 2005 was implemented, medical facilities are now expected to provide a medical forensic examination to patients reporting a sexual assault, including evidence collection, without requiring the patient to report to law enforcement or cooperate with prosecution and without billing the patient for these forensic services (VAWA 42 USCA S. 3796gg-4 (d) (1).

IHS, similarly concerned, made similar recommendations in their most recent Indian Health Manual (IHM). Their goal is to provide patient-centered care for the sexual assault victim. They stress the importance of having a specially trained victim advocate and SANE/SAFE respond and provide every patient with complete care including an evidentiary exam, even if they are reluctant to report the assault to law enforcement

immediately. They recognize that native communities are small and victims often feel vulnerable and want to remain anonymous (IHM, 2011). This belief is reinforced by data in the NCVS. They found that when the offender was a friend or acquaintance, 82% of sexual assaults were not report to law enforcement (Rennison, 2002). Clearly, in small tribal communities this is a significant issue.

Does the label matter and what does it really mean?

While the VAWA 2005 Act requires compliance by all States it does not stipulate what a State must do to comply. As a result there has been significant variance in compliance and terminology both by State and by different tribal community as well. These options have been referred to as "anonymous reporting", "blind reporting", "Jane Doe reporting", "restricted reporting", and "delayed reporting". Unfortunately, defense attorneys have used this terminology in an attempt to discredit the victims.

"Delayed reporting" is a term defense attorneys have more often tried to use to discredit victims, suggesting they were not "really" raped, but for some ulterior motive decided to report the incident as a rape "after the fact". It is also unclear what defines a "delayed report". Is it "delayed" if the victim waits hours, or days, or weeks, or years to tell anyone? Is it truly "delayed" if when she reports the rape to hospital staff she is not ready to talk with law enforcement, but decides to do so later? As a result of the confusion and attempts of defense attorneys to discredit a victim who makes a "delayed report" to law enforcement the term "delayed reporting" is not recommend (Archambault, Feb 12, 2012-IAFN Webinar).

In many communities if the patient wants a medical forensic exam with evidence collection but does not want to talk with law enforcement immediately at the time of the

exam, the medical facility will store the evidence collected in a secure storage area, for a specified period of time, properly maintaining chain-of-custody. There are currently no national standards for how long the medical facility must keep the evidence and storage times vary widely. In these cases the patient has time to make a decision about participating in the legal process without the fear of the loss of biological evidence on their body or clothing. They can talk to law enforcement after a good night sleep and with a trusted friend present. The victim may decide within hours, days, or weeks to make a police report. If this occurs the evidence collected and all documentation will be turned over to law enforcement upon request. The victim may also, however, be too embarrassed or fearful to come forward. If no police report is made in the specified time period, the medical facility will then destroy the evidence collected.

Other communities comply with the VAWA 2005 Reauthorization by utilizing "Blind reporting", "Jane Doe reporting," or "anonymous reporting". These terms all imply that while law enforcement is involved in some way, they are not informed as to the victim's identity. In communities that mandate the reporting of sexual assault, as some tribal laws require for adults as well as adolescents, medical professionals must meet the requirements of the mandatory reporting laws but they cannot release any additional information about the assault without the patient's consent. The victim, however, also retains the right not to talk to law enforcement or participate in the criminal justice system. It may mean that law enforcement is told a sexual assault has occurred, but given no additional information. When the medical professional is mandated to report the patient should be informed of this legal obligation, what triggers the mandated

report, what agency the report must be made to, and the contents of the report (USDOJ, 2004).

It may also, however, mean law enforcement is asked to take custody of the evidentiary kit when collected, with a number instead of the victim's name on the outside of the kit. The IHM stresses the importance of using a unique alpha-numeric identifier that cannot be tied to the patient (e.g. not the patient medical record number). The patient can then use this number to identify themselves later if they decide to make an official law enforcement report (IHM, 2011). In these cases the evidence is typically held by law enforcement for a specified time that will also vary from community to community from as little as 30 days, to one year, or indefinitely. As when the medical facility stores the medical evidentiary kit, this is done to give the victims a chance to decide if they want to talk with law enforcement and participate in the criminal justice system. If no report is made, the evidence may then be destroyed.

Destroying the evidence after the specified time has become somewhat controversial, as law enforcement wants access to the evidence collected to use to apprehend a possible serial offender. More recently as the amount of stored evidence increases, some medical facilities and law enforcement agencies have turned over the evidence to the crime laboratory to store, and in some states the crime lab is now processing the evidence when requested to do so by law enforcement. A concern with this practice is what will happen if a DNA profile is identified in an "anonymous" or "Jane Doe" kit and linked to a suspect. This is a realistic concern since most "anonymous kits" use an alpha-numeric identifier on the outside of the kit, but use the patient's name on the envelopes inside the kit as well as on the documents attached or in

the kit. Detective Archambault cautions that if law enforcement wants to identify the victim they will be able to do so, as "that is what law enforcement does. We find people who do not want to be found" (Archambault, Feb 12, 2012-IAFN Webinar).

When the evidence is turned over to law enforcement for storage, it is important for the victim to be informed what will likely happen to the evidence; will it be turned over to the crime law and will it be processed? It is also important to inform them about the limits of their "confidentiality". For instance, once an official law enforcement investigation is in progress, if law enforcement requests the medical records of the sexual assault exam visit as part of their investigation of a sexual assault, even if the victim themselves did not report the crime, the hospital must turn over the evidence. They do not need the patients consent to do so (Health Insurance Portability and Accountability Act (HIPAA, 45 C.F.R 164.512).

"Restricted reporting" is the term used by the military to identify sexual assault survivors who have come to the hospital for medical care that may also include evidence collection, but they do not want to talk with law enforcement or disclose their identity to their chain of command. In these cases evidence that is collected is held for one-year. The unit commander is told there was a sexual assault but is not told the victim's name and no investigation results unless the victim decides to come forward later and make an "unrestricted report".

Recommendations

Whenever a sexual assault victim comes to a medical facility reporting a sexual assault a specially trained fully informed medical professional, preferably a SANE/SAFE and advocate should be available to meet with the patient and explain the medical and

legal options and the implications of these choices. The patient should be encouraged to get medical care, including an evidentiary exam even if they are reluctant to report to law enforcement at the time of the exam. This choice should not be described as "uncooperative" or "delayed reporting". The patient has made the first important step by coming to the medical facility ad reporting the sexual assault to the medical professionals. Appropriate information and support should be provided immediately. If the medical professionals are mandated to report the assault to law enforcement in their communities they should disclose when and what will be reported and to whom. The patient should be fully informed about the limits of their confidentiality and what steps can and cannot be taken to protect their privacy.

The patient should also be informed that while the forensic medical evidence may be collected and preserved to be used later if the victim chooses to participate in a law enforcement investigation, other types of evidence may be lost at the scene of the assault and it may be difficult to locate witnesses to get their statements about what they observed. The longer they wait to talk to law enforcement, the more difficult it may be for the prosecutor to charge the case.

Clearly it is the responsibility of the advocate and medical professional to be fully informed about the implications and how any evidence collected will be handled in their community, so the patient can be fully informed. If evidence is held by the medical facility and destroyed by them if no report is made, they are indeed able to maintain patient confidentiality. However, if the evidence is being turned over to law enforcement, as occurs in IHS facilities, the patient needs to be fully informed about

limitations of confidentiality and about what will happen to any evidence they allow the medical professionals to collect.

This stresses the importance of having SART policies and procedures that are clearly and fully documented, so everyone truly knows what to expect and to continue to encourage law enforcement to bring the victim to the medical facility for care. Patients who absolutely do not want to be involved in the criminal justice system can then make an informed decision to or not to have evidence collected and can still receive medical attention. SANEs may also decide to not use the patients name anywhere in the kit if they are uncertain about reporting to law enforcement to provide additional protection to the concerned patient.

It is also important to recognize that the terminology used when a victim comes into a medical facility for an examination but is not willing, able, or ready, to talk to law enforcement immediately can have a significant impact on the criminal case if the victim later decides they do indeed want to go forward and talk to law enforcement. It can also have a significant impact on the patient if law enforcement decides to process the evidence later even without the patient making a formal law enforcement report. If the biological evidence collected will be turned over to law enforcement we cannot guarantee to the patient that it will remain "anonymous" and we need to inform them, to the best of our understanding, what could result. When the evidence is being turned over to law enforcement the SART should have written, agreed policies and procedures so the patient can be fully informed. Patients requesting evidence collection without law enforcement cooperation should be informed of the risks and benefits that may be encountered with

making this decision. Providing informed consent is the first step to providing "patient centered" care that allows a victim to regain some control after the assault.

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