Scattered, Smothered, and Covered:

Improving the local response to sexual violence

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On behalf of The Mayor's Council For Women - Justice Committee

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A white paper addressing gaps in the Chattanooga-Hamilton County collaborative response to sexual assault, and the disposition of sexual assault evidence in unreported cases. The Justice Committee recommends a Sexual Assault Kit Tracking System, a centralized forensic nurse program, and an increase in the length of time evidence is held in unreported sexual assault cases.

I. Introduction

The Justice Committee chose to address the collaborative city and county response to sexual violence[1] as this issue has far-reaching effects into the lives of too many citizens. This decision mirrors current trends across the nation of increased awareness and the resulting demand for a higher standard of care for those impacted.

II. Workgroup Structure and Associated Work

In preparation for the composition of this report, the Sexual Violence Response workgroup completed a review of literature of existing standards and best practices (both statewide and national) and factors influencing delayed reporting of sexual violence. The workgroup researched the neurobiology of trauma and Rape Trauma Syndrome (RTS). We also reviewed the responses, protocols/policies and current legislation of neighboring states to sexual violence, including: Alabama, Georgia, Kentucky, North Carolina, Mississippi and Virginia. Surveys of several communities utilizing Sexual Assault Kit Tracking were conducted, including: Memphis, Tennessee, Wayne County in Michigan, Idaho state, and North Carolina state. Interviews were conducted with off-record law enforcement, forensic examiners, emergency physicians and nurses to better understand the current approach. Data was reviewed and included from the Tennessee Incident-Based Reporting System (TIBRS), local law enforcement, and local health systems.

III. Issues Addressed

1. Local city/county response to sexual violence
    a. Identification of existing gaps in trauma-informed response
        i. Lack of cohesive process
        ii. Fragmented medical response
        iii. Under-utilization of Sexual Assault Response Team (SART)
2. Disposition of evidence in cases of unreported sexual assault
    a. Identification of existing limitations
        i. Delays in reporting or nondisclosure secondary to neurobiological response to trauma and victim disengagement
        ii. Utilization of Statute of Limitations for guidelines
        iii. Lack of cohesive practices across city/county

[1] This paper utilizes the terms “sexual assault” and “sexual violence” interchangeably, as both connote any type of sexual contact or behavior that occurs without the explicit consent of the recipient. Both terms should be understood as umbrella terms that include sexual activities such as rape, attempted rape, fondling, etc.

IV. Discussion

While the overall national response to sexual violence is resulting in the evolution of a rising standard of care, Chattanooga and Hamilton County's own collaborative approach remains outdated and fragmented.

Further, while many victims delay reporting sexual violence, this propensity is all the more so common for minor victims under the age of eighteen. Our review of literature identified that some minor victims delay reporting, not disclosing their assault or abuse, in many cases until years later. Should these survivors later opt to move through a judicial process from a place of healing, they should be able to do so, relying upon the existence and integrity of any collected evidence. However, the current guidelines for storing and subsequently destroying evidence in unreported cases may create yet another barrier for victims who are not given sufficient time to process the trauma following an assault. Too many victims may find themselves slipping through the cracks of both the medical and legal systems in our city and the surrounding areas.

As one of the three major cities in the state of Tennessee, Chattanooga (and Hamilton County) stands poised to serve as a model of exemplary care for all victims of sexual assault.

Lack of Cohesive Process

"A coordinated and collaborative approach to sexual assault provides reassurance and support to the victims of sexual violence, improves victim engagement to facilitate healing, and increases the potential for the just resolution of these cases," the US Department of Justice notes in the National Best Practices Handbook (2017). The City of Chattanooga and Hamilton County have shared a collaborative response to sexual violence since 1994, when the two entities first drew together and opted to rely on the services of a single organization for sexual assault services for adults and adolescents thirteen years of age and older. These services include medical-forensic examinations (MFE) and advocacy. With adequate staffing, the advocacy portion of the program is operated by two case worker-advocates who reach out to victims in the days and weeks following their assault. There is also a program manager, who may or may not carry a caseload. These three staff members offer community referrals, court accompaniment, legal advocacy, and can accompany a victim during the MFE if requested. On occasion, there are also volunteer-capacity advocates (of varying professional backgrounds) who are briefly trained to answer hotline calls and serve as advocates for nightshift and weekend coverage.

Unfortunately, the reliance upon a single organization means that organizational issues have impacted the overall collaborative effort: staff attrition, poor quality assurance control/lack of performance improvement measures for medical staff, advocates and hotline responders, lack of staff training, delays of evidence collection, dissemination of misinformation, lack of training for community partners, lack of public outreach, delays in medical care, poor relationships with law enforcement and other community partners, lack of adherence to basic confidentiality and current Health Insurance Portability and Accountability Act (HIPAA) standards, lack of security (for staff, patients, medical records, and evidence), lack of physical accessibility to clinic/advocacy spaces by those covered by the Americans with Disabilities Act, and insensitivity to community needs are some of the many issues besieging the local response to sexual violence.

Individual efforts to enhance the response to sexual violence, or those efforts promoted by outside community partners/organizations have been abandoned, likely secondary to "siloing."[2] Historically, community partners such as nonprofit organizations, health professionals, criminal justice agencies and law enforcement agencies all work in silos.[3] Each community partner identifies an issue and feels that it is either their responsibility alone to solve the issue or that it is incumbent upon someone else to solve the problem, without any grey area or overlap (Bevc, Retrum & Varda, 2015). This approach greatly limits the ability to fully address or resolve the issue in question. The Chattanooga-area is not immune to this "silo effect" in our response to sexual violence. This infrastructure has resisted any major systemic changes

[2] Pace, M., & Fite, E. (2019, October 15). Erlanger halts effort to expand rape crisis services; project quashed due to pushback amid CEO's ouster. *Chattanooga Times Free Press*. Retrieved from https://www.timesfreepress.com/news/local/story/2019/oct/15/erlanger-halts-effort-expand-rape-crisservice/505857/

[3] The "silo effect" has been described as "preferential partnering" and a tendency to shy away from collaboration across boundaries (Bevc, et al, 2015).

including many national evidence-based practice standards or national best practice guidelines, which has resulted in the current outdated response.

A nebulous but often-voiced concern of "duplicating services" has superseded the duty of the City/County to increase access to vital care and services. "Duplication of services" is not a concern for competing hospital systems, banks, cellphone companies, etc. Rather, when one organization holds a monopoly over a particular commodity or service as the only available option, they are no longer held to an industry standard. While "duplication of services" was a term found in several scholarly research articles as something to be avoided, nowhere was an explanation found as to why. More importantly, no research was found that demonstrated any correlation between an under-utilization of services and an increased number of service options available. The resistance to increasing the access to services following sexual assault in Chattanooga and Hamilton County appears to stem from a theory that sexual assault victims will choose no services at all if they are given more than one option; this is not supported by any research the Justice Committee workgroup could locate.

Fragmented Medical Response

Again, for Hamilton and Marion counties, the medical-forensic response to sexual violence for adults and adolescents thirteen years of age and older is provided almost entirely by a single non-medical nonprofit organization. The nonprofit contracts Sexual Assault Nurse Examiners (SANEs), also called Forensic Nurse Examiners (FNE) or Forensic Examiners (FE) under the direction of nurse coordinators and a physician medical director. These SANEs are registered nurses (RNs) of varying backgrounds and experience levels, some having only just graduated nursing school by a few months upon obtaining a contract to provide forensic examinations. All must complete a training course offered by the International Association of Forensic Nurses (IAFN), after which they are distinguished as "SANE-trained". However, only one or two SANEs currently contracted have attempted or achieved board certification, or are eligible[4] to apply for that certification. SANEs who achieve board certification for victims thirteen years of age and older are designated SANE-A, for Adults and Adolescents. (Those achieving board certification for specialization in pediatric examinations are designated SANE-P.) At the time of authorship of this report, there are fewer than thirty certified SANE-A nurses in the entire state of Tennessee (Schorn & Vanhook, 2019). In the Chattanooga region, there are currently only two certified SANEs. Additionally, the IAFN strongly recommends that only RNs with two years or greater experience be considered for SANE training (IAFN, n.d.).

While nationally recognized as an issue, recruitment, retention and training of SANEs is historically difficult locally, particularly in the more rural areas of Hamilton and Marion counties. Local clinic volume is relatively low, hampering consistent training of prospective

[4] Eligibility criteria are determined by the IAFN Commission for Forensic Nursing Certification and include: a RN with minimum two years' experience, completion of an IAFN-approved training course with a minimum of 40 didactic hours from a credentialed provider, completion of an approved clinical preceptorship, accrual of a minimum of 300 hours clinical practice (including preceptorship/teaching, consulting, peer review and medical forensic examinations), submission of an application with references, and payment of the testing fee (IAFN, n.d.).

SANEs. Local procedures require SANEs to shadow two examinations, and then perform a third exam under mentorship from a more experienced SANE before performing examinations independently. Unfortunately, there are typically month-long gaps between these examinations, resulting in poor recall of learned and demonstrated techniques. Speculum training is inconsistent. Frequently, a new SANE will shadow only one examination before performing a second examination under observation, will then be deemed “proficient”. In other instances, a SANE may shadow one examination and perform a “mock case” with a coordinator before being deemed “proficient.” To be clear, this may mean that there are occasions when a new graduate nurse has been deemed “proficient” without ever having been observed in an actual sexual assault case with a patient in crisis.

Nurse burnout and attrition are high for these contracted nursing positions. Staffing in the current response is optimal at fifteen nurses, but typically fluctuates between eight and eleven nurses at any given time. In the last six years, SANE staffing has neither reached nor maintained optimal staffing, and recruitment efforts are minimal. Although a few SANEs may attempt to cover scheduling vacancies, more frequently, whole shifts are left unstaffed. This means that a patient may be asked to wait for hours until the next staffed shift, compromising evidence and resulting in a severely decreased trauma-informed response to these vulnerable victims. The National Best Practices for Sexual Assault Kits (2017), the Scientific Working Group on DNA Analysis Methods recommendations (2016), and the Tennessee Bureau of Investigation’s own Evidence Guide (2015) all convey the absolute imperative of collecting evidence as soon as possible following sexual assault. Unpreserved forensic DNA evidence deteriorates rapidly with time, and is easily lost and/or contaminated during unsecured transit from one location to another.

Medical charts are peer-reviewed. However, the current system lacks consistency in these evaluations and thwarts real follow-up for deficiencies. Adverse to national standards and best practice guidelines, local SANEs are permitted to alter documentation at later dates/times, often without a clarification or late entry note. Current practices are not HIPAA-compliant nor do they allow for the secure transfer of information to law enforcement officers and attorneys where necessary, as advised by the National Best Practices for SAKs (2017). There is no local policy in place detailing the length of time medical-forensic records must be stored, and no written policy or procedure detailing the release of records to requesting entities.

Under current local procedures, a victim may call the established crisis hotline, where they are to be advised by a staff member or volunteer that if he/she were assaulted within the last five days, he/she may proceed to the clinic for a Medical-Forensic Examination (MFE).[5] Unfortunately, there is no provision of consistent training to staff members and volunteers who answer these hotline calls. Staff proficiency in crisis counseling and understanding of the medical-forensic process goes unevaluated. None of the persons answering the crisis hotline

[5] A health professional, law enforcement officer, or other community partner may also call on behalf of a patient/victim.

have medical-forensic training, nor do they read from a pre-scripted set of responses. The five day window for a MFE is at the discretion of the SANE, but the non-medical staff taking these hotline calls may "screen out" victims without contacting the SANE. These factors lead to frequent miscommunications and dissemination of inaccurate information to victims, support persons, law enforcement, community partners and hospital systems. Further, these issues delay acute medical care, timely collection of evidence, and cohesive patient-centered trauma response. As previously noted, several state and national best practice recommendations detail the importance of rapid assessment of patients for best preservation of evidence and medical evaluation as part of a trauma-informed response.

A victim may also be seen by a SANE in the hospital setting. If a victim presents to any hospital facility with a chief complaint/diagnosis of sexual assault, the hospital staff should offer to call the crisis hotline, though the patient may decline evidence collection or evaluation by a forensic provider. Anecdotally, local hospital staff training on the immediate frontline response to sexual violence is hit or miss, and often the initial call to the hotline is delayed by an hour or more. (At the time of this paper, there is no available data to examine how frequently local medical staff is accessing the established hotline as a resource for patients presenting with a chief complaint of sexual violence.) Far too many times during a period of attempting to locate an advocate or SANE in the Chattanooga area that can meet the victim, he/she has grown tired of waiting and left either the clinic or the hospital, rarely returning.

On condition of anonymity, several physicians spoke with a member of the Justice Committee's sexual violence response workgroup. One local emergency department physician noted in frustration, "Over the last ten years, I've probably called [the hotline]…fifty times, and I've never gotten anyone here. Do I have to keep doing these exams myself?" Several providers have noted that they perform the forensic-medical examinations within the emergency department setting because of historic difficulties accessing medical-forensic services within the current established approach. Another physician stated, "Yeah, I'll do the swabs, but there aren't pictures. I guess the police do that. But it's better than telling them [victims] they have to wait, or not getting those swabs at all."

A major recurring issue within the current response in the Chattanooga area lies in the transfer between locations if a victim goes to the hospital first. Whether they are receiving extensive testing or being admitted to the hospital, if they also want a medical-forensic exam, they must then wait for the SANE and advocate to arrive. Assuming there is a SANE on-call, current policy allows a nurse one hour to present to the patient's location for the exam. However, an advocate on-call does not have the same time stricture in place. If no SANE is on-call, the patient is left waiting – typically in an overcrowded emergency department - until the next staffed SANE comes on shift. If the patient is being discharged from the hospital, he/she will be directed to the nonprofit clinic. Little public data exists that examines the relationship between the number of patients presenting to the local hospitals requesting forensic services, and those

that present but are then directed to a separate location (with or without presenting to the second location for services).

Jennifer Pierce-Weeks, CEO of the International Association of Forensic Nurses (IAFN) stated in an October 2019 Chattanooga Times Free Press article, "If a victim has to go from point A, in this case the emergency department, to point B, whether it's evidence collection or something else, oftentimes, they don't make it there. And they don't make it there because they expected to receive their care at point A, and they just had to say out loud to God knows how many people, 'I was sexually assaulted' " (Pace, 2019).

Even locally, the meager data available supports Pierce-Weeks' statement. In 2018, a local hospital system reported 330 patients presenting with a chief complaint of sexual violence. In the same year, the local nonprofit crisis center performed only 127 examinations by comparison. The converse is also true; if a victim presents to the nonprofit organization, but needs medical triage, the MFE is deferred and he/she is advised to go to the emergency department for immediate medical care first. The victim will seldom return to complete the MFE.

In Nashville, the sexual violence response is based within the Nashville General Hospital, which acts as an umbrella under which the SANE program is shared and accessible to the local sexual assault center. Victims may choose whether they want to go to a hospital or the sexual assault center. This allows a more cohesive medical response, eases the process for victims, and addresses the SANE attrition issue by being in proximity to a wider pool of nurses. Potentially housing the entire process at one site allows more victims to report and seek immediate treatment, improving trauma-informed responses, evidence integrity and overall victim outcome. Speaking with the SANE program director in September, she noted that the program is expanding to be able to offer MFEs at each hospital in the Nashville area, to better serve any patient that may request an exam. SANE nurses and forensic providers will be available in each emergency department in the Nashville area. She also expressed her surprise that "…a city of Chattanooga's size has waited so long to improve the system-wide response [to sexual violence]."

"Research supports incorporating evidence collection with the medical exam and treatment at one time in one location leads to better health outcomes and more successful prosecutions, but medical providers often are ill-prepared when rape victims show up," Pierce-Weeks noted in the Free Press article. "The evidence collection portion of that evaluation is really built into the entire exam and treatment of the person - it's not two separate things," she said, "which is why most of the time across the country, the emergency room is where the exam happens for adults," (Pace, 2019).

New legislation introduced to Congress in early 2019 seeks to ensure that victims do not need to shuttle from one place to another for comprehensive medical-forensic care following sexual assault. The Survivors Access to Supportive Care Act (SASCA), or S.402, seeks to

increase access to care. It specifies that emergency departments should have trained medical providers ready to perform a medical-forensic examination at the time the patient presents at that location, not hours later.

Currently, the sole organization providing sexual assault services to adults and adolescents is limited by certain grant funding to serving those within Hamilton and Marion counties. However, according to a 2019 Hamilton County health report, Hamilton County serves as the center for health care in the East Tennessee region. Of the 73,266 admissions to the seven general medical and surgical hospitals of (Hamilton County) in 2016, 58% were residents of counties other than Hamilton (Chattanooga-Hamilton County Health Department, 2019).[6]

Under-utilization of the Sexual Assault Response Team

The Hamilton County SART is another opportunity for effective growth to better serve victims of sexual violence in the area. A sexual assault response team (SART) is a multi-disciplinary group of professionals[7] and survivors that work collaboratively within a jurisdiction. The focus of this team is to examine the practices and procedures surrounding the treatment of sexual assault victims, the handling of evidence and the investigation/prosecution of sexual assault offenders. The overall goal of an organized SART is to break down those "silos" that prohibit an effective and holistic team approach to improving the response to sexual assault. Greeson and Campbell (2012) noted that poor and/or nonexistent relationships among legal, medical, and mental health systems compound community sexual assault response issues. As a result of these fragmented responses, the overall response to rape is uncoordinated, and the systems respond to survivors in isolation from one another, placing the burden of reaching out to each system squarely on the survivor (Greeson, 2012).

In order for the Chattanooga-Hamilton County local SART to provide effective, timely, and collaborative responses, improvements must be made. Several law enforcement officers, community partners and former sexual violence response employees have described the monthly SART meetings as "ineffective," "useless," "disorganized" and "a waste of time." Under current practice, the SART attempts to review every reported sexual assault case from the preceding month, resulting in a cumbersome docket of case review.[8] While there are currently no established national best standards for SART, the Tennessee Best Practice Guidelines (2014) recommend at least quarterly meetings with a case review of four to five cases per year.[9] The National Sexual Violence Resource Center (NSVRC) SART Toolkit (2018) also notes, "Meeting more often than necessary can lead to members losing enthusiasm and skipping meetings because meetings are not seen as a good use of limited time."

[6] Patients who lived outside of Hamilton County resided in other Tennessee Counties (25%), in Georgia (25%), in Alabama (3%), and in other states (2%).
[7] These professionals can include medical providers, emergency responders, law enforcement officers, forensic technicians and scientists, district attorney's representatives and advocates.
[8] An unencrypted email, complete with a docket of patient names, dates of assault, and case statuses has historically been emailed to SART committee members. These emails were discontinued in 2018.

Over the last three years SART leadership changed no less than six times, as organizational management has also fluctuated. The continual turnover has resulted in an inability to build meaningful relationships with local law enforcement and District Attorney's office staff. Law enforcement officers, DA's office representatives, and other community partners who were attending SART meetings faithfully have become increasingly disengaged. This organizational attrition has also made it challenging to offer consistent trainings for law enforcement and other community partners, further resulting in an overall decreased effective community response to sexual violence.

Additionally, while both the NSVRC SART Toolkit (2018) and the Tennessee Best Practice Guidelines (2014) encourage the inclusion of survivors of sexual violence as participatory members of SART, the local SART has lacked such valuable input. The National Best Practices for Sexual Assault Kits notes that a trauma-informed multidisciplinary approach should also seek out and include voices from underserved or vulnerable populations in the community's response to sexual assault cases (US Department of Justice, 2017), though this is not current practice with the Chattanooga-Hamilton County SART.

Recommendations:

I. **Reorganization of Sexual Assault Response Team efforts to include additional counties and victims/survivors.**
   a. For maximum rejuvenation of SART efforts, SART should be re-homed under a centralized program based in the Family Justice Center (FJC), thereby increasing access to SART by other community partners already located within the FJC.
   b. Efforts should be made to re-engage law enforcement officers from all local jurisdictions and surrounding counties.
   c. Prosecution representatives, hospital system officials/medical providers, and local college representatives should be engaged and included.

II. **Reaffirm close collaboration with local community partners** including Hamilton County, Partnership Rape Crisis Center (PRCC), area hospitals, local colleges/ universities and the FJC.

III. **Utilization of Victim Link/Seek Then Speak** to collate all local options for victim/survivors and providers in one place for ease of access to services.

IV. **SANE program moved under comprehensive medical oversight, (such as the Health Department) and made city-wide.**
   a. One centralized program would serve all local hospitals, FJC, and PRCC.
   b. Providers in each outlying local emergency department should be trained to offer exams.
   c. Telenursing consultation could be developed and made available for untrained providers offering examinations.

V. **City/County representatives requested to support and endorse SASCA (S.402)[10]** legislation to increase victim access to medical care following sexual violence.

VI. **Utilization of the Family Justice Center (FJC) exam spaces and resources** in collaboration with community partners (including hospital systems) to increase access to needed services for victims following sexual assault, and enhance current procedures.
   a. The FJC would ensure a true "one stop shop" for all victims, including children, as the FJC already houses the Children's Advocacy Center.
   b. The FJC already has two dedicated examination rooms, is on the bus-line, is fully secured and private, and has access to law enforcement officers if victims desire reporting.

[10] SASCA (S.402) 2019 – The Survivors' Access to Supportive Care Act is a bill introduced to the 2019 Senate that seeks to plan, develop, and make recommendations to increase access to sexual assault examinations for survivors by holding hospitals accountable and supporting the providers that serve them.

Disposition of Evidence

Any effort to address the necessary reform of the collaborative response to sexual assault in our community would be incomplete without a conversation on the disposition of sexual assault evidence in unreported cases.

When a victim of sexual assault presents for a medical-forensic examination (MFE), he/she may choose to report the assault to police (and/or Title IX representatives if a student), or may opt not to report at all. In cases where the patient declines reporting, the medical professional may be required to report certain mandated reporting triggers, but the patient may also opt not to speak with law enforcement at all.

Declining to report does not preclude a willing victim from receiving a MFE.[11] In Tennessee, these unreported sexual assault kits (SAKs) are not sent for testing, but are instead stored at the jurisdiction where the assault occurred. These SAKs are classified with a unique numeric identifier and are anonymous except for that identifier. In 2016, state legislation required law enforcement to adhere to policies on the handling of unreported SAKs, including notifying victims of the identifier under which their evidence would be stored, and the length of time the SAK would be stored (three years) before it was subject to destruction. Chattanooga Police Department (CPD) formally acknowledged its adoption of the Tennessee Model Law Enforcement Policy on Sexually Oriented Crimes, and pledged to hold these anonymous kits for a period of three years, after which, the evidence would be subject to destruction.[12]

But this destruction of evidence proves problematic on multiple levels: in cases of delayed reports, delays/miscommunications in processing sexual assault kits, Combined DNA Index System (CoDIS) hits, reopening of cold cases and availability of evidence for appeals processes.

Destroying a SAK with an open statute of limitations (SOL) is problematic if a victim later decides to report after initially declining (but having a medical-forensic exam completed), or if new evidence comes to light, either of which scenario may make prosecution possible. Retaining evidence for an extended period of time can also help with other cases by identifying assailants with CODIS hits, and/or linking them to additional crimes.[13] Only a statute of limitations, and not the destruction of evidence, should constrain a victim's choice to pursue a judicial process.

The 2017 National Best Practices for Sexual Assault Kits states, "Policies for medical-forensic record retention should be created in accordance with statutes of limitations and other

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[11] Sample collection should be an option for all sexual assault victims who present for a medical-forensic exam, including those who choose not to report (unreported) or report anonymously (National Best Practices for Sexual Assault Kits, 2017). *Tenn. Code Ann. § 39-13-519.*

[12] Should a patient later decide to report within that three year timeframe, their evidence will be declassified and sent for testing at the Tennessee Bureau of Investigation crime lab.

[13] In the Golden State Killer case from the 1970s and 1980s, DNA evidence preserved beyond the SOL was tested with new technology and yielded a match to a serial murderer who was linked to other offenses including rape, robbery and burglary.

criminal justice needs rather than with traditional parameters for medical record keeping, storage, retention, and destruction."

There are many reasons that a victim of sexual assault may delay reporting or opt not to report at all. The Tennessee Best Practice Guidelines (2014)[14] notes that disclosure of sexual assault is not typically a one-time event, but rather a process. Those same guidelines further note that a more individualized process of disclosure is preferable, wherein a victim may take time to heal and evaluate his/her resources, before reporting or being encouraged to do so.

While neighboring states Arkansas, Georgia, Kentucky, Mississippi, Missouri, North Carolina, and Virginia have all responded to the demand for greater accountability and access to services following sexual violence, the greater Chattanooga Metropolitan area remains stagnant. Many of the above states have implemented or are developing a statewide sexual assault kit tracking system, and have lengthened or removed altogether the statute of limitations for sexually violent crimes, particularly those against minors and children.

Locally, the average age of victims opting for a MFE in conjunction with a report to police varies widely. According to the state database Tennessee Crime Insight, in 2018 there were 255 reported cases of non-consensual sexual offenses (wherein an offense was classified as rape, sodomy, sexual assault with an object, or fondling), an overall increase of almost 29%. Of these 255 reported cases, 139 cases involved a child or minor victim less than eighteen years of age. Many of these minor victims will often not disclose sexual assault at all, and if they do, it will often be years later (Townsend, 2016).

The complex cascade of physical and psychological symptoms and reactions following sexual assault from the first moments after the event and manifesting even years later has been termed Rape Trauma Syndrome, or RTS. Some clinicians dub RTS as a form of post-traumatic stress disorder (PTSD), and a large contributor to the understanding of why victims/survivors often opt not to report. During a sexual assault, the brain detects a threat to survival, and stimulates production of several hormones that affect the way memories are encoded. Memory recall of the assault is typically fragmented and impaired due to this rapid "dump" of biochemicals.

Explaining why so many victims/survivors delay reporting of sexual violence, psychotherapist and cultural anthropologist Mike Lew notes in "Victims No Longer" (2004) that victims/survivors need time and distance to "regain…equilibrium and gain enough perspective to begin recovery work following sexual violence." According to the National Child Traumatic Stress Network (2018) victims may also delay reporting or forego reporting altogether due to feelings of shame, embarrassment, guilt, denial and minimization of the assault, fear of bodily threats, consequences for self and/or perpetrator, fear of not being believed, low self-esteem,

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[14] The *Tennessee Best Practice Guidelines For Sexual Assault Response Services (Adult Victims)* of 2014 was based on the *Minnesota Model Policies for Forensic Compliance*, April 2011.

feelings of helplessness and hopelessness, and an overall lack of education and support following sexual violence. In his book, Lew writes to male survivors, explaining some of the common reasons for delaying reporting or choosing not to report:

> "*There was too much else going on. When you are dealing with daily crises and a basic struggle for survival, there are few resources and little energy left for anything else. You had to get your life under better control in the present before tackling the past. You were afraid. Although the abusive situation is over, it can still FEEL dangerous. Even a dead perpetrator's presence can be felt strongly. You were feeling too weak, battered, and hopeless to take action for yourself. Or you felt like such a terrible person that you didn't feel deserving of anything better. The time and place weren't right. Not everyone is ready to hear about abuse. You were right to wait until you found a safe and supportive environment for recovery. You didn't know you had options."(Lew, 2004)*

With the current policies of evidence retention and subsequent destruction in Tennessee, by the time a minor is ready to disclose a sexual assault, any evidence they may have had collected will most likely have been destroyed (Townsend, 2016).

Recommendations

I. **Implementation of a Sexual Assault Kit Tracking System**

a. Offers peace of mind and control to victims.
b. Provides transparency and accountability for law enforcement and state crime lab(s);
c. Streamlines law enforcement workflows by reducing contact between officers and victims for questions of evidence turnaround times, and ensuring no items of evidence are forgotten as in the current practice;
d. Adopting the same system already in place in Memphis provides a more cohesive response at the state level, and may encourage similar participation by other cities in Tennessee. Would enhance public safety by linking cases within and across jurisdictions (such as identifying serial offenders);
e. Aids in establishing trust between the community and law enforcement and a vote of confidence in the criminal justice system process for victims;
f. *There is currently no willing community partner in place with the existing infrastructure to support the kit tracking system and training efforts.*

II. **Formulation of a working group** to spearhead the SAK Tracking System initiatives and training endeavors, SANE program oversight, and serve as lobbying/legislative point of contact.

III. **Unreported evidence should be held longer**: either for the duration of the statute of limitations for each case; until the final disposition of any court case; or at least twenty (20) years, whichever is greater.

IV. **Reinstitute annual in-depth training for Special Victims Unit Investigators and patrol officers** regarding responding to SA victims.

a. Training is necessary for all personnel who have contact with victims of sexually oriented crimes, including dispatch/communications and initial responders, as well as those who investigate these crimes;
b. Ensure a sustainability plan for ongoing training;
c. Responders at every level need to recognize their accountability to the victim (TN Model LE policy) All officers should receive ongoing training that specifically addresses the realities, dynamics and investigations of these crimes, and legal developments pertaining to sexually oriented crimes;

V. **Collaborate with identified contacts for Sexual Assault Kit Tracking System initiatives**, including ISP Forensic Crime Lab director (Matt Gamette), North Carolina STIMS Administrator/Forensic Agent (Suzi Barker) and Memphis SAMS (J. Cameron Dunaway) contacts.

Conclusions

In conclusion, the landscape of trauma-informed sexual violence response has changed greatly since 1994. In the last twenty-five years, the City of Chattanooga has undergone a renaissance that has resulted in its ability to offer its citizens world-class internet speeds, innovative job opportunities and fostered cutting-edge health advances for their well-being. As Chattanooga and Hamilton County continue to become more metropolitan, our city and surrounding counties should also rise to the occasion of seeking a higher standard of care for its most vulnerable of victims. This may be accomplished by rejuvenating the multidisciplinary collaboration among community partners, increasing overall access to services following sexual violence, and ensuring that all victims may have the benefit of evidence if and when they choose to utilize it.

Respectfully submitted,

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And to the survivors of sexual violence in Chattanooga, Tennessee and the surrounding areas:

We hear you and we believe you. Thank you for giving us the opportunity do better.

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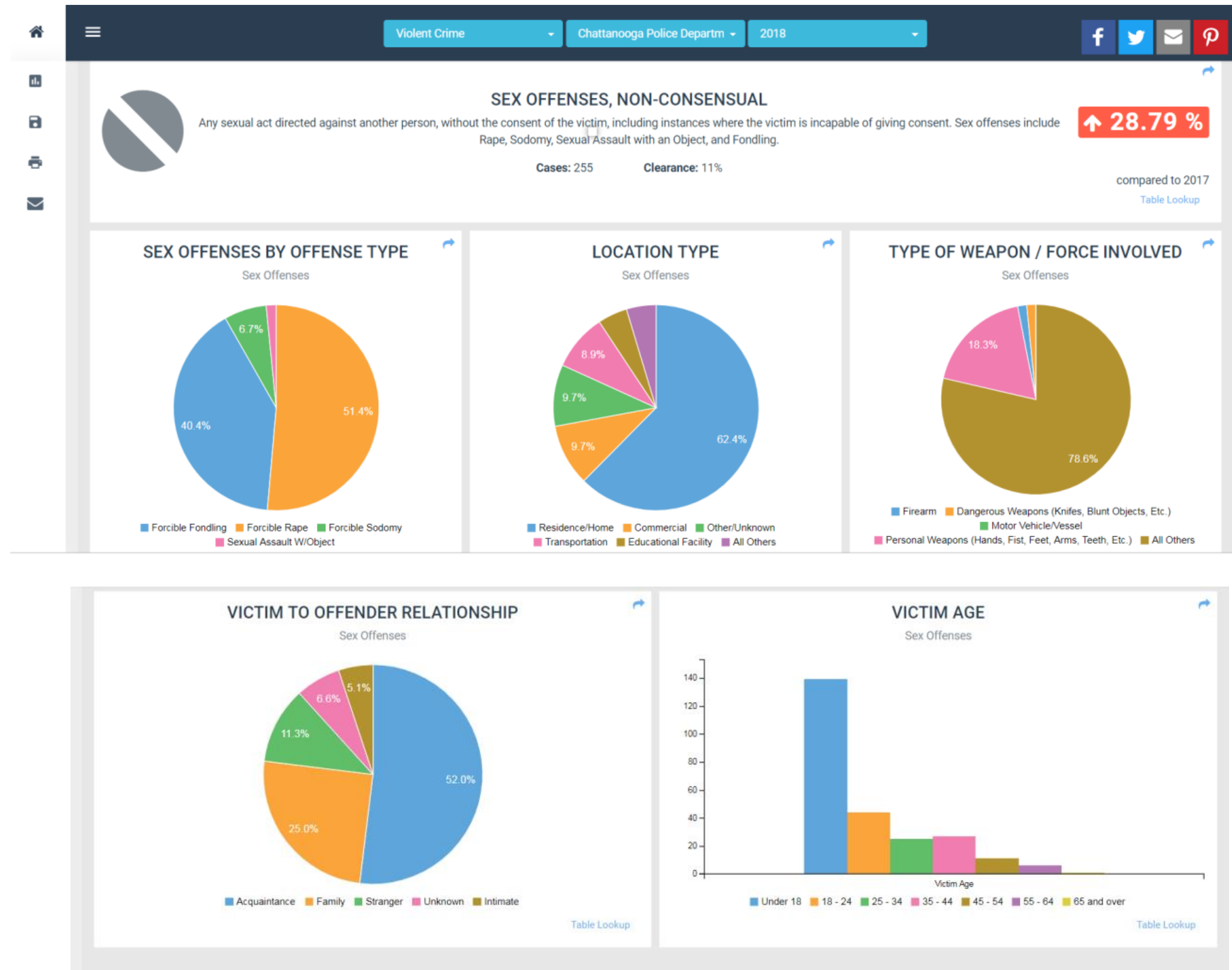
Appendix I

Tennessee Crime Stats Statistical Data – Chattanooga Police Department (2018)



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