WARNING — This excerpt is intended for use by medical, legal, social service, and law enforcement professionals. It contains graphic images that some may find disturbing or offensive. Minors and/or nonprofessionals should not be allowed to access this material.
Introduction to

Forensic Nursing

Principles and Practice

Forensic Learning Series

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FOREWORD

As nurses, we recognize that violence is a health care issue. It does not discriminate against gender, race, age, geographic region, economic boundaries, or religion. For those who are intrigued by science, the law, and the ability to aid in the judicial process, there lies an opportunity to work at the intersection of them all. This intersection is forensic nursing. Forensic nurses provide and implement patient-centered and trauma-informed care to persons who have suffered the unimaginable. Introduction to Forensic Nursing: Principles and Practice offers insight into this care. It illuminates the vast and ever-changing practice environment of forensic nursing and arms nurses with the knowledge to provide care to those experiencing violence and trauma.

Through the exploration of this text, present and future forensic nurses will strengthen their inner passion for providing medical forensic care to the patient populations they serve. Forensic nurses choose to be a voice for the voiceless and to provide evidence-based, compassionate care in cases of violence. As you embark on your forensic adventure, realize that, going forward, you have the opportunity to be an advocate for science. As you work with patients, be authentic, speak the truth, earn their trust, be supportive, and be unafraid to ask the tough questions. You are capable of changing the landscape of the health care setting. Remember that though your patients may be in their darkest hour, you can be the light for all the days ahead.

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**Preface**

“As is often the case, when a radical improvement in health care takes place, one visionary emerges.” —Virginia A. Lynch.

Virginia Lynch conceptualized nurses as the torchbearers and promoted improvement of medical-forensic practices, defined the practice of forensic nursing, and took the role to a global level. Over the past 3 decades, forensic nursing has emerged as a health care discipline that provides and improves the quality of care for society’s most vulnerable populations. Forensic nurses combine compassionate trauma-informed care with the latest scientific practices to bring safety, medical treatment, and justice to patients who experience trauma in all its forms.

*Introduction to Forensic Nursing: Principles and Practice* provides a pathway into many different areas of forensic nursing with a focus on trauma-informed care. Forensic nurses play a key role in the identification, collection, and preservation of evidence that may otherwise be lost during a patient’s hospital visit. They are specially educated to provide holistic, trauma-informed care to patients who have been victims of sexual assault, intimate partner violence, neglect, and/or physical assault. Their education includes training in the legal and forensic science aspects of the role. Forensic nurses work with those affected by many forms of maltreatment, including elder and child abuse and human trafficking.

Many of the chapters herein contain case studies designed to walk readers through scenarios encountered by forensic nurses, allowing readers to develop an understanding of the complexities of patients and the problems they face following violence. Both the experienced and novice health care provider will benefit from this new text.

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Reviews

Introduction to Forensic Nursing: Principles and Practice is an excellent resource for professionals that work at the intersection between the criminal justice system, forensic evidence collection, and medical care. Each chapter includes key points and case studies that enable the reader to easily digest the information and apply the lessons to their day to day work. Those who seek to understand the vital role that forensic nurses play in criminal investigations and the search for the truth should read this book.

Debbie Feinstein
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Forensic nursing is a specialized field that not only requires general nursing knowledge and skills but also knowledge of the inner workings of the vast criminal system. The textbook, Introduction to Forensic Nursing: Principles and Practice dives into the nuances necessary for nursing consideration when caring for assault victims. From the patient interview and evidence collection to the victim aftercare and legal proceedings, Introduction to Forensic Nursing: Principles and Practice succinctly details the current practices forensic nurses can incorporate to ensure victims of assault are cared for in a patient-centered environment and evidence is secured to strengthen the prosecution of the alleged perpetrator. Current and future forensic nurses will benefit greatly from the use of this textbook.

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The authors of Introduction to Forensic Nursing: Principles and Practice have built a robust foundation of knowledge on forensic nursing, equally palatable to those already in the medical field as well as prospective practitioners. One aspect of forensic nursing that makes it so special is the sheer number of disciplines routinely engaged in the work. From biology to psychology to law and beyond, Introduction to Forensic Nursing gives each one its due. With this book, the authors successfully lay the groundwork for a future with knowledgeable, well-rounded, trauma-informed forensic nurses leading the charge to serve the medical needs of victims of abuse and violence in tandem with the justice system.

Thomas Manion, Director
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Introduction to Forensic Nursing: Principles and Practice is a comprehensive textbook for those interested in the dynamic field of forensic nursing. This long-awaited textbook includes descriptions of the many roles of the forensic nurse along with tools and information for successful practice. The organization of the textbook allows easy access to the content, including an overview and historical perspective of forensic nursing, as well as sections with specific content related to borrowed science, violence across the lifespan, special populations, and special crimes. The chapters detail the role of forensic nursing in various fields, and many include case studies with enlightening discussion on how the concepts of forensic nursing would be applied to the scenario. The concept of trauma-informed care is pervasive and emphasized throughout the text. Applying the principles of trauma-informed care reaches far beyond the forensic nurse practice and is a skill that can be utilized by all nurses.

Introduction to Forensic Nursing: Principles and Practice fills a void for a complete evidence-based practice resource about forensic nursing all in one place. This scholarly resource will be an asset for nursing curriculums.

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OVERVIEW
Introduction to Forensic Nursing: Principles and Practice was developed in conjunction with the Academy of Forensic Nursing (AFN) to provide current and future forensic nurses with the opportunity to learn and grow within the field. Candidates who complete the book may register to take the posttest through AFN Learn to earn 13.0 contact hours. AFN is an approved provider of continuing education (CE) credits through the American Nurses Credentialing Center (ANCC).

EDUCATIONAL OBJECTIVES
Introduction to Forensic Nursing: Principles and Practice serves as an introduction to the broad field of forensic nursing and the care of patients whose cases intersect with legal systems. Upon completion of this text, the reader will have a strong understanding of forensic nursing, current best practices within subspecialties, and the possibilities for the forensic nurse of the future.

After reviewing this text, readers will be able to:
— Understand the history of the field of forensic nursing
— Describe the intersection of health care and the legal system in forensic nursing practice
— Identify the scientific fields that inform forensic nursing practice
— Describe the effects of violence across the lifespan
— Identify best practices when working with special populations
— Describe the role of the forensic nurse in cases of special crimes
— Delineate the steps of assessment and evidence collection
— Implement trauma-informed care in their own practice

COURSE FORMAT AND IMPLEMENTATION
For optimal results, the authors suggest reading the text in its entirety and completing the assessment in the back of the book.

If you are interested in receiving CE credits for the completion of this workbook, the posttest can be accessed on the AFN learning management system (LMS) at www.goafn.thinkific.com. Readers must purchase the CE for Introduction to Forensic Nursing: Principles and Practice and complete the available assessment. After registering and successfully completing the posttest with a score of 80% or higher, registrants will receive confirmation of earned credits from AFN and will be able to download their certificate for 13.0 contact hours immediately.

Registrants will be able to complete this process at their own pace. All fees related to receiving credit are determined by AFN and are the sole responsibility of the student.
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**Chapter 22: Native American Populations, Historical Trauma, and Role of the Forensic Nurse**

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Colonization and Its Effects on Indigenous Populations

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**DEFINITIONS**

**OBJECTIVES**
After reviewing this section, the reader will be able to:

1. Clearly identify and define key terms related to forensic nursing.
2. Accurately apply terms when analyzing cases of forensic nursing.

**INSTRUCTIONS**
The following terms are found throughout the text. This section should serve as a convenient reference for readers as they move through the chapters.

— **Adaptive Techniques:** Used by people with disabilities to provide developmentally specific care or assistance, such as wheelchairs, lifts, standing frames, gait trainers, augmentative communication devices, bath chairs, and recreational items (eg, swings or tricycles).

— **Actus Reus:** The guilty act (ie, the physical component of a crime).

— **Adolescent:** People between 10 and 19 years of age.

— **Adversarial Growth:** A phenomenon of acceptance of a traumatic event (or events), which includes positive psychological changes after the stages of recovery occur.

— **Adverse Childhood Experiences (ACEs):** Traumatic events that occur during childhood (eg, unstable housing; abandonment; domestic, sexual, physical, and emotional violence; and neglect) including witnessing violence and natural disasters.

— **Affiliated Volunteers:** Members of a recognized volunteer agency.

— **Alcohol-Enabled Sexual Assault (AESA):** Crime of sexual assault during which the perpetrator utilizes alcohol (either previously consumed by victim or provided by perpetrator) to incapacitate their victim.

— **All Hazards Approach:** Maximizes available resources to address the overall scope of emergency preparedness and planning, incorporating vulnerabilities and potential threats to the community.

— **Allostasis:** The process of the body responding to stressors in order to return to homeostasis.

— **Americans with Disabilities Act (ADA):** A civil rights act that came into effect in 1990 to prohibit discrimination against individuals with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places.

— **Anogenital Examination:** An examination of external genital organs.

— **Anoxia:** The absence of oxygen. During strangulation, the brain suffers an anoxic injury when the blood supply is completely obstructed.
Section II

OVERVIEW
HISTORY OF THE ROLE OF FORENSIC NURSING IN THE UNITED STATES

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KEY POINTS
1. The history of nursing began with a focus on maternal child survival up to 4 millennia ago in Persia, with additional records of deaconesses and nurse midwives in Europe in the 1300s.
2. Forensic nursing is heavily rooted in Sister Catherine McAuley’s philosophy and model of careful nursing.
3. In her 1991 thesis, Virginia Lynch described a concept in nursing based on her experience and created the theoretical framework of forensic nursing in North America today.
4. Forensic nursing is a dynamic field at all educational levels, with opportunities to develop expertise in many sub-specialties founded on 3 pillars – legal, forensic science, and nursing.

INTRODUCTION
The word “nurse” is derived from the Latin word “nutricius,” meaning the nurture and sustenance of infants.1 As such, nurses’ interest in the survival of children is a common entry into the role. Nurses are frequently referred to as the walking wounded,2 known for being honest, ethical, and caring for all types of patients, as well as learning to care for patients that are victims of violence. Forensic nursing is the intersection of nursing with the legal systems which utilizes borrowed elements of forensic science to assist patients who interact with the legal system.3-7

The first discovered documentation of medicine and forensic findings was in China and Mesopotamia, up to 6 thousand years ago.8 Likewise, during the 13th and 14th centuries, Europeans recorded midwives and deaconesses in court records opining confirmation of virginity, sexual assault examinations, pregnancy examinations, and psychiatric care. Court records indicate that one nurse midwife, Emmeline La Duchesse, appeared in testimony records about virginity from the 1300s.9,10

By the 18th century, deaconesses documented victims of violence and midwives testified about rape routinely in court. They continued to verify virginity status of women planning to marry into royalty.9,11,12 Many of these deaconesses were from the Catholic or Anglican European communities. The influence of Sister Catherine McAuley and her Sisters of Mercy spread the concept of careful nursing, a nursing
THE IMPACT OF TRAUMA ON HEALTH

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Callie Mersbergen, BSN, RN
Patricia M. Speck, DNSc, CRNP, FNP-BC, AFN-C, DF-IAFN, FAAFS, DF-AFN, FAAN

Key Points
1. Trauma activates the stress hormones. When the trauma ends, the body returns to homeostasis, but prolonged trauma can disrupt that process.

2. Traumatic events can lead to severe stress in children, affecting their memory, hormone and organ responses to stress, and their ability to form and maintain relationships.

3. A person’s environment (eg, where they are born, live, etc.) is a determinant of health, influencing overall health and longevity.

Introduction
The words “trauma” and “stress” are interchangeable in relation to health and wellness. The impact of trauma on health is present throughout the lifespan. The impact of traumatic events was first noted during the Civil War when many veterans were diagnosed with “soldier’s heart.” The term is now known as post traumatic stress disorder (PTSD) and includes an increased likelihood of cardiovascular disease. Stress remains poorly understood as scientific explanations for stress outcomes are less than 30 years old. The association of stress with disease development provides a platform to understand the disease burden on society. Epidemiologists quantify victims from police reports, crime reports, and other government collection agencies, including the United States Census. This provides household and income data, which are 2 social determinants of health. Today, epidemiologists observe stress-related diseases associated with a lifetime of abuse as seen in Figure 3-1.

The Stress Response
Almost 100 years ago, Selye described the stress response by stating “the body never forgets.” Selye’s General Adaptation Syndrome (GAS) explains how the response to stress occurs and how chronic stress leads to physiological change and significant health problems (Figure 3-1). Trauma activates the stress hormones, and the body enters into fight or flight mode. When the trauma stops, the body returns to homeostasis; however, under repetition or severe traumatic stress, the chronic activation prevents a return to homeostasis. The chronic elevation of...
you?” rather than “What is wrong with you?” forensic nurses can provide patients with an open opportunity to share their experiences. The 4 R’s serve as a guide to practicing trauma-informed care. These guidelines, further explained in Table 5-1, include Realization, Recognition, Response, and avoidance of Re-traumatization.  

<table>
<thead>
<tr>
<th>Actions</th>
<th>Description</th>
</tr>
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<tr>
<td>Realization</td>
<td>Realize the widespread impact of trauma and understand that everyone has some trauma (e.g., mass casualty [crashes, shootings, pandemic, weather events], government action/inaction [war, policy], racism [individual or structural], family trauma [abuse, exploitation, sexual violence, generational].)</td>
</tr>
<tr>
<td>Recognition</td>
<td>Recognize the different expressions of trauma (e.g., mental health, self-harm, depression, addictions, anger, fear, social phobias, aggression, and others).</td>
</tr>
<tr>
<td>Response</td>
<td>Use trauma-informed care principles to seek patient support for the inquiry (e.g., What happened to you?).</td>
</tr>
<tr>
<td>Resist</td>
<td>Ask the patient’s preferences for your discussion about trauma (e.g., May I speak to you about what happened?).</td>
</tr>
<tr>
<td>Re-traumatization</td>
<td></td>
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</table>

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There are 6 key principles of trauma-informed care that should be practiced in provider-patient relationships: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and sensitivity to cultural, historical and gender issues. These are further explained in Table 5-2.  

<table>
<thead>
<tr>
<th>Principle</th>
<th>Action</th>
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</thead>
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<tr>
<td>Safety</td>
<td>Making sure people feel physically and psychologically safe in the environment</td>
</tr>
<tr>
<td>Trustworthiness and transparency</td>
<td>Conducting decisions with transparency and the goal of building and maintaining trust with all persons</td>
</tr>
<tr>
<td>Peer support</td>
<td>Providing patients with knowledge, experience, and emotional/social support</td>
</tr>
<tr>
<td>Collaboration and mutuality</td>
<td>Intentionally partnering with all persons and treating everyone equally</td>
</tr>
<tr>
<td>Empowerment, voice, and choice</td>
<td>Providing paths to success, building strength with support during trauma, perceptions of harm, and building resilience through healing</td>
</tr>
<tr>
<td>Cultural, historical, and gender issues</td>
<td>Acknowledging personal/structural implicit and explicit bias</td>
</tr>
</tbody>
</table>

Often, stereotypes and implicit biases interfere with person-centered care of forensic nurses. Judgement is an implicit assignment of stereotypes to a person’s appearance, undermining patient safety. Biases hurt relationships, shut off avenues of communication, and diminish feelings of safety in patients. Table 5-3 identifies different types of biases and gives examples of judgmental behaviors.
FUTURE OF FORENSIC NURSING
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KEY POINTS
1. Roles and responsibilities in forensic nurse practices expanded to cover trauma in populations globally.
2. The maturity of the specialty of forensic nursing is dynamic and follows the nursing specialty nationally, influenced by the American Association of Colleges of Nursing (AACN) Essentials.
3. Legislation enhanced funding for programs nationally with expectations of continued funding for the general forensic nursing practice.
4. The impact of the COVID-19 pandemic reversed years of nursing practice restrictions and caused the growth of forensic telemedicine to address the needs of rural and remote populations of forensic nurses and their patients.
5. The Forensic Nursing Certification Board (FNCB) offers comprehensive certifications for generalist and advanced forensic nurses and is working with countries outside the United States to implement educational programs.

INTRODUCTION
The first forensic nursing meeting in the United States was held in Minneapolis at the University of Minnesota and primarily consisted of forensic nurses in sexual assault care. The early growth was directly related to each scientific and health care organization’s capacity to set standards and to provide a location for common interests for the specialty of forensic nursing to develop. The roles of the forensic nurse have since expanded and varied. They are dependent on the population, the patient’s age and stage of development, and the type of intersection with the legal system. For instance, gunshot wound or domestic violence victims typically present to emergency departments and may be met by a forensic nurse or team of forensic health care professionals. The original conceptualization of nurse clinician was narrow among attendees at the first meeting. Nonetheless, the term forensic nurse was later adopted, as was the first definition that stated, “Forensic nursing is defined as the application of the nursing process to public or legal proceedings, and the application of forensic health care in the scientific investigation of trauma and/or death related to abuse, violence, criminal activity, liability, and accidents.”

Regardless, forensic nurses in sexual assault care dominated organizational activities through special interest groups (SIGs), oftentimes with interprofessional members. Active and diverse were other SIGs representing psyche-mental health (MH) forensic nursing, corrections, research, consultation, death investigation, and education. Divisions among forensic nurses and nurses that aligned with family violence advocates remained for decades. Funding domestic violence responses, shelters,
BORROWED SCIENCE
it takes place. Numerous social, psychological, anthropological, and economic causes of violent crime exist.

Multiple philosophical theories of crime and delinquency guide the scientific study of criminology (Table 7-1).

<table>
<thead>
<tr>
<th>Table 7-1. Theories Useful to Criminologists in Their Attempt to Explain Crime Causation</th>
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<tr>
<td><strong>Theory</strong></td>
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</table>
| Rational Choice Theory | — Criminal behavior is an intentional choice  
| | — Criminals are not compelled or forced to commit crime  
| | — Criminal behavior is seen as more rewarding and less costly than non-criminal behavior |
| Sociological Positivism | — Behavior is the result of learning in the context of social structures, interactions, and situations |
| Biological Positivism | — Behavior is determined by biological factors beyond individual control |
| Psychological Positivism | — Psychodynamic theory: Early childhood experiences influence behavior later in life  
| | — Behavioral theory: Human behavior is developed through learning experiences  
| | — Cognitive theory: An individual’s perception and how it is manifested influences behavior |

**Victimology**

The term “victim” has ancient origins, dating back to the Hammurabi Code. “Victimization is an asymmetrical interpersonal relationship that is abusive, painful, destructive, parasitical, and unfair.” Victimology is the study of the relationship between the victim and offender, as well as their intersection with the justice system. As seen in Table 7-2, there are several theories in victimology that are used to explain how an individual may become a victim. While these theories explore how a victim’s lifestyle or behavior could impact their risk of victimization, the blame for the crime still falls wholly on the perpetrator.

<table>
<thead>
<tr>
<th>Table 7-2. Theories Useful to Researchers Studying Victimology</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theory</strong></td>
</tr>
</tbody>
</table>
| Mendelsohn’s Theory of Victimization | — Victims had an unconscious attitude that led to their victimization  
| | — Identified several different types of victims: innocent victim, minor guilty victim due to ignorance, voluntary victim, victim who is more guilty than the offender, perpetrator who becomes a victim, and individual who falsifies victimization |
| von Hentig’s Theory of Victimization (also known as Routine Activities) | — Victims are potentially negligent, provocative, and precipitate their own victimization (eg, individuals who have the same routine daily put themselves in the position to become a victim, creating vulnerability)  
| (continued) |
in an organized and linear way. There are 4 stages of healing following disruption of the integument: hemostasis, inflammation, proliferation, and maturation. Although the stages of wound healing are oftentimes linear, wounds can progress backward or forward depending on internal and external patient conditions.

Furthermore, the stages of healing are known by the characteristics of the stage, not the timing. The first phase, hemostasis, is characterized by constriction of blood vessels and capillaries where coagulation occurs. Fibrin is a binding agent, and platelets are a clotting agent. This stage for minor wounds is rapid, lasting seconds. In severe rupture of larger vessels, procoagulants and prothrombin assist in the development of a clot to stop bleeding.

The second stage of wound healing is the inflammatory phase, which begins with swelling to control bleeding and prevent infection. During this phase, damaged cells and pathogens are removed from the wound area. Most inflammation phase activities occur in the first 48 hours following a wound. White blood cells, growth factors, and enzymes create swelling, and the outward appearance is a hot, painful redness, only becoming problematic if persistent or creating an entire body system response (eg, cellulitis or sepsis).

The third stage, called the proliferative phase, is characterized by rebuilding the integument through supplying collagen and extracellular matrix. In this phase, the wound contracts and grows new blood vessels and nerves. Granulation tissue is the result of myofibroblasts, and when sufficiently healed, epithelialization is continuous through the next phase, maturation. In this phase, the wound closes and is thick, where the building blocks of collagen and fibrinogen are aligned with Langer’s lines (ie, tension lines).

Most injuries are in the final phase, maturation, for 1 month to 6 weeks. Along the healing trajectory, venous disease, infection, metabolic diseases, or old age may interfere in the rapid wound healing necessary to create a linear model for wound healing. Of note, keeping a wound moist, clean, and protected promotes rapid healing in all ages and may be the single cause for rapid healing following rape injury in the vestibular tissue.

**BALD STEP: AN INJURY AND PHYSICAL FINDINGS GUIDE**

Physical findings after trauma vary with the types of contact. Factors such as resistance or being restrained are likely to increase risk of injury, while intoxication or decreased levels of consciousness are associated with lower risks of injury. Additionally, there are numerous findings that mimic injury. The appropriate use of injury terms also indicates the mechanism of injury. Application of blunt force results in injuries such as bruises, bites, avulsions, abrasions, lacerations (ie, splitting the skin), and acute deformities of limbs such as sprains or strains. Tenderness may be an early indicator of deeper tissue trauma that could appear a few days later. Bruises are often mistakenly called ecchymosis, and co-morbid disorders such as low platelets promote ecchymotic spread. While ecchymosis is explainable, it is not trauma and instead reflects gravitational drainage from a distant source of impact as noted in Figure 8-1.

Lacerations, unlike bruises, release blood from the confined space and have characteristics such as irregular edges or cross-bridging of hair or connective tissue inside of the wound. Penetrating forces applied to skin, such as knives, result in injuries

![Figure 8-1. Bruises vs. Ecchymosis (© C. Carter-Snell, 2014. Used with permission).](image-url)
**The Psychology of Trauma**

Theresa Fay-Hillier, DrPH, MSN, PMHCNS-BC  
Maud D’Arcy, BSN, RN  
Melanie Alexander, RN, MSN

**Key Points**

1. The age of a child at the time of a traumatic event (or events) influences their ability to process trauma.

2. Exposure to childhood trauma increases susceptibility to psychopathologies, including posttraumatic stress disorder (PTSD) and substance abuse.

3. Forensic nurses mitigate trauma and promote healing by practicing trauma-informed and person-centered care.

**Introduction**

Trauma can be experienced throughout life, but it more commonly occurs during childhood. By age 16, more than two-thirds of children have experienced at least 1 traumatic adverse event. In addition to known adverse childhood traumatic experiences (eg, unstable housing; abandonment; domestic, sexual, physical, and emotional violence; and neglect), witnessing violence or natural disasters is also a traumatic experience for children. Children who experience one type of violence, such as physical abuse, are at greater risk for experiencing other forms of violence.

The Adverse Childhood Experiences (ACEs) study examined the connections between traumatic events during childhood and adverse health outcomes. The ACEs study found that as the number and intensity of traumatic events in childhood increased, adults died earlier than anticipated because they developed chronic physical and mental health diagnoses.

Health Outcomes of Positive Experiences is a framework identifying protective factors that can positively impact the outcomes of children who have encountered ACEs. The subjective impact and the resources available to support the person mitigates the impact of the trauma. There is greater risk for negative emotional and psychological consequences when the individual identifies feelings of immobility and helplessness during the trauma or has triggering memories of trauma. Children often have cognitive distortions or personal interpretations about what happened during an adverse event. When adults intervene, their language tends to influence the child’s description of what happened to them. Explaining that adverse events occur and providing adequate support allows children to process the event without blaming themselves. Eventually, often in adulthood, children are able to fully process the event and realize that they were powerless in changing the perpetrator’s behavior or environment.

**Recovery**

Recovery requires processing, so after an adverse event, children may withdraw to protect themselves and feel safe by sleeping more or crying often. They may also project anger toward playmates and pets. Following trauma, preschool-aged children may experience fear and separation anxiety when away from family members, leading to crying more frequently. Elementary school children typically express an anxious fear and may show feelings of guilt or shame with suicidal ideation, which is
There are a number of types of evidence that the forensic nurse will encounter in their daily practices. A high index of suspicion is necessary to observe a person, their behavior, and reactions to medical procedures to understand the complexity of forensic nursing. Once the forensic nurse is called to a patient’s bedside, everything is possible evidence and subject to careful handling and documentation. Table 11-1 identifies types of evidence.

<table>
<thead>
<tr>
<th>TYPE OF EVIDENCE</th>
<th>EXAMPLES</th>
<th>SAMPLING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trace Evidence</td>
<td>Trace items such as hair, fiber, debris, dried fluids, secretions, or other traces of chemical or inert elements</td>
<td>Uses tools and methods to identify, document location, and collect so the samples are preserved (eg, bindle folding)</td>
</tr>
<tr>
<td>Biological Evidence</td>
<td>Body fluids such as saliva, breast or vaginal fluids, ear wax, sweat</td>
<td>Uses tools and methods to capture samples for preservation (eg, cotton tipped applicator, where drying or freezing is preferred method for storage)</td>
</tr>
<tr>
<td>Technology Evidence</td>
<td>Electronic devices, photography, electronic records (eg, pornography)</td>
<td>Preservation of the technology; even if destroyed, oftentimes still in the “cloud”</td>
</tr>
<tr>
<td>Verbal Evidence</td>
<td>Anything said is verbal evidence. Documentation includes what patients say in quotes. Bias is a risk for the forensic nurse who is not objective.</td>
<td>HIPAA protects patient records, but not during an active criminal investigation. Other protections for records govern release.</td>
</tr>
</tbody>
</table>

**PROCUREMENT**

Taking any item into custody requires that the health care provider understands the preservation of samples weighed against the potential for blood-borne pathogens and hospital protocol. While not exclusive, adjustments may be necessary to take some evidence into custody. For instance, sharp items require safety in handling without disturbing the evidence on the sharp object. High value items, such as drugs or jewelry, require special handling and packaging to prevent theft.

**PRESERVATION**

Storage facilities in health care organizations often have a locked closet. To preserve evidence, the environment must be temperature-controlled and have an indexing system to help staff easily find objects in the closet. For instance, when someone checks evidence into the closet, the log identifies the person opening the door, the time the door opened, and the location of the item (ie, shelf number and numbered space). Every person who enters the closet must be documented. Temperature should also be recorded in the log. If the evidence is in a refrigerator, the same level of documentation is required, as demonstrated in Table 11-2-a and b.

<table>
<thead>
<tr>
<th>TYPE OF EVIDENCE</th>
<th>FROZEN</th>
<th>REFRIGERATED</th>
<th>TEMPERATURE CONTROLLED</th>
<th>ROOM TEMPERATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liquid Blood</td>
<td>Never</td>
<td>Best</td>
<td>Less than 24 hours</td>
<td></td>
</tr>
<tr>
<td>Urine</td>
<td>Best</td>
<td>Less than 24 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dry Biological Stained Item</td>
<td>Best</td>
<td>Acceptable</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(continued)
“crying,” “yelling,” or “wringing hands.” The nurse thoroughly describes injuries or the lack of injuries and normal anatomy. All evidence collected is documented, and some evidence, such as clothing, is described and photographed. Of particular interest are defects, such as missing buttons and tears.

Diagrams and body maps allow for a visual placement of injuries, so anyone reviewing the medical record sees the locations of any injuries or findings. Diagrams should include the size, shape, and color of the wounds next to the drawing (Figures 14-1-a and b). The objective written narrative provides the foundation for the diagrams. Photographs show the true and accurate representation of what the nurse observed during the examination.

The saying “if it wasn’t documented, then it wasn’t done” applies even more to forensic nursing than other situations. Therefore, comprehensive documentation in medical-forensic cases is necessary. The forensic nurse expects every case to have legal implications whether it is related to criminal activity, maltreatment, or a civil issue. Hospital departments such as risk management, patient safety, compliance, and accreditation often access forensic nursing documentation. Thorough documentation of an event, especially if the event occurred on hospital property, provides the basis for settlement negotiations or assists with reducing damages awarded during civil litigation. Poor documentation has the potential to negatively impact any case; therefore, the forensic nurse must take the time necessary to meticulously document all activities and findings in medical-forensic cases.

**Photographic Documentation**
Photography has been widely used in a variety of forensic practice areas including child maltreatment, nonfatal strangulation, sexual assault, physical abuse and neglect, interpersonal violence across the lifespan, and death investigation. Today, patients
Violence Across the Lifespan
the life course, as noted in Figure 16-1. Additionally, the frequency of the long-term effects of ACEs are chronicled in Figure 16-2.

The response to ACEs is multidisciplinary. Multidisciplinary teams (MDTs) include child protection agencies, prosecuting attorneys, forensic physicians, advanced forensic nurses with pediatric specialization, registered nurses, forensic interviewers, and advocates. Advocates guide families through the interpretations and explanations of the evidence generated by the MDT supporting a charge of child abuse or neglect. When there are biases, misinterpretations, or communication failures with families, the consequences are significant. Quality and safety in child abuse evaluation are essential to ensuring a program is free of bias. These processes ultimately protect children from further harm.

Forensic nurses consider many factors when working with children. In forensic nursing cases, parents are often fearful, exhibiting significant anxiety. Navigating stressful information related to the child is an important skill for the forensic nurse to master. Forensic nurses possess other skills including, using psychomotor dexterity when the child is uncooperative, evaluating genitalia, and adhering to precise protocols. After the child has a full evaluation, forensic nurses provide follow-up instructions that guide them to specialized referrals and/or consultation with the child’s primary care provider.

Pediatric forensic nurses work collaboratively with other disciplines participating in MDTs that meet regularly, and the members provide their vocational expertise during the case discussion, where the forensic nurse or physician comments on the medical issues involved with the cases. These teams often count on the advanced forensic nurse’s expertise, relying on them to provide a differential diagnosis that eliminates all other possible causes for the findings, which guides the pathway to prosecution. Registered nurses provide information related to their evaluation, documentation,
Violence against adolescents and adults occurs primarily in the home. There are 3 methods of violence—physical, psychological, and sexual. Anyone can become a victim of violence, and each developmental stage has different, predictable risks. Forensic nurses are frontline health care providers caring for patients who have experienced violence across the lifespan.

Types of Violence
A person may experience a single or multiple types of violence within a relationship, and it may not only be directed toward the primary victim but also to the people and animals loved by the victim. The violent behaviors are designed to control victims through ploys that use:

- Physical abuse, such as pushing or hitting
- Sexual abuse, including forcing a person to have sex or engage in sexual activity
- Emotional abuse, such as degrading, gaslighting, and influencing/controlling their behavior
- Intentionally damaging property
contrast, independent elder adults may be more likely to be victimized by individuals they know, such as a non-caregiver, unrelated friend or business partner. When a family member is the caregiver of an elderly individual, the stress and burden of caregiving are associated with abuse. Additionally, reports have been made of multiple incidents of abuse occurring together, such as physical abuse reported along with financial abuse or neglect.5

CASE STUDIES

Case Study 18-1

This 83-year-old female patient was residing in a long-term care facility with Medicaid as the payer of first resort. She was diagnosed with dementia, osteoarthritis, and depression. When another patient who had higher-paying private funding applied to the facility, she was placed in a van with her possessions, taken to a town miles away, and left in a back alley. She was picked up by several men who kept her in a building where other men would come and pay to have sex with her. The patient was found despondent, bleeding from her vagina and rectum, and suffering from wounds to her entire body that were in various stages of healing. She was taken by emergency medical services (EMS) to a trauma center where a forensic nurse examiner (FNE) was called in to assess her and complete a medical evidentiary examination. The patient was oriented to person only (ie, only able to identify herself and close relatives) but did reveal being “left somewhere, and they all hurt me. They just kept hurting me.” An evidentiary kit was completed, which included trace, biological, and photographic evidence. Thirty days later, the patient was discharged to a safe and competent long-term care facility. She died 6 months after admission.

Discussion

The patient’s original long-term care facility was fined, and arrests were made, including the administrator and the van driver. These individuals pled guilty to a lesser prison sentence. The patient was never able to identify the perpetrators who held her captive; therefore, no arrests of her offenders were made.

Case Study 18-2

This 72-year-old male patient had a history of addiction to alcohol and methamphetamine. He was also a type 1 diabetic and had a physical disability with limited use of his left lower extremity secondary to a train accident. He “burned his bridges” with friends and family during his younger adult life but became sober in his 60s. The patient’s cousin and her daughter permitted him to move in with them. One evening, the patient’s neighbors found him screaming for help as he dragged himself to their door. EMS was called, and he was taken to a nearby hospital where he was treated for his wounds and admitted. An FNE was consulted to interview and document his wounds. The forensic medical interview revealed several years of him being forced to sit on a bench, being repeatedly beaten and kicked, burned with

Figure 18-1. Patterned wound.
Photograph courtesy of Debra Holbrook.
Section

SPECIAL POPULATIONS
which participants were infected with syphilis and then denied health care services), as reasons to refuse participation in modern research.

**HEALTH DISPARITIES**

Health disparities exist in different populations’ morbidity and mortality from injury or illness, life expectancy, disease burden, ability to pay for health care, treatments, and access to care, as seen in [Table 21-1]. The Institute of Medicine, Unequal Treatment cited differences in health care and outcomes for minorities in the areas of:

— Asthma
— Cancer, including breast, lung, and colorectal
— Cardiovascular diseases, including myocardial infarction and heart attack
— HIV/AIDS
— Mental health
— Screening and preventive services

The COVID-19 pandemic revealed that many of these disparities continue. For example, early in the pandemic, it became apparent that African Americans were more likely to require hospitalization and to die from the disease. Another distressing example of health care disparities is the maternal mortality rate or the number of pregnancy-related deaths. The United States ranks 55th globally for maternal mortality, with Black non-Hispanic mothers twice as likely to die from pregnancy-related reasons. The life expectancy of African Americans remains lower than that of non-Hispanic Whites. Addressing health disparities within a community requires focusing on equity and social justice in research and health care delivery.

**SOCIAL DETERMINANTS OF HEALTH**

Social determinants of health (SDOH) are defined by the Centers for Disease Control and Prevention (CDC) as conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. Over the last 30 years, health care professionals discovered evidence that many factors beyond the efficacy of medical care impact health outcomes on individual and population levels. Nonmedical factors such as economic stability, education level, neighborhood, and social community context affect a person’s wellness. In addition, structural factors including national wealth, income inequality, and access to health and education create barriers that prevent certain groups from achieving health outcomes comparable to others.
The authors of this chapter are committed to using terminology that respects and honors the individuals to whom this chapter refers. Currently, there are over 570 federally recognized American Indian and Alaskan Native Indian tribes in the United States. While no single term is universally accepted by all Indigenous peoples in the United States, the terms “American Indian, Alaskan Native, Indigenous, and Native American,” are used for data reporting purposes only and appear in the form the terminology was originally published. It is not meant to minimize, exclude, or generalize the individuals involved, nor endorse one form of terminology over the other. Further, we are choosing the term “survivors” rather than “victims” to honor the strength and resiliency of the Indigenous people.

**Key Points**

1. The Native American/American Indian (NA/AI) population migrated to the American continent over 40 000 years ago. Approximately 500 years ago, European colonization led to disease exposure, death, cultural genocide, eugenic policies, and legislative divestment of treaties between sovereign nations, leading to historical trauma and the dilution of Native oral traditions and history.

2. The NA/AI population experiences higher rates of rape and disappearance among women, increased drug and alcohol abuse, and jurisdictional mazes between reservation, local, and federal authorities, resulting in high incarceration rates.

3. Today, NA/AI women and their children bear the burden of continued structural racism in federal and local legislation that, without stakeholder engagement, denies justice to the sovereign nations and Native peoples.

4. Forensic nurses have a responsibility to use trauma-informed care to create safe spaces for NA/AI patients.

**Introduction**

Indigenous history transcends millennia, and over 40 000 years ago, the people migrated freely over the lands. Established trade routes across Asia and the Americas existed for centuries and supported common tribal nations’ ethnobotany and therapeutic recipes that included certain teas, tinctures, poultices, salves, and balms, which contained ingredients unavailable in all tribal nations’ climates. In addition, the American Indian, Alaskan Native, Indigenous, and Native American cultures had dominant views of women as sacred and complete, able to transmogrify a spirit or soul into a physical state of being in a child. Women were contributors...
**Sexual and Gender Diversity in Patients**

Ecoee Rooney, DNP, RN, AFN-C, SANE-A, DF-AFN
Diana K. Faugno, MSN, RN, CPN, AFN-C, SANE-A, SANE-P, FAAFS, DF-IAFN, DF-AFN

**Key Points**

1. Trauma-informed care principles actively create safe environments for sexually and gender diverse (SGD) patients, with transparent processes that allow for the development of trustworthiness, peer support, and mutual self-help.

2. Health care providers must maintain unconditional positive regard for SGD patients and their health care needs by using trauma-informed principles to establish a positive healing environment.

3. Recognize that persons who identify as SGD who are victims of sexual violence or intimate partner violence (IPV) often hesitate to access survivor resources due to negative historical encounters with professionals, lack of services sensitive to their identities, and out of fear of revictimization due to heterocentric structures.

**Introduction**

Sexuality is a part of being human. *Sexual orientation* is an enduring emotional, romantic, sexual, or affectional attraction to another person. Sexual orientation can be a fluid concept, and people may use a variety of terms to describe their sexual orientation.1 Sexuality refers to the combination of one's biological sex, sexual orientation, sexual practices, and gender identity.2 Historically, the sexes were socially controlled through various institutions in efforts to “protect” individuals and society from the perils of sexual variety and expression. Religion characterizes some forms of sexuality as sinful, the legal system has criminalized certain sexual behaviors, and the medical community medicalized certain forms of sexual variety and expression, namely homosexuality,3 as a disease or an illness. However, social attitudes recently changed to encompass a wider range of sexual diversity. For example, the American Psychiatric Association removed the diagnosis of homosexuality as a mental disorder from its manual in 1973.1

Sexual identity politics exposed the social and political inequalities of a heterosexist society by focusing on equality rights for LGBTQIA+ individuals (ie, those that identify as lesbian, gay, bisexual, transgender, queer, or another gender or sexual identity). The civil rights movement for LGBTQIA+ rights experienced success over the past 70 years in mobilizing efforts to change discrimination on the basis of sexual orientation and gender diversity, deem sodomy laws unconstitutional, ensure domestic partner benefits, and obtain civil unions and same-sex marriage rights. Such political and social success, in part, is through the community-wide efforts of the LGBTQIA+ population, their allies, and organizations such as the American Civil Liberties Union and the Human Rights Campaign. In this chapter, the authors will refer to the LGBTQIA+ population by using the term *sexually and gender diverse (SGD)*.
Case Study 27-1

An adolescent girl presented to the emergency department (ED) for acute sexual assault by 2 men. She was accompanied by her mother and a family member and reported no prior consensual sexual activity. The forensic nurse provided medical and forensic health care and completed appropriate mandatory reporting. The patient was discharged home with her mother. While she did not disclose to the nurse what happened, she did disclose to law enforcement and Child Protective Services (CPS) that her mother was selling her, along with her adolescent and pre-pubertal siblings, for drugs. However, the investigators of the case stated it was “too fantastical to be believed,” and no further investigation was completed.

Two years later, this same patient returned to the ED after a police raid, during which she was found naked in a room full of adult males. She reported that she was forced to perform sexual acts on everyone in the room. She was accompanied by law enforcement to the hospital for a medical forensic examination and was immediately identified as a trafficking victim. Based on the recent findings, the forensic team became concerned and conducted an inquiry on prior forensic visits. Sadly, they realized she had been seen for sexual assault before. It was noted that a thorough initial investigation was not completed.

Discussion

In this situation, a thorough investigation would have alerted the forensic nurse, CPS, and law enforcement of the red flags of familial human trafficking. Familial trafficking does occur, and those who are victimized are often very young when the trafficking begins. If the nurse had been able to recognize the red flags of human trafficking during the patient’s first visit to the ED, they could have approached the patient with their concerns. Saying things like, “I just want you to know that you are in a safe place,” or “I am concerned about your safety. Is it okay if I ask a few questions about what brought you here today?” helps to establish a safe environment and begin that conversation.

Since victims of trafficking experience significant trauma, it is essential for health care providers to practice trauma-informed care. Trauma-informed care requires that health care providers focus on creating a safe environment for their patients. Once established, being...
EMERGENCY PREPAREDNESS: NATURAL AND MANMADE DISASTERS

Joyce P. Williams, DNP, MFSA, RN, FAAFS, DFI-IAFN, FAAN
David A. Williams, DDS, MS, MPH

KEY POINTS
1. An all-hazards approach in a disaster maximizes available resources to address the overall scope of emergency preparedness and planning.
2. The nurse’s primary role in emergency preparedness and the disaster cycle is to provide public health and medical services.
3. Individuals and families can exercise disaster preparedness by being informed, gathering knowledge of safety measures, and preparing survival materials.

INTRODUCTION
Disasters cause injury, death, and economic impact and bring about loss of life and varying levels of mass destruction. Today, disasters are commonly classified into 3 broad categories: natural, manmade, or hybrid. Natural disasters are catastrophic events caused by severe weather, global changes, or other nonhuman causes, while manmade disasters result directly from human actions. Hybrid disasters are caused by a combination of natural events and human actions. Categories of disasters and examples of each are shown in Table 30-1.

<table>
<thead>
<tr>
<th>NATURAL</th>
<th>MANMADE</th>
<th>HYBRID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hurricanes/tornadoes</td>
<td>Stampede</td>
<td>Technical</td>
</tr>
<tr>
<td>Earthquake</td>
<td>Transportation/mass transit</td>
<td>Environmental elements</td>
</tr>
<tr>
<td>Tsunami/flood/drought</td>
<td>Air disaster</td>
<td>Poor urban planning</td>
</tr>
<tr>
<td>Wildfires/bushfires</td>
<td>Pipeline incidents</td>
<td>Pandemics</td>
</tr>
<tr>
<td>Extreme heat/cold</td>
<td>Marine/riverine incidents</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Terrorism/mass shootings</td>
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</tbody>
</table>

DISASTER SURVEILLANCE
Changing climates are responsible for more than 9 percent of global deaths each year. Because there are so many variables whereby a disaster may occur, tracking in multiple venues is necessary. Infectious disease outbreaks from emerging viruses spread
SPECIAL CRIMES
TECHNOLOGY AND RISK

Elizabeth B. Dowdell, PhD, RN, AFN-C, FAAN
Patricia M. Speck, DNSc, CRNP, FNP-BC, AFN-C, DF-IAFN, FAAFS, DF-AFN, FAAN

KEY POINTS
1. Trauma is universal, widespread, harmful, and costly to individuals and society at large.
2. Technology is growing at an exponential rate, and there are new tools and language that increase risk-taking behavior with both unknown or known persons with or without criminal motives.
3. Technology is a useful tool for individuals with nefarious motives, thereby putting all individuals at risk for trauma, which causes negative mental health outcomes.
4. Forensic nurses should be familiar with digital natives, screening tools, and the terminology used to communicate with their patients regarding technology.

INTRODUCTION
Risk-taking by an individual is a pattern of unnecessary engagement in activities or behaviors that are dangerous or highly subject to chance. The risk-taking pattern of behavior is often associated with substance abuse, gambling, high-risk sexual behaviors, and extreme sports.\textsuperscript{1,2} Not surprisingly, risk-taking is now also happening in the online world.

The internet is a positive medium for innovation, education, and economic growth around the globe, and for Generation Z, the internet transformed their experience of growing up. Persons born into and raised in a digital world are often called digital natives as they grew up with digital technology (eg, computers, cell phones, etc.). People born before 1990 are not viewed as digital natives and instead are referred to as digital immigrants. Regardless of status or age, the internet has increasingly become a necessity. Children as young as 18 months old are now introduced to games and educational software through handheld mobile devices (eg, smartphones, tablets). All levels of education are actively using the internet in classrooms and homework assignments, as well as for communication, reports, and social networking. Recently, the COVID-19 pandemic closed many offices and workplaces, creating an era of remote work for millions of adults.\textsuperscript{3,4}

ONLINE RISK
Internet risk-taking has grown more common as mobile devices have become part of everyday life, and it frequently has offline consequences. This type of risk behavior is different than the more conventional health risk behaviors of smoking, alcohol use, unsafe sex, and substance abuse.\textsuperscript{2,3} Online risk-taking involves a variety of behaviors that tend to cluster together,\textsuperscript{2,5,6} and they occur on a variety of websites and social media (Table 31-1). Websites often encourage information sharing, and for children and adolescents especially, online risk involves disclosing a wide range of personal information on social media sites, including pictures, names, ages, and locations. Individuals who intend to commit crimes against children often visit these sites because
STALKING

Pamela Tabor, DNP, AFN-BC, DF-AFN, DF-IAFN

KEY POINTS
1. It is essential for forensic nurses to understand what constitutes stalking and recognize that stalking may be an independent crime or may co-occur with other criminal actions.
2. Anti-stalking laws exist at both the state and federal levels in the United States; each state and territory, as well as DC, has legislation in place.
3. There are tools to assist victims of stalking, such as the computer-based Stalking and Harassment Assessment and Risk Profile (SHARP).

INTRODUCTION
Stalking is an interpersonal crime that is underscored by a persistent and repeated pattern of unwanted pursuit and harassment. This is a malicious crime that threatens the victim’s sense of safety and/or actual safety. It is estimated that 6 to 7.5 million people are stalked annually in the United States. Stalking affects 1 in 6 women and 1 in 17 men at some point during their lifetime.¹

STALKING BEHAVIOR
There are numerous stalking behaviors, methods, and tactics that induce fear in victims. The widespread use of technology has made it easier for stalkers to act as a constant, invisible intruder and provides limitless opportunities for them to immerse themselves into their victim’s life. The 4 categories of stalking behavior are described below (Table 33-1).

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>DEFINITION</th>
<th>EXAMPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surveillance</td>
<td>Keeping tabs on the victim</td>
<td>Spying; using technology such as a GPS or malware; showing up uninvited; using a third party to harass and spy on victim</td>
</tr>
<tr>
<td>Life Invasion</td>
<td>Stalker continually inserts themselves into the victim’s life</td>
<td>Phone calls; texting; emailing; spreading damaging gossip; malicious complaints against the victim; sending cards/notes/letters; invading victim’s social media; sending unsolicited gifts</td>
</tr>
<tr>
<td>Intimidation</td>
<td>The act of inducing fear</td>
<td>Implicit, explicit, and/or third-party threats; forced confrontations; property damage; suicidal threats; threats of harm to victim, their family, or their pets</td>
</tr>
<tr>
<td>Interference</td>
<td>Disruption of the victim’s life personally, professionally, and/or socially</td>
<td>Initiating spurious legal actions; physical/sexual assault of victim; attacks against third parties; property damage</td>
</tr>
</tbody>
</table>
isolating their victims. They may weaponize drugs and alcohol against victims in 1 of 3 ways:

1. The patient voluntarily ingests a drug or alcohol; the incapacitating effects create an opportunity for a sexual assault crime to take place.

2. The patient involuntarily ingests a drug that the perpetrator provided.

3. The patient voluntarily ingests a drug believing that the drug is another. The perpetrator’s intent is to render the victim incapacitated by knowing the effects of the actual drug that they gave the victim. The defense is that the victim took the drug; the ploy is that the drug was not properly represented.

Other examples of drug-facilitated and alcohol-enabled crimes include driving under the influence, homicide, poisoning, occupational exposure, physical assault, drug-endangered children, and human trafficking.

The forensic nurse is aware of patient presentations following suspected drug-facilitated and alcohol-enabled crimes, often recommending or ordering toxicology testing for them. Forensic nurses obtain consent and conduct their examination using trauma-informed, person-centered techniques to assess the capacity of consent for testing. Suspicious symptoms often include loss of memory with or without unexplained injury, reported voluntary or involuntary ingestion of a substance, and signs and symptoms of impairment (Figure 34-1).

The forensic nurse is trained in procedures for management of evidence, including the processes of identification, collection, packaging, and storage, while maintaining

Figure 34-1. Signs, Symptoms, and Memory Related Symptoms of Impairment. Pederson S, Volz J, Quaile H, Speck P. 2021. Used with permission.
Introduction to Forensic Nursing

...avoid misinterpretation. It should focus on the precise details of the assault for the purposes of medical diagnosis and treatment, including considerations for bodily and anogenital injury; assessment for risk of pregnancy and STIs; evaluation of each specimen's evidentiary value; determination of any loss of consciousness or memory; and evaluation of the use of weapons, force, restraints, or threats. The history should be obtained in a sensitive and supportive manner, starting with open-ended questions. Any support persons at the bedside should refrain from interrupting or asking leading or suggestive questions.

PHYSICAL AND ANOGENITAL EXAMINATION WITH EVIDENCE COLLECTION

A thorough head-to-toe examination with a detailed anogenital examination should be performed on all patients with their consent. The clinician should carefully note from the history what body parts could be a potential source of DNA transfer so that these areas can be swabbed, in addition to where injuries may be located. The clinician should record injuries carefully using objective terminology and the patient's subjective symptoms. Supplemental photodocumentation is necessary to support written documentation.

On female patients (Figure 35-1), the detailed anogenital examination should begin with a gross visual inspection of the outer labia majora, followed by separation of the labia majora to evaluate the labia minora. Then labial traction is performed to visualize the vestibule, including the mucosal area within the labia, such as the clitoris and surrounding area, urethra and periurethral tissue, hymen, posterior fourchette, and fossa navicularis. Each structure should be assessed and photographed with a binocular microscope (ie, a colposcope) at varying magnifications. Once external genital evidence collection is complete, the clinician should proceed with inspection of the anus, perianal folds, and perineum. Evidence from this area should be collected before speculum insertion, as consideration must be given to the natural gravitational flow...
Victim Name _____________________   Date of Birth _________   Case # _____   Report # ________________

**LEFT EYE - OUTER EYELID/UPPER AND LOWER CONJUNCTIVA/SCLERA**

**RIGHT EYE - SCLERA/UPPER AND LOWER CONJUNCTIVA/OUTER LID**

**MOUTH - PALATE/TONGUE/FRENULUMS/INNER AND OUTER LIPS**

For forensic nurse examiner name/signature ____________________

*Figure 36-2. Sturgeon’s SAVEcD Tool - Strangulation Assessment for Victims with Evidence Collection and Documentation*

*Courtesy of Sally Sturgeon, DNP, RN, SANE-A, AFN-BC.*
CAMPUS SEXUAL ASSAULT
Josie Doss, PhD, RNC-OB, AFN-C, SANE-A
Shantee Henry, DNP, RN, SANE-A

KEY POINTS
1. Sexual violence is pervasive on college campuses but remains largely unreported.
2. Persons experiencing sexual assault on college campuses are at an increased risk for depression, anxiety, post traumatic stress disorder (PTSD), and unsuccessful academic endeavors due to the increased likelihood of continued interaction with the perpetrator.
3. Institutional reporting and disciplinary processes are required by the federal Title IX Educational Amendments of 1972 (Title IX).
4. The Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act (Clery Act) is a federal mandate that requires institutions of higher education to disclose information about crime on campuses.

INTRODUCTION
College students, primarily female students between the ages of 18 and 24, are at an increased risk for sexual violence both on and off campus.1 In 2019, the Association of American Universities report2 indicated that the overall rate of non-consensual sexual contact (ie, penetration, attempted penetration, sexual touching, or inability to consent) on college campuses is 13%. The report further indicates that rates for women (20.4%) and those who identify as transgender, nonbinary, gender questioning, lesbian, bisexual, or gay (20.3%) are 4 times higher than the rates for men (5.1%). The majority of these assaults are believed to occur during the first or second semester of college and the latter part of the calendar year2,3 and are often committed by individuals known to the survivor.1

Alcohol and drug use are factors contributing to sexual violence,4 with 75% to 80% of student victims reporting that they consumed alcohol prior to the event.2 Approximately 66% of these victims reported offender alcohol consumption prior to the event. For the 3.7% of women who reported non-consensual penetration, 11.8% suspected another substance was given to them without their knowledge prior to the incident.2

Campus sexual assault is widely under-reported.1 Approximately 1 in 5 female college student victims report their assault to law enforcement.1 Drug-facilitated sexual assault reporting is even lower. Survivors surveyed in the report provided a number of reasons for not reporting: they could “handle it themselves,” the incident was not serious enough to merit a report, embarrassment, lack of proof, confusion about what happened, uncertainty about what constitutes assault, fear of retaliation, lack of knowledge about how to report, and/or fear of how the criminal justice system would treat them.1,2 Despite college resource availability, only 29.5% of women and 17.8% of men who reported non-consensual penetration contacted a campus-based program or resource.2
**Forensic Nurses on a SWAT Team: Care Under Fire**

Deborah Pierce, RN, BSN, CEN, ATCN, TNCC, TECC, TPATC
Jeremy Ackerman, MD, PhD, FACEP

**Key Points**

1. The provision of medical support for a law enforcement Special Weapons and Tactics (SWAT) team requires specialized training so the forensic nurse is able to effectively meet the demands of “care under fire.”

2. The planning and preparation for each mission is essential for overcoming the challenges of caring for injured individuals during an active tactical situation.

3. Field care of an injured person with potential ongoing threats is unique due to limited resources and security concerns, unlike care rendered in a hospital.

**Introduction**

Providing medical support for a law enforcement SWAT team is a uniquely challenging and fulfilling role for a forensic nurse. The assessment, treatment, and transportation of acutely injured persons during tactical SWAT operations is frequently filled by nurses and other advanced health care providers who are trained to respond under fire. Nurses’ roles within a SWAT team vary from contractors to employees to volunteers. Forensic nurses work under the supervision of and in collaboration with a physician or medical director. Where there is independent, advanced nurse practice, other collaborators often consist of additional advanced practice providers, including physicians. Nurses working with SWAT teams may function in a health care provider role exclusively; may be deputized in a limited law enforcement role; or be fully trained and a duly sworn law enforcement officer. In contrast to hospital-based care, providing care in the field relies only on the equipment carried in, much like a medic in the military war theater. Due to the nature of tactical engagements in the United States, there is a heavy emphasis on management of penetrating trauma, primarily gunshot wounds. A forensic nurse in this role is primarily responsible for care of injured until traditional emergency medical services (EMS) is available on scene, which includes officers but also bystanders and suspects, as conditions permit. SWAT acts to preserve evidence, but the medical SWAT role focuses on preservation of life, and rarely involves evidence collection. Once the scene is secure, investigators, crime scene personnel, and patrol officers secure and lead management of the scene.

SWAT teams often have a paramedic who joins the team when they are called out on a mission. While less commonly used, a forensic nurse’s training and scope of practice enhances a team’s medical response capabilities, beyond the paramedic’s role. Caring for injured persons, often police officers, under tactical conditions is uniquely different from hospital or clinic care because the environments are hostile, unsecured, and inherently dangerous. Tactical training and careful planning are required to assure medical care is delivered safely. Specialized training is necessary.
ASSESSMENT

SINGLE BEST ANSWER MULTIPLE CHOICE

1. The document that influenced Forensic Nursing Core Competencies is:
   A. FNCB Core Competencies
   B. AACN Essentials
   C. ANA Nursing Code of Ethics
   D. IAFN Scope and Standards of Practice

2. The following is NOT a key element in forensic nurse core concepts:
   A. Knowledge attainment
   B. Technology management
   C. Lifelong learning
   D. Independence

3. The concepts defining relationships in nursing are:
   A. Nurse, crime, victim, and legal system
   B. Nurse, patient, environment, and health
   C. Patient, perpetrator, and legal system
   D. Patient, nurse, crime, and health

4. When stressed, a person can expect:
   A. Pupil dilation
   B. Reduced heart rate
   C. Reduced digestion
   D. Increased micturition

5. A key component of compassion fatigue is the stress resulting from:
   A. High workload every shift with COVID-19
   B. Adequate Staffing for the shift
   C. Minimal overtime
   D. Working with patients who have experienced traumatic events
46. Gang classification generally includes:
   A. Ten or more members and linkage to a name that is not recognized by anyone else to keep their gang identity private.
   B. Independent identity and public recognition by others that they are a criminal gang.
   C. Three or more members, shared identity, and the purpose is to engage in criminal activity.
   D. Maintaining an anonymous identity to engage in criminal activity without getting caught.

47. Identify the 3 violent gang types:
   A. Organized Criminal Gangs, Street Gangs, International Gangs
   B. Organized Criminal Gangs, Prison Gangs, Foreign-born Gangs
   C. Motorcycle Gangs, Prison Gangs, Street Gangs
   D. Motorcycle Gangs, Organized Criminal Gangs, Prison Gangs

48. Inmates who are at highest risk for victimization in prison settings include:
   A. Inmates who are guilty of violent offenses
   B. Inmates who have lower levels of education
   C. Members of gangs
   D. Inmates with chronic illnesses, substance abuse disorders, mental illness and the elderly

**MULTIPLE CORRECT ANSWER MULTIPLE CHOICE**

1. Factors that can directly impact family dynamics and risk for violence include:
   A. Financial and/or housing instability
   B. Substance use disorders
   C. Education level
   D. Adverse childhood experiences

2. Which are components of a nursing forensic examination?
   A. Focused assessment
   B. Review of system interview.
   C. Photography and body diagrams
   D. Detailed injury assessment
   E. Collection of forensic evidence

3. Which ways can the forensic nurse help a someone who has experienced dating violence?
   A. Obtain a medical and forensic history using trauma-informed principles
   B. Provide a detailed head-to-toe assessment to determine the extent of injuries
   C. Identify and collect potential evidence that is on the body and clothing