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Relationship Between Conviction Rates of Child Abuse Perpetrators and Forensic Medical Examinations Performed By Trained Versus Non-Trained Examiners on Victims of Child Sexual Abuse

Leila Smith Bragg
Georgia Southern University

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THE RELATIONSHIP BETWEEN CONVICTION RATES OF CHILD ABUSE PERPETRATORS AND FORENSIC MEDICAL EXAMINATIONS PERFORMED BY TRAINED VERSUS NON-TRAINED EXAMINERS ON VICTIMS OF CHILD SEXUAL ABUSE

by

LEILA SMITH BRAGG

(Under the direction of Carol J. Strickland)

ABSTRACT

Thorough and detailed forensic medical examinations on sexually abused children can result in findings that make stronger cases against alleged perpetrators involved in child sexual abuse. A retrospective chart review was conducted of 1561 child abuse cases occurring in the Middle Judicial Circuit of Georgia during a 3-year period. Charts were reviewed to assess whether or not the child received a forensic medical examination and if the examination was performed by a trained or a non-trained forensic examiner. Court conviction data were obtained from the office of the district attorney in order to compare conviction rates to the forensic medical examiner training. Of 1561 child abuse charts reviewed, 756 (48.4%) were sexual abuse cases. The major finding that emerged during the research, whether or not the perpetrator was convicted, was the surprising lack of forensic medical examinations being performed on children who were victims of sexual abuse. In addition, the majority of cases were never even referred to the district attorney's office for prosecution. A corollary and serendipitous finding was the emotional healing that began to take place as a result of the child receiving a forensic medical examination.

INDEX WORDS: Child sexual abuse, Forensic nurse examiner, SANE, Colposcope, Children's advocacy centers, Emotional healing, Conviction rates, Forensic medical examinations, Child sexual abuse perpetrators
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by

LEILA SMITH BRAGG

B.S.N., Emory University, 1970

M.S.N., Georgia Southern University, 2005

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THE RELATIONSHIP BETWEEN CONVICTION RATES OF CHILD ABUSE PERPETRATORS AND FORENSIC MEDICAL EXAMINATIONS PERFORMED BY TRAINED VERSUS NON-TRAINED EXAMINERS ON VICTIMS OF CHILD SEXUAL ABUSE

by

LEILA SMITH BRAGG

Major Professor: Carol J. Strickland
Committee: Donna Hodnicki
Kathy Thornton

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DEDICATION

To Ennis,

my husband and soul mate,

for his belief in me and for his never-ending encouragement and support.
ACKNOWLEDGEMENTS

A special thanks goes to my four children, Ennis, Jr., Leila, Ira, and Mary,

my son-in-love, Will, daughter-in-love, Angela,

and my precious grandson, William,

for being there for me throughout my years in graduate school.

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CHAPTER 1

INTRODUCTION

The forensic medical examination performed on sexually abused children is an important part of the legal process. Thorough and detailed examinations make stronger cases against alleged perpetrators involved in child sexual abuse (Kelley & Yorker, 1997). The skill and ability of the examiners, therefore, is critical to maximizing success of the legal prosecution of alleged perpetrators of these crimes. This chapter will present the problem statement, study purpose, and the conceptual framework that guided this exploration.

Problem Statement

One of the problems that contributes to a lack of perpetrator convictions is the short supply of medical experts to perform examinations and to document findings. Without properly trained forensic examiners performing accurate examinations, perpetrators may avoid prosecution due to loopholes such as inadequate documentation or insufficient evidence. Lack of training in forensic medicine, lack of expert examiners, time constraints on physicians, and the reluctance of physicians to testify in court have all contributed to the emergence in the past 27 years of the role of the forensic nurse (Ledray, 1997; Ledray & Barry, 1998). A forensic nurse acts as an expert examiner as a result of specialized training to perform forensic medical examinations. A forensic nurse examiner not only brings skill and expertise in the performance of the forensic medical examination but also a holistic view of the child and family. The forensic nurse examiner
is the most well-prepared experienced professional in the areas of psychosocial, emotional, and physiological assessment and management of the sexually abused child.

*Purpose of the Study*

The purpose of this study was to explore the relationship between conviction rates of child abuse perpetrators and forensic medical examinations performed by trained versus non-trained examiners on victims of child sexual abuse. Other forensic examination elements included the number and location of examinations, the use of a colposcope, and physical findings. Demographics considered were age, gender, race, and county of residence of the child. The perpetrator’s relationship to the victim was also recorded.

*Significance of the Study*

Research has shown that the level of training of the forensic examiner is a critical element in the initial physical evaluation of child sexual abuse (Kelley & Yorker, 1997). In this regard, the role of the trained forensic nurse examiner is invaluable not only for initial physical examination, but also in subsequent treatment and long-term management of the victim and family. By acting as an advocate for the victim and family, forensic nurse examiners have an opportunity to make significant contributions to society-at-large. Studying the relationship between characteristics of forensic examiners who perform medical examinations and the subsequent conviction rates of the perpetrators of abuse is an important step which may result in a better understanding the factors that will more effectively lead to successful outcomes in the area of child sexual abuse. Such data may lead to increased success in court actions and to improved clinical protocols utilizing trained forensic nurse examiners. Further nursing research can lead to public awareness
and increased funding resulting in social change ultimately benefiting the victims, families, and society. Health policy recommendations can be made to provide ongoing training and continuing education for forensic nurse examiners in order to build stronger collaborative relationships between the medical and judicial systems in cases of sexual abuse of children to effect improved outcomes.

*Hypothesis and Study Questions*

The study hypothesis was: There will be a significantly higher number of perpetrator convictions in a group of children who were examined by trained forensic examiners compared to a group of children who were examined by non-trained forensic examiners.

Several study questions emerged from the review of the literature: What types of professionals are performing forensic examinations and in what settings? What are the types of physical findings obtained on forensic examination and to what extent do examiners use the colposcope? What is the relationship of the perpetrator to the child victim and what types of convictions are obtained following prosecution?

*Conceptual Framework*

There is a dearth of conceptual models that relate to the forensic nursing role. One model that provides a conceptual model for the study was developed by Lynch (1995) titled The Integrated Practice Model of Forensic Nursing. The Integrated Practice Model of Forensic Nursing developed by Lynch (1995) is shown in Figure 1 (reproduced with permission).
In Lynch’s Model, which will be referred to as the conceptual framework, the role of the nurse is conceptualized as a combination of nursing science, forensic science, and criminal justice that creates a framework to deliver holistic care to alleged victims, alleged perpetrators, and significant others. The forensic nurse attempts to understand human behavior and responds to the acts of crime and violence (V. Lynch, personal communication, March 31, 2004).

Lynch’s Model is composed of nine circles within a triangle surrounded by two concentric circles. The three sides of the triangle represent the multi-oriented roles of
forensic nursing. Role expectations is the base side of the triangle with role behavior and clarification of roles comprising the other two sides. Inside the triangle are nine circles. At the bottom left three overlapping circles represent human behavior, social sanctions and crime and violence. At the bottom right three overlapping circles represent forensic nursing, health care and victim and offender. The top of the triangle has three overlapping circles which are nursing science, forensic science and criminal justice. A symbol with three components sits in the center of the triangle. The symbol is made up of the scales of justice with the caduceus superimposed and a flame above. The symbol represents a balance between the medical and legal communities (Lynch, 1995). The new field of forensic nursing is depicted by the flame of nursing at the center of the triangle (V. Lynch, personal communication, March 31, 2004).

The two concentric circles surrounding the triangle represent the Fields of Expertise, Societal Impact, and Health Care System. The Fields of Expertise identifies the trained forensic nurse examiner in contrast to the General Professional health care provider that may have no specific forensic training in child sexual abuse examinations. The Societal Impact relates to the Conviction Rates of Perpetrators as well as to the possible exoneration of alleged perpetrators and to the emotional, physical, and psychological healing of the child sexual abuse victim. The Health Care System brings to bear the multidisciplinary approach used in the child sexual abuse case utilizing Interviewing, Consultation, Referrals, and Expert Witness.

The Lynch Model portrays the forensic nurse as a collaborator with law enforcement and the courts striving to protect the human rights of victims and also the rights of the alleged perpetrators. According to Lynch, the Lynch Model focuses on the
necessity for society to respond to problems that develop between the related fields of nursing, forensic science, and the criminal justice system. Lynch feels that the
effectiveness of the forensic nurse is based, in some part, on the ability to interact with
other scientific, legal, medical and social professionals, victims, suspects and alleged
perpetrators (V. Lynch, personal communication, March 31, 2004).

Use of the Lynch Conceptual Model in the Development of the Bragg Model

The Lynch Conceptual Model provides the foundation for the Bragg Model
developed by the investigator for the study. The Bragg Model incorporates areas of the
Lynch Model (see Figure 2). The foundation of the Bragg Model is the overlapping of
nursing science, forensic science, and criminal justice. The Bragg Model consists of the
three interlocking factors of victim and offender, health care, and forensic nursing from
the Lynch Model. The Bragg Model identifies the direction and focus of the study. The
Bragg Model illustrates the victim of abuse being identified; the victim is then referred
for an examination to a Health Care professional. The health care examiner is either
trained or untrained. The trained examiner is a professional (nurse, physician, nurse
practitioner, or physician assistant) who has had additional forensic training with
supervised clinical experience preparing them for all the multiple components of the
forensic examination. The Bragg Model indicates the attributes of the trained examiner:
Interviewing Skills used with the victim; Physical Examination of the victim;
Consultation with parents or non-offending caregivers, agencies, and other professionals;
Referral from and to health care agencies and law enforcement and in professional
consultation on difficult cases; and Expert Witness at trials and hearings. The end result
in the Bragg Model is the beginning of Emotional Healing of the victim and those close to the victim.

The *untrained* examiner is a professional who has completed their basic education without having completed any additional forensic training. The examiner findings are then reported to the Criminal Justice System.

Figure 2. Bragg Model

The investigator has utilized a comprehensive analysis and synthesis of current literature, clinical experience in the area of child sexual abuse, and in conducting forensic examinations on child victims of sexual abuse, to construct the Bragg Model. This study
investigates whether the level of training of the forensic examiner has a significant effect on the outcome of the conviction rates of offenders.

**Study Variables**

The independent variable in the study is the Level of Training of the examiners, which includes two levels: trained or non-trained. The dependent variable is the conviction status of the perpetrator with two levels: convicted or not convicted.

**Definition of Terms**

The definition of terms for the study are as follows:

**Child Sexual Abuse Victim**-a child who has been the victim of sexual behavior between a child and an adult or between two children when one of them is significantly older or uses coercion. The sexual behaviors include touching breasts, buttocks, and genitals whether the victim is dressed or undressed; exhibitionism; fellatio; cunnilingus; and penetration of the vagina or anus with sexual organs or with objects.

**Conviction Rates of Perpetrator**-rate at which the perpetrator is found guilty in a court of law for sexually abusing a child.

**Examiner Training**-forensic training that examiners receive in interviewing skills, in the performance of the forensic medical examination with colposcopy, as expert witnesses, and addressing the emotional healing needs of the child abuse victims including a minimum of 40 hours didactic training and 40 hours of clinical training.

**Medical Component**- forensic medical examinations by a trained forensic nurse examiner using specialized equipment in the evaluation of sexually abused children.
Assumptions

The assumptions of the study were:

1. Children are the victims of sexual abuse.

2. Case documentation of sexual abuse will provide data that are useful to answer the research questions and prove or disprove the hypothesis.

3. Case documentation will be complete and accurate.

Limitations

The limitations of the study included:

1. There were a small number in the sample of sexually abused children who received forensic medical examinations in the Middle Judicial Circuit during 2000-2002.

2. The study was limited by the number of trained forensic examiners and non-trained medical examiners performing the forensic medical examinations.

3. The number of conviction rates of the perpetrators was low.
CHAPTER 2
REVIEW OF LITERATURE

Several areas of significance in forensic medical examinations for sexually abused children were discovered in the review of literature. This chapter will discuss the evolution of practice of the forensic medical examinations, the emergence of forensic nurse examiners, forensic examination training, and certification. The level of examiner training, use of the colposcope, relationship of trained examiners to perpetrator conviction rates, conviction rates, and need for further research will be addressed.

Evolution of Practice of Examinations

A review of the literature reveals that forensic nurse examiners have begun to gain prominence in response to the increased need for trained examiners (Ciancone, Wilson, Collette, & Gerson, 2000). Prior to the mid-1980's, very little emphasis was placed on the sensitive subject of child sexual abuse, assessment and management. The medical evaluation of the sexually abused child was virtually ignored by physicians (Heger, Emans, & Muram, 2000). In the early 1990's there was an increase in the awareness of the importance of appropriate education in the area of child sexual abuse. Medical schools and nursing schools were not including child sexual abuse content in their curricula. The challenge was to bring this very real problem to light since many physicians found it hard to imagine that the children they were treating could be victims of sexual abuse. Clinicians had to come to terms with their own inner rejection of the fundamental concept that adults would use children for their own sexual gratification (Heger, Emans, & Muram, 2000).

In the 1980's while the medical community was struggling with this new area of concern in pediatrics, forensic nursing was emerging as a distinct specialty area of nursing. Forensic nursing is based on knowledge from nursing, law enforcement, and
forensic science. The knowledge gleaned from these disciplines advocating for the victims of child abuse and for following the proper legal approaches provides a foundation for handling these cases (Lynch, 1993).

Emergence of Forensic Nurse Examiners

The shortage of physicians played a major role in the development of the forensic nurse examiner role. Pediatricians were concerned about the time demands placed on them by the lengthy forensic medical examinations in child sexual abuse cases and were unwilling to testify in court because of frequent court delays that interfered with their practices (Ledray & Barry, 1998). Private physicians who performed but were untrained in forensic medical examinations missed much needed evidence that was essential to the case. It is clear from the study by Kelley and Yorker (1997) that forensic nurse examiners began to assume an increased role in the evaluation and treatment of children suspected of sexual abuse. The lack of forensic training in physician and nurse education, and the time needed for forensic examinations, resulted in the emergence of the forensic nurse (Ledray & Barry, 1998).

Compared to any other discipline, nursing is the most appropriate profession to take this role. Nursing education prepares a nurse with a perspective that values caring, and consideration of multiple psychological, emotional, social, and physiological factors, including the family and a community focus. The helping role of the forensic nurse includes providing emotional and informational support to the child and to the family. The roles of educator and coach contribute to improved health outcomes and the role of counselor and child advocate are central to forensic nursing. All of these roles provide a natural venue for the emotional healing of sexually abused children.

In 1991, forensic nursing was formally recognized during the Annual Meeting of the American Academy of Forensic Sciences in Anaheim, California (Lynch, 1993). In the summer of 1992, the International Association of Forensic Nurses (IAFN) was
formed. Three years later, in 1995, the American Nurses Association officially recognized forensic nursing as a specialty area in nursing (International Association of Forensic Nurses, 2002). For the purpose of this study, forensic nursing (of which sexual assault nurse examiner (SANE) programs are a part) includes all registered nurses and advanced practice registered nurses who are trained in the science of examining victims of sexual and physical assault or abuse to include the collection of the evidence and testifying in court as expert witnesses.

Heger et al. (2000) suggest that since diagnosis of child sexual abuse requires increased skills and experience, the development of a system of multidisciplinary centers emerged called Children's Advocacy Centers (CACs), to meet the needs of children. These centers began to re-focus the attention on the child and to provide support to non-offending family members through a multidisciplinary team concept (National Children's Alliance, 2000).

**Forensic Examination Training**

Current issues related to the forensic nurse's role focus primarily on education, certification, and legal issues. Journal articles and publicity regarding this rapidly expanding field have led to the identification of definitions and roles, and the development of educational programs (International Association of Forensic Nurses, 2002). Forensic nursing began to be taught in formal graduate educational programs (Lynch, 1993). Subsequently, as early as 1993 Lynch (1993) reported that the University of Virginia at Charlottesville was the first institution of higher education to offer graduate courses preparing advanced practice roles in clinical forensic nursing. Additional universities in the United States, including the University of Massachusetts at Worcester and the University of Louisville School of Nursing, began offering various programs in their schools of nursing after this date (Lynch, 1993).
Currently, there is a wide variety (Figure 3) of educational approaches to train forensic examiners including graduate level preparation, continuing education, SANE training, advanced pediatric SANE training, and on-site clinical training by physicians and registered nurses. Kelley & Yorker (1997) conducted a national mailed survey questionnaire with 260 non-physician health care providers including nurse practitioners, registered nurses, and physician assistants. Seventy-seven percent of the registered nurse group in the final sample of 151 subjects were SANEs. Sixty-one percent of the participants in the survey held a master's degree or higher, 16.4% received a graduate level course in child abuse, and 78.3% participated in continuing education programs. Thirty-three percent had completed the SANE program, 77.5% had received on-site clinical training from physicians, and 33.7% had obtained on-site clinical training from registered nurses. In the state of Georgia, the Georgia Network to End Sexual Assault (GNESA) offers both the basic SANE training and the advanced pediatric SANE training. The training requires 40 hours of didactic instruction and 40 hours of clinical training that includes pelvic examinations and sexual assault examinations. In addition, training leading to certification requires working with law enforcement and the district attorney in criminal trial proceedings. Requirements for advanced pediatric SANE include an additional 24 hours of didactic training and 40 hours of clinical training working with a pediatrician managing child sexual abuse (GNESA, 2001).
Figure 3. Examiner Training Options

FORENSIC EXAMINER

UNTRAINED IN FORENSIC EXAMINATION

General Professional Training

TRAINED IN FORENSIC EXAMINATION

LEVELS OF TRAINING

Graduate education

Advanced pediatric

SANE training

SANE training

On-site clinical training

Continuing education
Hornor and McCleery (2000) described pediatric nurse practitioners’ (PNPs) knowledge of genital anatomy and the ability to recognize sexual abuse. Most (80%) of the 83 pediatric nurse practitioners (PNPs) who responded to the 33-item questionnaire stated they were not adequately trained in recognizing normal prepubescent female anatomy. Kelley and Yorker's (1997) study investigating physical assessment findings in cases of child sexual abuse, raised the question of whether standardized training and credentialing should be required of all health care providers who perform these examinations.

Certification

Certification has become a norm for advanced nursing practice. Many nursing specialties have a means for certification of knowledge. Until recently there was no avenue to become certified in SANE. In 2002, the International Association of Forensic Nurses offered the first certification examination leading to the designation of SANE-A (SANE-Adult and Adolescent) (International Association of Forensic Nurses, 2002). A functionally autonomous component of IAFN, the Forensic Nursing Certification Board, works with the Center for Nursing Education and Testing (C-NET) to administer the examination (K. Marrero, personal communication, March 5, 2004). The development and validation of the Basic SANE examination has taken several years to complete and plans for the certification of advanced pediatric SANEs are in the developmental stage (International Association of Forensic Nurses, 2002).

It is clear from the literature that university schools of nursing need to continually examine and create innovative curricula to ensure quality education and current practice standards, including content in forensic nurse examination (Lynch, 1993). A collaborative relationship between health care organizations and nursing schools would maximize the highest standards in the field of child sexual abuse.
Level of Examiner Training

Forensic examiners, including nurse practitioners, physicians, SANEs, and advanced pediatric SANEs with extensive training are able to perform more thorough forensic examinations on child abuse victims than non-trained examiners. Christian et al. (2000) described how trained forensic examiners know that "children who have been sexually abused may not provide a complete description of their assault...therefore, the decision to collect forensic evidence should not be determined by the child's description of the assault" (p. 103). Girardin (2001) concurred with Christian's assertion that SANEs have an exceptional opportunity to sensitively examine victims of sexual abuse. While providing caring interventions during the examination, the examiners are able to gather essential evidence and to document findings with photography that aid in either the conviction or exoneration of the suspected perpetrator.

Emotional healing of the sexually abused child is directly related to the support of the medical professional involved. Heger et al. (2000) reported that the interaction of the healthcare provider with the sexually abused child could be a powerful step towards wholeness and ultimately toward the emotional healing of the child. Ledray (1999) stressed that the nursing process in the area of practice with sexually abused children includes addressing the emotional issues and sources of support for the child and family. McClain et al. (2000) further suggested that one of the primary goals of the forensic examiner should be to begin the process of restoring the child's sense of dignity and control.

Use of Colposcope

Adams (1997) conducted a survey of nurse practitioners, registered nurses, and physician assistants who performed forensic examinations on suspected sexually abused children and reported that examiners who used colposcopes, a tool for magnification and photographic documentation, tended to have a higher experience level with the
examination than examiners who do not use the instrument. The colposcope allows for magnifications of the viewed areas. The areas include the hymen, the vaginal tissue, and the anal area. Small contusions and lacerations can be identified. Use of the colposcope photography makes repeated examinations unnecessary and allows for viewing of photographs by consulting experts in distant cities via the Internet. The colposcope affords the examiner an excellent opportunity for viewing variations of appearance in the normal genital structures in children and the hymens of newborns (Adams, 1997).

There is an advantage to having trained forensic nurse examiners performing medical examinations on victims of suspected child abuse (Girardin, 2001; Hatmaker, 1997; Hohenhaus, 1998; Ledray & Barry, 1998; Ledray & Simmelink, 1997).

SANEs have repeatedly demonstrated that they are qualified and, in many cases, are better expert witnesses than are physicians. The amount of expertise and extent of training in forensic evidence collection, not a medical degree, makes a health care provider an expert in a sexual assault case. SANEs have additional training specific to this area that most physicians do not have. (Ledray & Barry, 1998, p. 284)

**Relationship of Trained Examiners to Perpetrator Conviction Rates**

Girardin (2001) suggested that meticulous examinations often strengthen the case against an assailant and that forensic nurse examiners are trained to make certain that all evidence is of the highest quality. Prior to 1997, the evidence supporting the SANE was primarily anecdotal and testimonial. Recognizing the need for more factual data, Ledray and Simmelink (1997) conducted an audit of 97 submissions of rape evidence sent to the lab for analysis from jurisdictions around the state. The audit revealed that evidence kits submitted by SANEs of Minnesota were significantly more likely to be complete and better documented than those submitted by non-trained nurses or non-trained physicians. Proper documentation was included in 100% of the SANE examinations as opposed to
79% in the non-SANE examinations. The SANE kits had no errors that undermined the integrity of the evidence collected. These findings demonstrated that the trained SANEs knew what evidence to collect, were more thorough in the examinations, and gave knowledgeable testimony in court. Conversely, evidence from 13 of the 73 kits submitted by non-trained examiners, was not admissible in court because of improper documentation (Ledray & Simmelink, 1997).

Both Hatmaker (1997) and Hohenhaus (1998) noted dramatic examples of the expertise of trained nurse examiners. Similarities in the citings point to proficiency on the part of the forensic nurse examiner that leads to the eventual conviction of the perpetrators. Hatmaker's examiner gathered the only physical DNA evidence connecting the victim and her attacker while Hohenhaus' nurse examiner described an expert opinion in a patterned injury interpretation that was a major factor in the assailant's conviction. The defense claimed that the blunt trauma was caused by a clasp on a metal ring but because of the location of the injuries, the SANE testified that the injuries were consistent with nonconsensual intercourse.

**Conviction Rates**

Forensic nurse examiners are in a unique position to recognize, collect, and preserve evidence in a legally acceptable manner. Hoyt (1999) suggested a direct connection between the actions of forensic nurse examiners and the interruption of the cycle of violence through perpetrator conviction. Girardin (2001) proposed that not only are SANE examiners trained to perform forensic medical examinations, including collecting forensic evidence, but they are educated to testify as an expert witness in court, thus increasing the conviction rate of perpetrators of sexually abused children.

Brewer, Rowe, and Brewer (1997) studied 200 closed child sexual abuse cases. The findings indicate that medical evidence is associated with prosecution status. One potential problem when attempting to prove child sexual abuse is the lack of
corroborating medical evidence. The study explored factors including the age of the victim, the seriousness of the abuse, the timing of the abuse, the victim-offender relationship, the presence of medical evidence, and the number of victims but did not include the examiners performing the examinations. Even though this study examined 19 independent variables that might influence the conviction rate, it fell short of studying whether the variable of the trained forensic nurse examiner was significant in the prosecution of child sexual abuse cases.

Studies to date have not investigated the direct link between trained forensic nurse examiners and the conviction rate of perpetrators of sexually abused children. Christian et al. (2000) suggested that the relationship between forensic evidence and prosecution of perpetrators has not been studied carefully and it would be valuable information for those professionals involved with medical and legal systems related to child sexual abuse. Finkelhor (1998) focused on the breakdown in tracking child sexual abuse cases, perpetrators prosecuted, and final outcomes after prosecution. He suggested that research is desperately needed to determine which investigative policies, procedures, and standards concerning the medical examinations of sexually abused children will maximize the most accurate confirmation or dismissal of allegations of sexual abuse in children.

Need for Further Research

There is a gap in the literature about the importance of the training of the forensic nurse examiner and the application of that information to the actual conviction rates of the perpetrators. Further work in this area is warranted. In a recent study (Ciancone et al., 2000) investigating outcome data from a group of SANEs, the majority of respondents were unable to report the number of prosecutions, convictions, and acquittals because of a lack of a tracking system. One recommendation from the study was the need to improve documentation in areas such as prosecution rates and outcomes so that
the impact of the forensic nurse examiner program on conviction status could be evaluated more effectively.

Studies by both Christian et al. (2000) and Adams (1997) have also reiterated this same viewpoint. Christian and colleagues reported that questions raised by medical personnel regarding the guidelines for forensic evidence collection in children warrant more research. Consistent with this viewpoint, Adams’ (1997) recommended further research to develop clear procedures for the evaluation of children and for establishing standards for the training and certifying of forensic examiners. The goal is to increase the courtroom credibility of the experts who testify on the medical findings in sexually abused children. A combination of peer review, case review, quality assurance, telemedicine, and use of the Internet to send colposcope photography to experts at distant sites, would improve the level of training for the forensic nurse examiner. In summary, Adams' study added more knowledge to the forensic evidence collection of sexually abused children, establishing new practice guidelines resulting in improved court testimony.

These previous studies have noted the importance of trained forensic nurse examiners and outcome data, but have fallen short of linking the training of the examiners to the conviction rates of the perpetrators. Ledray, a pioneer in forensic nursing, confirms that future investigations must examine the relationship between the forensic nurse examiner and the conviction rate of the perpetrator (L. E. Ledray, personal communication, February 6, 2002). Ledray and Simmelink (1997) stated that with outcomes research, corrective action can be taken to benefit the field of forensic nursing.

Similarly, Allen (1999) recognized of the need for a simple yet highly effective tracking mechanism that would validate changes in conviction rates. The work reported a strong correlation between the analysis of outcomes and the improvement in evidence collection procedures and documentation techniques for forensic nurses. Improved
documentation can lead to a better understanding between law enforcement officers and forensic nurse examiners who work together on behalf of sexually abused children. As a result of overloaded court dockets, law enforcement officers are faced with crimes such as illegal drug charges, armed robberies and murders, and may minimize child sexual abuse. With law enforcement officers becoming a part of the larger multidisciplinary team to handle cases of child sexual abuse, outcomes will be improved.

Research has shown that the role of the trained forensic nurse examiner is invaluable in the treatment of sexually abused children. Forensic nurses, in the advocate role, assist in the revelation of the truth which serves justice, and make a significant contribution to society and to the nursing profession. Future investigations must study the relationship between the forensic nurse examiners performing the medical examinations of victims and the actual conviction rates of the perpetrators. This information could potentially be useful to increase successful court actions by utilizing trained forensic nurse examiners rather than non-trained medical examiners. In addition, recommendations could be made to support ongoing training and continuing education for forensic nurse examiners to further bridge the gap between law enforcement and health care. Research aimed at this specific link may also build an even stronger relationship between the medical and judicial systems through working together to decrease the sexual abuse of children.

Summary

Historically forensic medical examinations had not been performed on victims of child sexual abuse until approximately twenty years ago. Physicians began performing the examinations but were faced with time constraints and court involvement. Recognizing that the holistic approach is critical in these cases, nurses began asserting that nursing was the most appropriate profession to do the examinations. The levels of training for performance of the examinations have continued to be varied to include
graduate level education, advanced pediatric SANE training, basic SANE training, continuing education, and on-site clinical training. Further research is needed to compare the conviction rates of child abuse perpetrators to the forensic medical examinations performed by trained versus non-trained examiners on victims of child sexual abuse.
CHAPTER 3
METHODOLOGY

This chapter will cover the design of the study including study variables and instrumentation, target population and sample in the Middle Judicial Circuit of Georgia, sampling design, and power analysis. The methods used for the protection of human subjects, chart review form, level of training telephone interview questionnaire, collection of data, and data analysis will be addressed.

Design of the Study

This research study was a retrospective chart review using a non-random sample of convenience of all sexual abuse cases of children aged 7 months to 17 years old in the Middle Judicial Circuit of Georgia during 2000-2002. The total number of abused children that entered the system was 1561. The charts of those children at The Sunshine House CAC (Site A) were reviewed to gather data around the evaluation of the sexual abuse cases. Chart review data were then tabulated to provide quantitative data for analysis. From the chart review, the examiners were identified and contacted for telephone interviews. Table 1 lists variables included in the Chart Review Form and the Level of Training Telephone Interview Questionnaire. Data from all instruments were entered into an Excel database for final analysis. Because legal outcomes are most often lengthy, the chart review was limited to include only those years for which conviction status (commonly known up to approximately one year after the incident) would be available in time to the researcher. Levels of the perpetrators included convicted or not convicted.
Table 1. Study Variables and Instrumentation

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chart Review Form</td>
<td>Victor ID</td>
</tr>
<tr>
<td></td>
<td>DOB</td>
</tr>
<tr>
<td></td>
<td>Age</td>
</tr>
<tr>
<td></td>
<td>Gender</td>
</tr>
<tr>
<td></td>
<td>Race</td>
</tr>
<tr>
<td></td>
<td>County</td>
</tr>
<tr>
<td></td>
<td>Forensic Examination</td>
</tr>
<tr>
<td></td>
<td>Examination Date</td>
</tr>
<tr>
<td></td>
<td>Physical Findings</td>
</tr>
<tr>
<td></td>
<td>Perpetrator Relationship to Victim</td>
</tr>
<tr>
<td></td>
<td>Perpetrator Conviction Status</td>
</tr>
<tr>
<td></td>
<td>Comments</td>
</tr>
<tr>
<td>Level of Training Telephone Interview</td>
<td>ID of Examiner</td>
</tr>
<tr>
<td>Questionnaire</td>
<td>Title of Examiner</td>
</tr>
<tr>
<td></td>
<td>Examination Location</td>
</tr>
<tr>
<td></td>
<td>Colposcope Use</td>
</tr>
<tr>
<td></td>
<td>Training of Examiner</td>
</tr>
<tr>
<td></td>
<td>Comments</td>
</tr>
</tbody>
</table>
**Target Population and Sample**

The target population for this study included all children identified as being sexually abused who entered the Middle Judicial Circuit system. Initially, the inclusion criteria selected for this study consisted of the charts of all sexually abused children ages 7-12 in the Middle Judicial Circuit who were examined during 2000 and 2001. The initial age range of 7-12 was selected because children in this range tend to be more verbal than younger children and teenagers, and would be more likely to be more vocal and would provide a larger sample for the study. It was determined that if an adequate number was not available, then the ages and/or years studied would be expanded. After an initial review of charts, an adequate number was not available for this study, therefore, the ages and years were expanded to include the charts of children ages 7 months to 17 years examined during 2000, 2001, and 2002. A 3-year period for the chart review was chosen to increase power and to reduce the likelihood of statistical error. The database identified 756 charts of sexually abused children.

According to information received from The Sunshine House CAC, the circuit consists of five rural counties in Georgia: Candler, Emanuel, Jefferson, Toombs, and Washington (see Figure 4). The total population of children under 18 years of age in the circuit is 26,693 with an annual caseload of 269 sexually abused children, or approximately 1% of the total (The Sunshine House Children’s Advocacy Center, 2000).
Figure 4. Middle Judicial Circuit

**Sampling Design**

A non-random sample of convenience was used because of the availability of the intake charts at Site A. Because the subjects were not randomly selected, the generalizability of the results are limited. However, the sample is diverse since it includes child sexual abuse victims and subjects from five counties over a 3-year period.

**Power Analysis**

In order to determine the number of subjects needed in each of the two groups (trained vs. non-trained examiners), a table of sample size requirements for detecting differences in various proportions, assuming an α of .05 and a power of .80 was used (Polit & Hungler, 1999). Estimated proportions for the groups were obtained using Cohen’s conventions for effect size. Using the most conservative estimate (to minimize the risk of Type II error), the approximate number of subjects needed per group would be 70-75.

**Protection of Human Subjects**

The children whose charts were reviewed were those abused cases who entered the system in the Middle Judicial Circuit during 2000-2002. Confidentiality was maintained by not using the names of the child victims or the subjects and assigning an identification number that was known only to the investigator and the assistant. The investigator’s assistant was a graduate student at Georgia Southern University who assisted in gathering data from the chart review. While reviewing the charts, the investigators recorded the names only as identification numbers and did not have access to the charts after the research was completed. Names of alleged perpetrators were identified from the chart review and information regarding conviction status was obtained from public information at the office of the district attorney.

The subjects in the study were the examiners whose name appeared on the chart identifying them as the person who performed the forensic medical examination. There
were no risks for the subjects (also known as examiners) who completed a Level of Training Telephone Interview Questionnaire (Appendix A) because their names were confidential and each subject was assigned an identification number that was known only to the investigator and her assistant. Permission was obtained prior to the questionnaire from the director at Site B where some of the examinations occurred during the 3-year period of the study. A card (Appendix B) was mailed to all other examiners in private practice in the Middle Judicial Circuit informing them of an upcoming phone interview.

Written records of minors comprised the data used and were identified by assigned numbers. Because this is a retrospective chart review, letters of support from each study site were obtained in order to gain access to the files of minors. The study was approved by the Institutional Review Board at Georgia Southern University (Appendix D).

Chart Review Form

A Chart Review Form, (Appendix A), developed by the investigator, was not tested for reliability and validity. However, the investigator was familiar with the intake charts at Site A and had personal knowledge that this information was available. The form includes all variables included in the study. As previously discussed, the victims were identified by an assigned number, and data were collected as discussed.

Level of Training Telephone Interview Questionnaire

Trained forensic nurse examiners and non-trained medical examiners were identified after a telephone interview with the subjects, using the Level of Training Telephone Interview Questionnaire developed by the investigator (Appendix A). The subjects were assigned a number denoting identification and maintaining confidentiality.

Because of the newness of the specialty, there are no standardized, national certification or training requirements for forensic medical examiners. Therefore, it is difficult to determine the Level of Training. In this study, the Level of Training Telephone Interview Questionnaire was designed using the Georgia Network to End
Sexual Assault (GNESA) guidelines endorsed by the Georgia Nurses Association (GNESA, 2001). In the guidelines, the requirements for basic SANE include 40 hours of didactic instruction and 40 hours of clinical training that includes pelvic examinations and sexual assault examinations. The advanced pediatric SANE requirements include an additional 24 hours of didactic training and 40 hours of clinical training working with a pediatrician managing child sexual abuse.

Collection of Data

Chart reviews described in Appendix A were done at Site A by the investigator and her graduate student assistant after requesting and receiving a letter of support from the Executive Director at Site A (Appendix C). A database was created from information obtained from the victim reports and alleged offender reports. Questions arising during data collection were verified by pulling individual victim charts.

Subjects for the Level of Training Telephone Interview Questionnaire (Appendix A) were selected based on their name and contact information appearing on record as the forensic medical examiner in the chart reviewed. During the 3-year period of the study, forensic medical examinations on sexually abused children in the circuit were performed by a physician, nurse practitioner, or advanced pediatric SANE nurse. The children were examined in private offices, emergency rooms, or at two CAC sites 90 miles apart. As stated earlier, a letter of support was obtained from Site B regarding contacting the forensic examiner by phone. All other subjects were initially contacted by card prior to the telephone interview.

The Level of Training Telephone Interview Questionnaire was administered to the subjects during a telephone interview by the investigator who collected data regarding the level of training. Both trained and non-trained forensic examiners designated in the chart review were the subjects for this study and examiners identified who were not at Site A or Site B were initially contacted at work by mail (Appendix B) advising them of an
upcoming telephone interview at work in order to answer a questionnaire regarding their level of training. Because this was a retrospective chart review, informed consent was obtained only from examiners in the Middle Judicial Circuit not located at Site A or Site B. The examiners were contacted by a card mailed to them at work requesting them to mail a card back (Appendix B) giving consent prior to the telephone interview at work which allowed them to answer the questionnaire regarding their level of training. To maintain reliability for future research purposes, the data obtained from the chart review regarding the perpetrator conviction status was verified by the investigator from public information at the District Attorney’s office.

Data Analysis

The independent variable in this study was the level of training of the forensic examiner. It had a nominal measurement level and included two levels: trained forensic medical examiners and non-trained medical examiners. The conviction status of the perpetrator was the dependent variable and had nominal measurement levels of convicted and not convicted. Because the measurement levels of the dependent variable and independent variable were nominal, the statistical test that was planned for analysis was the Chi-Square test, which detects differences in proportions between groups (Polit & Hungler, 1999). For example in the current study, the Chi Square test would detect the significance of differences in the proportion of perpetrators who are convicted in a group of children who were examined by trained examiners vs. the proportion of perpetrators who are convicted in a group of children who were examined by non-trained examiners.

Summary

A retrospective chart review was conducted of 1561 child abuse cases occurring in the Middle Judicial Circuit of Georgia during a 3-year period. Charts were reviewed to assess whether or not the child received a forensic medical examination and if the examination was performed by a trained or a non-trained forensic examiner. A chart
review determined the identification of the examiners. Determination of the level of training for the examiners was obtained through a telephone interview. Court conviction data were obtained from the office of the district attorney in order to compare conviction rates to the forensic medical examiner training. Chi square analysis was planned to test the study hypothesis.
CHAPTER 4

FINDINGS

Findings of the study will be reported in this chapter. The findings include chart review statistical summary, demographic characteristics of child victims receiving forensic medical examinations, power analysis, study hypothesis, study question data, and factors that influenced the study findings.

*Chart Review Statistical Summary*

Of the total 1561 charts reviewed for the three study years, 756 (48.4%) were identified as sexual abuse cases (Table 2). Of the 756 sexually abused children, 38 (5%) received forensic medical examinations. Of these, 14 (50%) were performed at The Sunshine House CAC during the last four months of 2002 after the medical component was added to the services offered at the center. Of the 38 (5%) sexually abused children receiving forensic medical examinations, 10 (1.3%) were eliminated from the study because they were outside the five county area, leaving 28 (3.7%) children included in the study who received forensic medical examinations.

Table 2. Chart Review Statistical Summary

<table>
<thead>
<tr>
<th>Chart Characteristic</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number Charts</td>
<td>1561 (100.0%)</td>
</tr>
<tr>
<td>Other Types Abuse</td>
<td>805 (51.6%)</td>
</tr>
<tr>
<td>Sexual Abuse Cases of Children</td>
<td>756 (48.4%)</td>
</tr>
<tr>
<td>Total Sexual Abuse Cases of Children</td>
<td>756 (48.4%)</td>
</tr>
<tr>
<td>Not Receiving Forensic Examinations</td>
<td>718 (95.0%)</td>
</tr>
<tr>
<td>Receiving Forensic Examinations</td>
<td>38 (5.0%)</td>
</tr>
<tr>
<td>Excluded Cases</td>
<td>10 (1.3%)</td>
</tr>
<tr>
<td>Total Number Cases Receiving Forensic Examinations</td>
<td>28 (3.7%)</td>
</tr>
</tbody>
</table>
Demographic Characteristics of Child Victims Receiving Forensic Examinations

The 28 child victims represented all ages, races, and both genders (Table 3). The majority (96.4%) were girls aged 7 to 12 years of age. Candler County (39.3%) represented the most sexual abuse cases receiving forensic examinations in the circuit followed by Toombs at 21.3%. Emanuel and Washington counties were tied at 17.9%. Jefferson had only one case (3.6%) receiving a forensic medical examination. Most (57.2%) of the examinations occurred during 2002.

Table 3. Demographics of Children Who Were Sexually Abused Receiving a Forensic Medical Examination

<table>
<thead>
<tr>
<th></th>
<th>N* (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>0-6</td>
<td>10 (35.7%)</td>
</tr>
<tr>
<td>7-12</td>
<td>14 (50.0%)</td>
</tr>
<tr>
<td>13-17</td>
<td>4 (14.3%)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1 (3.6%)</td>
</tr>
<tr>
<td>Female</td>
<td>27 (96.4%)</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>1 (3.6%)</td>
</tr>
<tr>
<td>White</td>
<td>13 (46.4%)</td>
</tr>
<tr>
<td>Black</td>
<td>12 (42.9%)</td>
</tr>
<tr>
<td>Biracial</td>
<td>2 (7.1%)</td>
</tr>
<tr>
<td><strong>County</strong></td>
<td></td>
</tr>
<tr>
<td>Candler</td>
<td>11 (39.3%)</td>
</tr>
<tr>
<td>Emanuel</td>
<td>5 (17.9%)</td>
</tr>
<tr>
<td>Jefferson</td>
<td>1 (3.6%)</td>
</tr>
<tr>
<td>Toombs</td>
<td>6 (21.3%)</td>
</tr>
<tr>
<td>Washington</td>
<td>5 (17.9%)</td>
</tr>
<tr>
<td><strong>Year</strong></td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td>9 (32.1%)</td>
</tr>
<tr>
<td>2001</td>
<td>3 (10.7%)</td>
</tr>
<tr>
<td>2002</td>
<td>16 (57.2%)</td>
</tr>
</tbody>
</table>

*total N=28
Power Analysis

Using the most conservative estimate (to minimize the risk of Type II error), the approximate number of subjects needed per group would have been 70-75 (Polit & Hungler, 1999).

Study Hypothesis

The study hypothesis was:

There will be a significantly higher number of perpetrator convictions in a group of children who were examined by trained forensic examiners compared to a group of children who were examined by non-trained forensic examiners.

Since the sample size was inadequate (See Table 4), statistical testing of the study hypothesis was not undertaken.

Table 4. Study Hypothesis Variables*

<table>
<thead>
<tr>
<th>Variables*</th>
<th>Levels</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Examiner Training</td>
<td>Trained</td>
<td>24 (85.7%)</td>
</tr>
<tr>
<td></td>
<td>Untrained</td>
<td>4 (14.3%)</td>
</tr>
<tr>
<td>Conviction Status of Perpetrator</td>
<td>Convicted</td>
<td>4 (14.3%)</td>
</tr>
<tr>
<td></td>
<td>Not Convicted</td>
<td>24 (85.7%)</td>
</tr>
</tbody>
</table>

*Chi Square test was not conducted due to inadequate sample size.

Study Questions

Three study questions were asked as a result of the review of the literature. These were:

Study Question 1. What types of professionals are performing forensic examinations, and in what settings?
Table 5 indicates that most examiners (85.7%) were trained and most examiners (85.7%) reported completing the advanced pediatric SANE training (50%) or attending intensive continuing education programs taught by a forensic pediatrician (35.7%) on child sexual abuse. The most common settings for the examinations were at the two CACs, 50% at Site A and 35.7% at Site B. The remaining examinations (14.3%) were either at the emergency room or in a physician’s office.

**Study Question 2.** What are the types of physical findings obtained on forensic examination, and to what extent do examiners use the colposcope?

Physical findings were only present in 21.4% of the cases (see Table 5). Most examiners used a colposcope (85.7%) during the examination.

**Study Question 3.** What is the relationship of the perpetrator to the child victim, and what types of convictions are obtained following prosecution?

In all the cases of the children who were sexually abused, the perpetrator was known to the child. The relationship of the child to the perpetrator varied but 68% were family members. Regarding types of convictions (see Table 6), it is remarkable to note that only 4 (14.3%) of the perpetrators were convicted. However, 7.1% are still pending. Law enforcement was not involved 21.5% of the time.
Table 5. Forensic Examination Data

<table>
<thead>
<tr>
<th>Examiner Title</th>
<th>N*</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site B Pediatrician</td>
<td>10</td>
<td>(35.7)</td>
</tr>
<tr>
<td>Advanced pediatric SANE</td>
<td>14</td>
<td>(50.0)</td>
</tr>
<tr>
<td>Private MD/Nurse Practitioner</td>
<td>4</td>
<td>(14.3)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Examination Location</th>
<th>N*</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site B CAC**</td>
<td>10</td>
<td>(35.7)</td>
</tr>
<tr>
<td>The Sunshine House CAC**</td>
<td>14</td>
<td>(50.0)</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>3</td>
<td>(10.7)</td>
</tr>
<tr>
<td>MD office</td>
<td>1</td>
<td>(3.6)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Colposcope Used</th>
<th>N*</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>24</td>
<td>(85.7)</td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>(14.3)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical Findings</th>
<th>N*</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genital</td>
<td>4</td>
<td>(14.3)</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>(7.1)</td>
</tr>
<tr>
<td>None/Inconclusive/Unknown</td>
<td>22</td>
<td>(78.6)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Perpetrator Relationship</th>
<th>N*</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>5</td>
<td>(17.9)</td>
</tr>
<tr>
<td>Mother</td>
<td>1</td>
<td>(3.6)</td>
</tr>
<tr>
<td>Grandmother</td>
<td>1</td>
<td>(3.6)</td>
</tr>
<tr>
<td>Brother</td>
<td>4</td>
<td>(14.3)</td>
</tr>
<tr>
<td>Step-grandfather</td>
<td>1</td>
<td>(3.6)</td>
</tr>
<tr>
<td>Uncle</td>
<td>4</td>
<td>(14.3)</td>
</tr>
<tr>
<td>Male Cousin</td>
<td>4</td>
<td>(14.3)</td>
</tr>
<tr>
<td>Mom's Boyfriend</td>
<td>2</td>
<td>(7.1)</td>
</tr>
<tr>
<td>Male Friend</td>
<td>6</td>
<td>(21.3)</td>
</tr>
</tbody>
</table>

* total N=28

** Children's Advocacy Center
Table 6. Types of Convictions of Perpetrators

<table>
<thead>
<tr>
<th>CONVICTED</th>
<th>N* (%)</th>
<th>N* (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grand Jury/Indictment/Plea/Prison</td>
<td>1</td>
<td>(3.6)</td>
</tr>
<tr>
<td>Grand Jury/Trial/Jury/Guilty/Prison</td>
<td>1</td>
<td>(3.6)</td>
</tr>
<tr>
<td>Juvenile Court/Trial/Plea/Probation</td>
<td>2</td>
<td>(7.1)</td>
</tr>
<tr>
<td>TOTAL CONVICTED</td>
<td>4</td>
<td>(14.3)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NOT CONVICTED</th>
<th>N* (%)</th>
<th>N* (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dismissed</td>
<td>2</td>
<td>(7.1)</td>
</tr>
<tr>
<td>Law Enforcement/No Arrest</td>
<td>14</td>
<td>(50.0)</td>
</tr>
<tr>
<td>No Law Enforcement</td>
<td>6</td>
<td>(21.5)</td>
</tr>
<tr>
<td>Pending</td>
<td>2</td>
<td>(7.1)</td>
</tr>
<tr>
<td>TOTAL NOT CONVICTED</td>
<td>24</td>
<td>(85.7)</td>
</tr>
</tbody>
</table>

GRAND TOTAL 28 (100.0)

*total N = 28

Factors that Influenced Study Findings

Hypothesis testing was not conducted due to inadequate sample size. With the addition of offering forensic medical examinations at Site A perhaps further research could now more fully explore the relationship between the conviction rates of child abuse perpetrators and forensic medical examinations performed by trained versus non-trained examiners on victims of child sexual abuse.

Figure 5 indicates that 50% of the examinations performed during the 3-year period at Site A were performed in the last four months of 2002. The reason that this happened was the addition of the forensic nurse examiner to the Center at that time. Although forensic medical examinations performed at Site A during 2003 were not included in the study, they are included in Figure 5 to show the impact that the addition of the medical component had on the performance of the examinations in this rural area.
The Sunshine House CAC began in 1992 as a child abuse prevention facility. The first services involved administrative support and encouragement to ensure the establishment of local child abuse protocol committees, child fatality subcommittees, and multidisciplinary teams. Within five years, child abuse victims served increased from 29 to 471. The Sunshine House was one of the first five CACs in Georgia and became a charter member of Children’s Advocacy Centers of Georgia and the National Network of Children’s Advocacy Centers, known today as the National Children’s Alliance (C. V. Donaldson, personal communication, June 2, 2003).

Following the national CAC model, The Sunshine House added direct client services to its education and prevention programs. Federal funding provided a mental health professional on staff and child victim’s advocate. In 1995, state funding through the Rural Georgia Initiative was obtained to see if one CAC could serve rural counties and an entire judicial circuit. The Sunshine House became a model for the State as
services were available to the five counties of the Middle Judicial Circuit; Candler, Emanuel, Jefferson, Toombs and Washington. Courtesy services, by agency request, have been provided to other counties in the region and occasional agencies in other states.

Prior to 2002, a forensic medical examination for children in the Middle Judicial Circuit had not been available outside of Macon or Atlanta. The nearest CAC offering forensic medical examinations was in Macon. Augusta’s CAC referred examinations to the Medical College of Georgia. Chatham County saw only patients who resided in their county because of the physicians’ reluctance to appear in court for cases outside their county (C. A. Rice, personal communication, May 7, 2003).

To obtain an examination, investigators and caseworkers faced the prospect of a trip to a CAC in Macon and/or Atlanta or they would have to rely on the family to obtain the needed examination for the victim. Transportation in rural counties is always problematic, and taking a child 200 to 400 miles round trip to a city was intimidating to many people. The examination was either not performed, or was done by someone without adequate training, further traumatizing the child with emergency room visits, invasive procedures, or rape kits. Without the benefit of the examination, no evidence or expert testimony was available for investigation and prosecution purposes in many child sexual abuse cases.

As CAC data collection improved, both within this center and others throughout the state, a missing component became evident: a forensic medical examination. For children in rural counties, a forensic medical examination was nearly non-existent. Therefore, the medical component that provided forensic medical examinations of children where sexual abuse had been alleged was implemented in the last four months of
2002. These examinations by a trained, advanced pediatric SANE were made available in the child-friendly environment of the CAC to reduce the trauma of sexual abuse to the child and family. In addition, the trained, advanced pediatric SANE was available to serve as an expert witness and to provide evidence and testimony in court.

Other factors influencing the study included low numbers of cases in counties in which child sexual abuse is not reported. Stronger multidisciplinary teams bring more cases to the forefront. Additional factors affecting both the low number of examinations received and the low number of conviction rates in the study are commitments such as full caseloads and attitudes of "It's only sexual abuse" on the part of law enforcement and the district attorney's office. Through research such as the current study, knowledge will be gained that may assist in changing these factors.

Summary

Of 1561 child abuse charts reviewed, 756 (48.4%) were sexual abuse cases. Of these cases only 3.7% of the sexually abused children in the circuit received a forensic medical examination during the 3-year period studied. The examinations were performed by a trained forensic examiner 85.7% of the time: 35.7% by a forensic physician and 50% by an advanced pediatric SANE. The remaining examinations (14.3%) were performed by a physician or nurse practitioner who had no training in the forensic medical examination. A colposcope was used by trained forensic examiners 85.7% of the time when examinations were performed. Only 14.3% of all the cases involving children who received forensic medical examinations led to convictions. In contrast, 78.6% of the total cases were never referred to the district attorney's office for prosecution. Two (7.1%) cases remain pending.
CHAPTER 5

CONCLUSIONS, RECOMMENDATIONS, AND NURSING IMPLICATIONS

This study was designed to investigate the relationship between conviction rates of child abuse perpetrators and the forensic medical examinations performed on victims of child sexual abuse in the Middle Judicial Circuit. As the research process evolved, pertinent theoretical perspectives emerged. This chapter will present research hypothesis testing and a summary of study data. Other factors discussed are case tracking, liability and accountability, training, serendipitous findings regarding emotional healing, and directions for further research.

Research Hypothesis Testing

The research hypothesis for this study was:

There will be a significantly higher number of perpetrator convictions in a group of children who were examined by trained forensic examiners compared to a group of children who were examined by non-trained forensic examiners. The hypothesis could not be tested due to inadequate sample size.

Chart Review Data

Sexual abuse in children in the Middle Judicial Circuit occurs across all ages, all races, both genders, and all counties. The perpetrator was known to the child in all cases and 19 (67.8%) of the 28 were family members.

Of the total 1561 charts reviewed for the three study years, 756 (48.4%) were identified as sexual abuse cases. Of the 756 sexually abused children, 38 (5%) received
forensic medical examinations. Of these, 14 (50%) were performed at The Sunshine House CAC during the last four months of 2002 after the medical component was added to the services offered at the Center. Of the 38 (5%) sexually abused children receiving forensic medical examinations, 10 (1.3%) were eliminated from the study because they were outside the five county area. This left only 28 (3.7%) of the 756 children included in the study who received forensic medical examinations.

One of the most alarming and significant study findings was that sexually abused children in rural counties have been denied the advantage of receiving a forensic medical examination. The findings show that 95% of the sexually abused children who were seen at The Sunshine House CAC, during the years 2000-2002, who should have had an examination did not, in fact, receive one. Of significance is the fact that after the introduction of the medical component at The Sunshine House CAC, examinations are now being done in the rural Middle Judicial Circuit of Georgia. After these examinations were offered at The Sunshine House CAC, sexually abused children in the Middle Judicial Circuit received forensic medical examinations and there was a dramatic increase in the number of examinations performed in the circuit. Prior to that time, examinations were just simply not performed. Access to the examinations was limited due to the time and distance involved in traveling to Site B or transportation difficulties with the families.

Although the presence of medical findings occurs in only 10% of the sexual abuse cases, they remain a significant factor in the criminal investigation. The 10-year study of 94 children by Heppenstall-Heger et al. (2003) revealed that factors influencing the normal examinations following sexual abuse of children are the nature of the abuse of children, the fact that children heal quickly, and that children commonly have delayed
disclosures of the abuse. In the current study by the investigator, 14.3% had genital findings, 7.1% had other physical findings, and 78.6% had no physical findings confirmed. Adams’ (1994) study reviewing case files and colposcopic photographs of 236 children whose perpetrators were convicted of child sexual abuse reported that the majority of sexually abused children will have normal or nonspecific genital findings following the abuse. The report further showed that it is uncommon to find positive genital findings after the abuse has occurred.

**Inadequate Number of Providers**

Of the 28 forensic examinations, 85.7% were performed in CACs by trained forensic examiners using a colposcope. The remaining examinations (14.3%) were performed in a less than ideal setting of either a local emergency room or a private physician’s office without the use of a colposcope. Four children (14.3%) were examined by either a non-trained pediatrician or non-trained nurse practitioner. Trained forensic nurse examiners are needed in rural areas to fill this need for evaluation of child sexual abuse. Improved forensic medical examination training to include the use of the colposcope with photographic documentation is desperately needed to ensure appropriate evaluation of sexually abused children so that the physical and emotional healing process can begin for these children (Heger et al., 2000).

**Interview Data**

Four (66.6%) of the six healthcare providers responded to the request for a telephone interview. Two (50%) non-trained pediatricians stated that they received no training in medical school regarding the performance of a forensic medical examination on sexually abused children. The non-trained examiners reported that they had
performed less than five examinations per year on victims of child sexual abuse. They also responded that training is desperately needed for healthcare providers in this underserved area. The forensic pediatrician and advanced pediatric SANE nurse both reported receiving intensive training including 40 hours of didactic and 40 hours of clinical training. The trained healthcare providers reported that not only is the colposcope valuable during the forensic medical examination but also the added digital image documentation and light source is essential.

Perpetrator Data

The data suggest that only 7% of the perpetrators were convicted and sent to prison, 7% received probation, and 7% of the cases are still pending investigation. Most significant is that 79% of the cases never reached the District Attorney’s office. The data suggests that there is a judicial lack in the prosecution of child sexual abuse cases that is possibly linked to the lack of collaboration between agencies involved in the prosecution, including social services, law enforcement, and the District Attorney's office. The number of caseloads overwhelms social services and law enforcement. The district attorneys are faced with overloaded court dockets for prosecuting cases and thus sexual abuse cases are pushed to the bottom of the pile.

In addition, there are other barriers which interfere with case prosecutions. There remains some law enforcement resistance to change, which when coupled with occasional power struggles among community agencies, interferes with the judicial process. These barriers are challenging but can be overcome through the use of a team approach over a period of time. Building strong community relationships and working closely with community resources will decrease resistance to change that is common
when new programs are introduced. Gathering information from other centers along with how these obstacles are resolved will be helpful (Ledray, 1999). Yearly sponsored training for community agencies to educate on "best practices" methods will encourage collaboration among team members. Strengthening state leadership support can assist to limit the "turf struggles," to increase training, and decrease turnover to eventually develop a collaborative effort by state agencies.

Case Tracking

Participation in research activities by the forensic nurse examiner within the practice setting and applying research findings to the practice may help to facilitate prosecution of the perpetrators. Involvement in research is one crucial component of case tracking which can be used in evaluating critical areas needing attention in getting cases through the justice system and following up on referrals from the examinations (National Children's Alliance, 2000). Long term benefits of case tracking would include improvement in evidence collection procedures and documentation techniques and could be used to validate changes in the indictment and conviction rates in child sexual abuse cases (Allen, 1999).

Tracking the number of cases referred by law enforcement to the prosecutor; the number accepted for prosecution; the number of pleas, jury trial, and conviction rates; and the number of on-site medical examinations in cases of child sexual abuse are all needed areas in future research.

Liability and Accountability

Liability and accountability is an important issue in the field of forensic nursing. This area is actually an issue for all forensic nurse examiners but particularly in the field
of child sexual abuse. A diagnosis of suspected child sexual abuse has serious legal consequences and errors in diagnoses can lead to a child being removed from his or her home or to the criminal conviction of an innocent person. In contrast, failure of the forensic nurse examiner to recognize child sexual abuse could result in the child being continually exposed to the abuse by the perpetrator (Kelley & Yorker, 1997). Forensic nurse examiners have an obligation to strive for continued specialized education in order to maintain the standard of care required for the tremendous responsibility this role entails.

Training

Forensic nurse examiners, desperately needed in the area of child sexual abuse, are being trained and are developing expertise in order to provide the evaluations needed when allegations of child abuse occur. Technology has aided in overcoming geographic limitations, and healthcare providers in rural areas are having the opportunity to collaborate with physicians at distant sites with expertise in the area of child sexual abuse. In this dynamic field, the increased use of telemedicine and image documentation software programs allows images to be transmitted to a trained physician for consulting. These technological advances offer excellent opportunities for health care professionals in rural areas to receive expert consultation. Forensic nurse examiners are increasingly experiencing independence and physicians are welcoming them as collaborative partners. Through the National Children's Alliance, Children's Advocacy Centers of Georgia, and Georgia Network to End Sexual Assault, professional development opportunities are offered continually. CACs are training their clinicians to perform forensic medical examinations.
The Bragg Model in Figure 6 developed during the research emphasizes the attributes and roles of the trained examiner: *Interviewing Skills* used with the victim; *Physical Examination* of the victim using *Colposcopy; Consultation* with parents or non-offending caregivers, agencies, and other professionals; *Referral* from and to health care agencies and law enforcement and in professional consultation of difficult cases; and *Expert Witness* at trials and hearing.

The qualities in the Bragg Model lend to *Emotional Healing* of the sexually abused child. When the sexually abused child is presented to the forensic nurse examiner, he or she may exhibit many emotional signs as a result of the stress of the abuse (Heppenstall-Heger et al., 2003). Nursing interventions utilize the skills of the forensic nurse examiner as building blocks and help to ameliorate the negative consequences of the abuse while building a positive starting point for emotional healing for the child.
Using Interviewing Skills from the Bragg Model, the forensic nurse examiner assures the child that he or she has become a hero for telling what happened to him or her, turning the child's fear and secrecy into bravery. Anxiety can be reduced by reassuring the child that he or she can grow up to be "normal" and that the child is not different from other children. Guilt becomes innocence when the child is told that he or she is not responsible for the abuse and that it is not their fault that the abuse happened. Denial often results in disclosure as the forensic nurse examiner builds on the trust he or she has developed with the child (Heger et al., 2000).
The forensic nurse examiner uses specialized training to perform a routine, head-to-toe complete Physical Examination with Colposcopy described in the Bragg Model, while explaining to the child that the anogenital examination is part of the routine examination. In a child-friendly center, embarrassment and shame are replaced with dignity and increased self-esteem as the forensic nurse examiner explains to the child the procedures of the examination using play therapy and allows the child to handle the equipment. Distrust is replaced by trust as the forensic nurse examiner demonstrates the examination techniques to the child (Ledray, 1999). Lack of control during the abuse becomes empowerment when the forensic nurse examiner allows the child to make choices, such as picking the gown to be used for the examination, which games he or she would like to play during the examination, and which ear is to be checked first. Further relief is experienced as follow-up is performed by the forensic nurse examiner concerning treatment of sexually transmitted diseases or negative pregnancy tests in adolescents (McClain et al., 2000).

Consultation in the Bragg Model with experts in the field using specialized software allows for collaboration with other members of the multidisciplinary team including law enforcement and child protective services and produces results of the child feeling protected. Loneliness or feeling regretful, because of disclosing, changes into a feeling of being supported and loved. This transition takes place as the forensic nurse examiner and members of the multidisciplinary team, including the child advocate, mental health counselor, and victim services, advocate for the child through collaboration and follow-up with appropriate referral in the Bragg Model. Hopelessness begins to
change into hopefulness and wholeness as the forensic nurse examiner in the Bragg Model uses referrals to counseling with mental health resources (McClain et al., 2000).

In the Bragg Model, additional protection is felt by the child as the forensic nurse examiner acts as an Expert Witness in court to aid in preventing the alleged perpetrator from further access to the child. The physical and photographic evidence that the forensic nurse examiner gathers in the course of one examination can help to present an historical account of the findings at trial (National Children's Alliance, 2000). Clearly, the forensic nurse examiner begins to address the emotional needs of the sexually abused child and initiates the emotional healing process as multi-task oriented roles are performed (Ledray, 1999).

*Emotional Healing Investigation Needed*

Future research needs to include the emotional healing of the child and the child's subsequent adjustment as an adult. The sexually abused child may or may not have physical injuries, but always experiences emotional trauma that may last a lifetime (Heppenstall-Heger et al., 2003). The original hypothesis was directed toward investigating if the trained versus nontrained forensic examiners had any relationship to conviction rates. What emerged during the study was the importance of emotional healing of the sexually abused child. Emotional healing is defined as restoring the state of positive feeling to the sexually abused child's health (Heger et al., 2000). A review of the literature revealed the emotional healing of the sexually abused child is directly related to the support of the medical professional involved. Heger et al. (2000) report that the interaction of the health care provider with the sexually abused child can be a powerful step towards wholeness and ultimately the emotional healing of the child.
Ledray (1999) stresses that the nursing process in the area of practice with sexually abused children includes addressing the emotional issues and sources of support for the child and family. McClain et al. (2000) further suggest that one of the primary goals of the health care provider should be to begin the process of restoring the child's sense of dignity and control. There is a gap in the literature linking the continuous thread of interaction of the forensic nurse examiner directly with the emotional healing of the sexually abused child.

Directions for Further Research Needed

Further research is needed to compare the conviction rates of the perpetrators to the examinations performed on the victims of child sexual abuse. More research needs to be done to determine why the cases are dropped from prosecution. A drop code to identify the reason for not pursuing prosecution could be used to further analyze reasons for failed conviction rates (Gray-Eurom, Seaberg, & Wears, 2002).

Further research to determine the emotional healing beginning with the forensic medical examination needs to be done. Non-directive child-centered play therapy could accomplish this without re-traumatizing the child (E. Emerson, personal communication, March 8, 2004). Other research could be done with sexually abused children who have become adults using longitudinal studies to assess the perception of their own emotional healing.

Finally, case tracking may be instrumental in increasing the conviction rates of the perpetrators by improving evidence collection procedures and documentation techniques. Applying research findings to the practice will allow the forensic nurse examiner to track the cases with an emphasis on examining the reasons child sexual
abuse cases are not being prosecuted in the judicial system (National Children's Alliance, 2000).

Summary

This study has contributed to the knowledge base of forensic nurse examiners and their role in increasing the number of conviction rates of sexually abused children. The research was originally designed to explore the relationship between conviction rates of child abuse perpetrators and forensic medical examinations performed by trained versus non-trained examiners on victims of child sexual abuse. However, the major finding that emerged during the research was the surprising lack of forensic medical examinations being performed on children who were victims of sexual abuse. In addition, the majority of cases were never referred to the district attorney's office for prosecution.

A corollary and serendipitous finding was the emotional healing that began to take place as a result of the child receiving a forensic medical examination. Whether the perpetrators are convicted or not, including a forensic medical examination by a trained professional in the investigation process begins the emotional healing that is so necessary in the life of a child (Heger et al., 2000). Of utmost importance is the journey of the child from sexual abuse to emotional healing. By articulating forensic nursing roles, nursing knowledge and nursing skills to other professionals, collaborating with other professionals in client care, teaching, supervision, and research, and keeping open lines of communication with law enforcement, forensic nurse examiners in CACs have a tremendous opportunity to provide paths to healing and to offer sexually abused children a bright and productive future. This journey of healing will enable the forensic nurse examiner to instill his or her passion for the well being of the child into his or her practice
and to ensure a holistic outcome of emotional healing for the sexually abused child and his or her family.
REFERENCES


Georgia Network to End Sexual Assault (GNESA) (2001). *Basic SANE Training Program Guidelines* (No. 1). Atlanta, GA: Georgia Network to End Sexual Assault (GNESA).


APPENDIX A

1) INSTRUMENT A-CHART REVIEW FORM

2) INSTRUMENT B-LEVEL OF TRAINING TELEPHONE INTERVIEW QUESTIONNAIRE
INSTRUMENT A

CHART REVIEW FORM

VICTIM ID#______________ PHYSICAL ABUSE □ SEXUAL ABUSE □

DATE OF BIRTH __________ AGE________________

GENDER  Male □  Female □

RACE  Black □  White □  Hispanic □  Other □

COUNTY OF ABUSE
  Candler □  Emanuel □  Jefferson □
  Toombs □  Washington □

FORENSIC MEDICAL EXAMINATION  Yes □  No □

DATE OF EXAMINATION____________

ID# OF EXAMINER__________________ TRAINED □  UNTRAINED □

TITLE OF EXAMINER*____________

LOCATION OF EXAMINATION* __________

COLPOSCOPE USED    Yes □  No □

PHYSICAL FINDINGS* ______________________

PERPETRATOR RELATIONSHIP TO VICTIM*____________________

PERPETRATOR CONVICTION STATUS*_____________________

COMMENTS ON CONVICTION STATUS_____________________

DATE OF CONVICTION____________________________________

*See Code Sheet attached
INSTRUMENT B

LEVEL OF TRAINING TELEPHONE INTERVIEW QUESTIONNAIRE

ID#____________________

TITLE OF EXAMINER*________

What training/equipment would you like to see in the area of forensic medical examinations in SE rural GA?____________________________________________________________

LOCATION OF EXAMINATIONS PERFORMED*________

DO YOU HAVE ACCESS TO A COLPOSCOPE?       Yes □    No □

DO YOU USE A COLPOSCOPE DURING EXAMINATIONS?    Yes □    No □

IF YOU HAD ACCESS TO A COLPOSCOPE WOULD YOU USE IT?

   Yes □    No □

HOW VALUABLE DO YOU FEEL A COLPOSCOPE WOULD BE TO YOU?

____________________________________________________________

HAVE YOU BEEN TRAINED IN THE USE OF A COLPOSCOPE?

   Yes □    No □

HOW MANY EXAMINATIONS DO YOU PERFORM?

Monthly_______Yearly________Total Completed <10____  10-25____over 25____

# YEARS EXPERIENCE DOING EXAMINATIONS______________

NUMBER OF HOURS RECEIVED IN TRAINING  Didactic_____Clinical______
INSTRUMENT B continued

FORENSIC SEXUAL ABUSE TRAINING

☐ SANE Training
☐ Advanced Pediatric SANE Training
☐ Teaching Hospital/CAC Forensic Training
☐ Continuing Education Units (CEUs) Total CEUs _____
☐ One Semester Forensic Sexual Assault Nursing
☐ Forensic Conference/Seminar/Workshop
☐ Ongoing Peer Review
☐ Other  Describe______________________________

*See Code Sheet attached
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<th>TITLE OF EXAMINER</th>
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<td>Registered Nurse</td>
</tr>
<tr>
<td>4</td>
<td>Other</td>
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<tr>
<td>5</td>
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</tr>
<tr>
<td>6</td>
<td>Advanced Pediatric SANE</td>
</tr>
<tr>
<td>7</td>
<td>Site B Physician</td>
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<tr>
<td>8</td>
<td>Private Physician</td>
</tr>
<tr>
<td>ID #</td>
<td>LOCATION</td>
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<td>Off Site-Physician office</td>
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<td>Off Site-Hospital</td>
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<td>Off Site-Site B</td>
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<tr>
<td>7</td>
<td>Other</td>
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<td>On Site-TSH</td>
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## Forensic Medical Examination Physical Findings List

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<td>Physical Findings-Other</td>
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<td>3</td>
<td>None/Inconclusive/Unknown</td>
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## Forensic Medical Examination Alleged Perpetrator Relationship List

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<td>Biological Mother</td>
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<tr>
<td>Biological Father</td>
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<td>Sister</td>
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<td>Friend</td>
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<tr>
<td>Adoptive Parent</td>
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<td>Step Parent</td>
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<tr>
<td>Uncle</td>
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<table>
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<th>Non-Family Offender</th>
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<tbody>
<tr>
<td>Mother’s Boyfriend</td>
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<td>Father’s Girlfriend</td>
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<td>Caregiver</td>
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</tr>
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<td>Friend</td>
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<td>Neighbor</td>
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<tr>
<td>Stranger</td>
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<td>Other</td>
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## Perpetrator Conviction Status List from DA

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<td>35</td>
<td>Bond Hearing/Granted/Conditional</td>
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<td>34</td>
<td>Bond Hearing/Judge Denied Bond</td>
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<td>Case Placed on Trial Calendar</td>
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<tr>
<td>6</td>
<td>Grand Jury/Trial/Jury/Mistrial</td>
</tr>
<tr>
<td>7</td>
<td>Grand Jury/Trial/Jury/Not Guilty</td>
</tr>
<tr>
<td>31</td>
<td>Indictment</td>
</tr>
<tr>
<td>26</td>
<td>Juvenile Court/Dismissed</td>
</tr>
<tr>
<td>23</td>
<td>Juvenile Court/No Arrest</td>
</tr>
<tr>
<td>22</td>
<td>Juvenile Court/Not Guilty/Judge</td>
</tr>
<tr>
<td>21</td>
<td>Juvenile Court/Trial/Guilty/Sex. Off. Tx/Prob</td>
</tr>
<tr>
<td>24</td>
<td>Juvenile Court/Trial/Plea/Sex Off. Tx/Probation</td>
</tr>
<tr>
<td>25</td>
<td>Juvenile Court/Tried as Adult in Superior Court</td>
</tr>
</tbody>
</table>
APPENDIX B

1) CONSENT REQUEST CARD

2) CONSENT RETURN CARD
CONSENT REQUEST CARD

Dear

I am a graduate student at Georgia Southern University pursuing my Master of Science in Nursing/Family Nurse Practitioner degree and am asking for your volunteer participation in a research study. I am conducting a GSU sponsored study in the area of child sexual abuse and am interested in determining what you would like to see in the area of forensic medical examination training for our circuit. You and approximately 10 others are being asked to participate in the research project because you have been a part of the forensic examiner team for the Middle Judicial Circuit and your contact information was obtained through a work database. Confidentiality of the data and access to the data collected from you will be maintained by the assigning of identification numbers that will be known only to the investigator or her assistants. If applicable, approval from your site supervisor has been obtained and your decision to participate in no way will affect your job status as a forensic examiner.

In order for you to answer a questionnaire for this purpose, I will be contacting you by telephone at work in the summer of 2003 for a phone interview that should take approximately 10-15 minutes to complete. If you are willing to have a telephone interview, please complete the enclosed card and return to me. I look forward to hearing from you soon.

Sincerely,

Leila S. Bragg, BSN, RN, SANE
CONSENT RETURN CARD

I am willing to be interviewed on the phone.

YES_________

Signature__________________________

Printed Name_______________________

Telephone #________________________
APPENDIX C

1) LETTER OF SUPPORT-THE SUNSHINE HOUSE CHILDREN’S ADVOCACY CENTER

2) LETTER OF SUPPORT-SITE B
LETTER OF SUPPORT REQUEST-THE SUNSHINE HOUSE

Carol Donaldson, Executive Director
The Sunshine House Children’s Advocacy Center
P. O. Box 617
Swainsboro, GA 30401

February 14, 2003

Dear Mrs. Donaldson,

My name is Leila Bragg. I am a graduate student in the School of Nursing at Georgia Southern University pursuing my Master of Science in Nursing/Family Nurse Practitioner degree. I am conducting a research project involving the level of training for forensic examiners in the area of child sexual abuse in the Middle Judicial Circuit including the counties of Candler, Emanuel, Jefferson, Toombs and Washington.

I am writing for permission to access The Sunshine House Children’s Advocacy Center charts for the purpose of this research project and to create a database from the information obtained. If you would be willing to allow access, please prepare a letter (see attached example) on your letterhead. The letter will be submitted to the Georgia Southern University Institutional Review Board. I will be contacting you in person to set up a date and time. I will send a copy of the results to you if you would like.

Thank you for your support.

Sincerely,

Leila S. Bragg, BSN, RN, SANE
Graduate Student
School of Nursing
Georgia Southern University
Statesboro, Georgia 30461

enclosure
LETTER OF SUPPORT-THE SUNSHINE HOUSE

February 14, 2003

Institutional Review Board
Georgia Southern University
Statesboro, GA

I give permission to allow Leila Bragg, BSN, RN, SANE access to the charts at The Sunshine House for the purpose of her Master’s Thesis Research Project exploring the relationship between conviction rates and child sexual abuse forensic medical examinations. This is an area of importance and research is greatly needed and welcomed.

Sincerely,

Carol V. Donaldson
Executive Director
LETTER OF SUPPORT REQUEST-SITE B

February 14, 2003

Dear

My name is Leila Bragg. I am a graduate student in the School of Nursing at Georgia Southern University pursuing my Master of Science in Nursing/Family Nurse Practitioner degree. I am also the medical coordinator and forensic nurse examiner at The Sunshine House Children’s Advocacy Center in Swainsboro.

I am conducting a research project in the area of child sexual abuse and would like input from your forensic examiners regarding the level of training needed for examinations in rural Georgia. The research project will include a telephone interview with the forensic examiners at Site B who have performed forensic medical examinations on children in the Middle Judicial Circuit including the counties of Candler, Emanuel, Jefferson, Toombs and Washington. The telephone interview should take approximately 10-15 minutes to complete and will be done during the summer of 2003.

I am writing for permission to have a telephone interview with the forensic examiners at Site B as described above for the purpose of this research project and to create a database from the information obtained. If you would be willing to allow these telephone interviews, please prepare a letter (see attached example) on your letterhead. The letter will be submitted to the Georgia Southern University Institutional Review Board. I will send a copy of the results to you if you would like. Should you have any questions, you can reach me by email at lbragg_sunshinehouse@yahoo.com or by telephone at 478-237-7801.

Thank you for your support.

Sincerely,

Leila S. Bragg, BSN, RN, SANE
Graduate Student
School of Nursing
Georgia Southern University
Statesboro, Georgia 30461
enclosure
LETTER OF SUPPORT-SITE B

February 14, 2003

Institutional Review Board
Georgia Southern University
Statesboro, GA

I give permission to allow Leila Bragg, BSN, RN, SANE access to our telephone listing of examiners for her to survey at Site B for the purpose of her Master’s Thesis Research Project exploring the relationship between conviction rates and child sexual abuse forensic medical examinations. This is an area of importance and research is greatly needed and welcomed.

Sincerely,
APPENDIX D

1) INSTITUTIONAL REVIEW BOARD APPROVAL LETTER

2) INSTITUTIONAL REVIEW BOARD MODIFICATION APPROVAL LETTER
After an expedited review of your proposed research project titled “The Relationship Between Conviction Rates of Child Abuse Perpetrators & Forensic Medical Examinations Performed on Victims of Child Sexual Abuse,” it appears that (1) the research subjects are at minimal risk, (2) appropriate safeguards are planned, and (3) the research activities involve only procedures which are allowable under the following research category:

Research, involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects

Therefore, as authorized in the Federal Policy for the Protection of Human Subjects (45 CFR §46.101), I am pleased to notify you that the Institutional Review Board has approved your proposed research.
This IRB approval is in effect for one year from the date of this letter. If at the end of that time, there have been no changes to the expedited research protocol, you may request an extension of the approval period for an additional year. In the interim, please provide the IRB with any information concerning any significant adverse event, whether or not it is believed to be related to the study, within five working days of the event. In addition, if a change or modification of the approved methodology becomes necessary, you must notify the IRB Coordinator prior to initiating any such changes or modifications. At that time, an amended application for IRB approval may be submitted. Upon completion of your data collection, please notify the IRB Coordinator so that your file may be closed.

C: Dr. Tom Case, IRB Chairperson
   Dr. Bryan Riemann, IRB Associate Chairperson
   Ms. Melanie Reddick, IRB Administrative Assistant
After a review of your proposed modifications request for your research project titled “The Relationship Between Conviction Rates of Child Abuse Perpetrators and Forensic Medical Examination Performed on Victims of Child Sexual Abuse,” it appears that (1) the research subjects are at minimal risk, (2) appropriate safeguards are planned, and (3) the research activities involve only procedures listed in the following expediteable research categories:

Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded in a manner that subjects cannot be identified, directly or through identifiers linked to the subject.

Therefore, as authorized in the Federal Policy for the Protection of Human Subjects (45 CFR §46.101), I am pleased to notify you that the Institutional Review Board has approved your proposed modification. If you have any questions, comments, or concerns about these conditions of approval, please do not hesitate to contact me. Please send a copy of all revised and/or additional materials to the IRB Coordinator at the Office of Research Services and Sponsored Programs (PO Box 8005).

This IRB approval is in effect for one year from the date of this letter. If at the end of that time, there have been no changes to the expedited research protocol, you may request an extension of the approval period for an additional year. In the interim, please provide the IRB with any information concerning any
significant adverse event, **whether or not it is believed to be related to the study**, within five working days of the event. In addition, if a change or modification of the approved methodology becomes necessary, you must notify the IRB Coordinator prior to initiating any such changes or modifications. At that time, an amended application for IRB approval may be submitted. Upon completion of your data collection, please notify the IRB Coordinator so that your file may be closed.

C:  
Dr. Tom Case, IRB Chairperson  
Dr. Bryan Riemann, IRB Associate Chairperson  
Mr. Thad Meeks, IRB Coordinator