
# The Metropolitan Police Department's Implementation of The Sexual Assault Victim's Rights Amendment Act of 2014 (SAVRAA)

by

Elisabeth Olds
SAVRAA Independent Expert Consultant

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Presented to Chief Cathy L. Lanier
Metropolitan Police Department

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**Executive Summary**

The Sexual Assault Victims' Rights Amendment Act of 2014 (SAVRAA) is the result of survivor and systems advocacy efforts to improve the District of Columbia's response to sexual assaults. The new law provides specific rights for survivors of sexual assault, victim-centered guidance and regulations for the Metropolitan Police Department (MPD) and other system actors, and defined a clear continuum of services for survivors of sexual assault. Specifically, SAVRAA provides victims with the right to a community-based victim advocate, to confidential communication with that advocate, and to have that advocate present at any interview with law enforcement.[1] Survivors of sexual assault also have a right to know the results of their toxicology and evidence kits after they are processed[2], to be notified of law enforcement's contact with the suspect[3], and to not be billed for forensic exams.[4] The law also defines and requires timely transport and processing of evidence kits taken during forensic examinations after an assault,[5] and new reporting requirements for law enforcement, as well as the structure and membership of the coordinated community response to sexual assault through the Sexual Assault Response Team (SART).[6] An Independent Expert Consultant was statutorily required to report on its implementation for a period not to exceed two years.[7]

This report is the second report from the Independent Expert Consultant and is the primary review of the Metropolitan Police Department's implementation of SAVRAA. Although SAVRAA did not become law until November 2014, the statute requires that this review begin in March 2013. Therefore, this report covers the period from March, 2013 through June 2015 and emphasizes more recent implementation efforts. The vocabulary used in these reports is also worthy of note. While the term "survivor" is viewed by many as preferable to "victim" because it connotes empowerment, this report uses these terms interchangeably because the term "victim" is used in the DC Code and in accompanying policies and procedures.

The Sexual Assault Victims Rights Amendment Act of 2014 (SAVRAA) requires the Metropolitan Police Department to implement changes in protocol and process in accord with the letter of the law, as well as adopt a philosophical change to conform to its overall intent. Specifically, SAVRAA requires MPD to: (1) inform the sexual assault victim of the toxicology results and findings of his or her sexual assault forensic examination evidence kit; (2) make reasonable attempts to notify a sexual assault victim of MPD's intent to communicate with the suspect; and (3) allow advocates to accompany victims to all interviews with law enforcement. The new law also requires MPD to publish certain statistics about their sexual assault investigations annually, and to transport forensic evidence kits to the Department of Forensic Sciences (DFS) and the Office of the Chief Medical Examiner (OCME) within seven days of a forensic exam.

The review of the Independent Expert Consultant has found that the spirit and intent of the law were being implemented at MPD for at least a year before the law took effect, and that the department has fully implemented the letter of the law. Because SAVRAA became law so

[1] DC Code §23-1909.
[2] DC Code §23-1910 (1).
[3] DC Code §23-1910 (2).
[4] DC Code §4-561.03.
[5] DC Code §4-561.02.
[6] DC Code §4-561.12.
[7] DC Code §4-561.04.

recently, the logistics of implementing some of the requirements remain a work in progress and will require more time to determine whether any problems exist. Where improvements, training and attention to logistical process are needed, MPD is making every effort to do so. Therefore the recommendations in this report describe these efforts and focus almost entirely on additional resources, process improvements, and training rather than any need for a change in philosophy or overall direction with regard to sexual assault investigations. Additionally, this report also contains recommendations regarding issues outside of MPD's direct control that still greatly impact law enforcement's ability to successfully investigate sexual assault cases in a victim-centered manner or have a notably negative impact on the well-being of survivors who report to law enforcement.

**Methodology**

The Independent Expert Consultant was statutorily required to review the following and make recommendations as to any improvements needed: training for all personnel and advanced training for the SAU detectives; internal policies and procedures related to sexual assault including standard operating procedures and general orders; complaints and feedback from the public regarding sexual assault cases; and a random sample of MPD's case files to ensure that they are being fully investigated in a manner consistent with MPD's general orders and standard operating procedure as well as SAVRAA.[8]
Beyond the strict letter of the law, the advocacy around and reforms encapsulated in SAVRAA also require a survivor-centered approach throughout the continuum of services for sexual assault survivors from the point of seeking information about services, to obtaining medical care, advocacy and counseling, to reporting to law enforcement and the prosecution of the case.

After determining whether the letter of the law is being implemented, the goal of this review was to determine whether victim-centered behavior and policies are being followed as well using a procedural justice framework, i.e., one that focuses primarily, though not exclusively, on processes, communication and consistency, rather than outcomes. This review combined reading and analyzing randomly chosen investigative files, MPD's policies, procedures, training curricula and citizen complaints with extensive interviews with all Sexual Assault Unit detectives[9] and supervisors, MPD's Victim Services Unit personnel who work directly with sexual assault survivors, as well as 26 survivors of sexual assault who had reported to MPD after March, 2013. When survivors were interviewed, their cases were also reviewed in MPD's records management system to compare survivor perceptions and experiences of the law enforcement response to the detective's demeanor in the recorded interviews, statements and decisions about the case as well as the case outcome.

In addition to the cases of survivors who were interviewed, three hundred cases were chosen at random from more than 1800 total cases from March 2013 for review. The criteria for

[8] The Independent Expert Consultant was also required to determine whether MPD was compliant with the provision in SAVRAA that directs MPD to pick up forensic evidence kits within seven (7) days of an exam and deliver them to the Department of Forensic Sciences and/or the Office of the Chief Medical Examiner, as well as whether those cases were appropriately documented by MPD when reported. This evaluation is contained in the PERK Audit that accompanies this report.
[9] Two detectives were unavailable due to extended leave or scheduling issues. They will be interviewed prior to the end of the project and their comments included in subsequent reports.

this review were taken from the process outlined by the Women's Law Project[10] in their ongoing and nationally recognized review of the Philadelphia Police Department's sexual assault cases.

Cases were reviewed based on whether:

- Procedures were complaint with MPD's general order 304.06, the unit's standard operating procedures, and SAVRAA's requirements;
- All relevant witnesses were interviewed if available (and all reasonable efforts were made to contact said witnesses when they were not);
- All indicated forensic testing was requested and results returned;
- Victim interviews were conducted in a trauma-informed manner, without blame or interrogation;
- Case classification was consistent with MPD's General Order 304.06 Adult Sexual Assault Investigations, and General Order 304.01 ;
- Probable cause determinations were consistent with the evidence collected.[11]

As of this writing, 215 cases have been reviewed based on these criteria and viewed through the lens of available research on best practices regarding law enforcement's response to sexual assault and trauma informed care. Basic demographic information and information about the circumstances of the assaults were also included. Recorded interviews of survivors and suspect as part of MPD's case files allowed a comparison of the case classification to the crime as reported by the victim, as well as the appropriateness of the conversation between the survivor and the detectives.

Twenty-six (26) survivors were interviewed in person or by telephone. They were recruited for this project through the Victim Assistance Network (VAN), individual sexual assault and mental health service providers, as well as those serving the homeless and other special populations. After being apprised of the confidential nature of the interview, all survivors were asked the same open ended questions, but were encouraged to share their experiences as they wished. The fact that the interview was entirely confidential was reviewed before the interview started. The questions that survivors were asked are:

- What prompted you to report to MPD and how did you go about making that report?
- What do you remember most about making that report and/or talking with MPD patrol officers or detectives?
- Beyond making the initial report, tell me about your experience with the rest of the process – was it good, bad, what worked or was helpful and what was not?
- What would have been more helpful or better for you in this process?

Survivors' experiences were extremely varied, but common themes and identified patterns and problems were used to guide the review of MPD cases as well as interviews with detectives and

[10] Police Executive Research Forum, "Improving the Response to Sexual Assault," March 2012, pg. 38. Available at: http://www.policeforum.org/assets/docs/Critical_Issues_Series/improving%20the%20police%20response%20to%20sexual%20assault%202012.pdf.

[11] The Women's Law Project included ensuring that no polygraphs were threatened or performed on victims. This concern is irrelevant to MPD's process and therefore was not part of the review.

other personnel. They also informed additional research and data collection about other systems actors.

All training curricula given to MPD personnel from 2013 to the present day were provided for review as well as the opportunity to observe a new recruit class as they learned about sexual assault laws in the DC Code at the Police Academy. MPD's Internal Affairs Division and the DC Office of Police Complaints provided copies of all complaints related to sexual assault cases from 2013 through 2014.[12]

**Significant Findings**

1. MPD's General Order 304.06 Adult Sexual Assault Investigations and the Sexual Assault Unit's Standard Operating Procedure are compliant with the law, the continuum of services as it exists currently in the District, and reflect nationally recognized best practices as described in the International Association of Chiefs of Police (IACP) Model Policy on Sexual Assault Investigations.
2. MPD's case intake process that relies heavily on an around-the-clock, immediate response by detectives as well as the case review process implemented in the Sexual Assault Unit (SAU), though difficult due to staffing and resource issues, ensure that cases are fully investigated and any oversights or individual biases that may enter an investigation are checked.
3. Cases are being classified and charged according to the evidence presented, and MPD's classification system ensures that all cases are fully investigated regardless of whether they initially appear to have all of the provable elements of a crime under the DC Code or appear to be likely to be prosecuted successfully. Cases are not being inappropriate screened out or unfounded.
4. Forensic evidence is being gathered in a timely way by MPD but was not being processed in the legally required time frame by the Department of Forensic Sciences until July 2015. These delays had a significant impact on investigations and victim satisfaction with the process. MPD picked up evidence kits within 2.45 days of a forensic exam and delivered those kits to DFS and OCME for testing, well within the 7 days required by SAVRAA.
5. The overwhelming majority of available witnesses were interviewed by detectives, and when they were not, the case review process required that they go back and do so prior to closing a case. Staffing and resource issues sometimes prevented full follow up with witnesses, and some witnesses were no longer available when delayed reports were made.
6. Determinations of probable cause were appropriate based on the available evidence, though in cases where forensic evidence was not dispositive, some warrants were presented prior to forensic evidence reports being returned from the lab. Some warrants were also declined for reasons that were unclear in the documentation or seemed inconsistent with the evidence available in the case file.
7. Detectives are interviewing survivors in a trauma-informed way, and 77% of survivors interviewed reported that they felt believed or like detectives were empathetic. Language around consent, use of force, and alcohol consumption sometimes became problematic, and interviews sometimes seemed abrupt or rushed. Fifty-four percent (54%) stated they

[12] The DC Office of Police Complaints provided de-identified complaints to preserve the anonymity of those coming to their office for relief.

would like more information about the case as it progresses and better information about the reasons for the ultimate outcome. Survivors interviewed were notably frustrated with the warrant process and the reasons for a declined warrant.

8. The survivor's right to have a community-based advocate present for law enforcement interviews has been implemented. However, there are unintended consequences such as an awkward process that does not work well with the actual flow of a case, and signals that may be sent to the survivor that the detective is untrustworthy.

9. It is too soon to determine whether the survivor's right to toxicology and/or forensic evidence kit results or the survivor's right to be notified of law enforcement's intent to contact the suspect have been successfully implemented, but there were 38 cases in which observing these rights were noted in case files.

10. In 18% of the cases reviewed, the survivor showed signs of being severely and persistently mentally ill, requiring far more specialized care than the SAU, as law enforcement, can or should provide. These survivors often made more than one report making their presence in the unit's workload seem elevated beyond their individual unduplicated numbers. SAU detectives did not investigate these cases any differently than their other cases and in some instances went out of their way to provide them with additional assistance.

11. Citizen complaints were few with only 10 related directly to sexual assault cases, and those were fully investigated by MPD. Their resolution was appropriate based on the documentation provided for review. Of the eight verifiable complaints, two were filed against SAU detectives, and eight were filed were filed against patrol officers for failure to take police action or call the SAU, or for making rude or victim-blaming statements. Disciplinary action was taken against one detective and two patrol officers.

12. Training curricula reflect the general order at the time the training was given and are victim centered and trauma informed, as well as relevant, useful and technically correct. However, there is no ongoing and increasingly advanced program of training about sexual assault investigations. The training that exists is provided intermittently rather than what would ideally be provided as a consistent menu of ongoing and progressively advanced options.

13. The Sexual Assault Unit (SAU) is understaffed based on an analysis of their workload and nationally recognized staffing and deployment studies. Sexual assault case reporting has increased by 17% since 2013 and continues to rise. Staffing levels and resources impact a detective's ability to follow up with a victim and keep them informed, interview all available witnesses, follow up on evidence kit processing reports, and conduct non-custodial suspect interviews.

**Recommendations**

1. A progressively advanced and ongoing training program should be implemented for new recruits, existing patrol officers, and SAU detectives and supervisors**.** This training should include the Forensic Experiential Interview Technique (FETI) and training on modeled language about consent, force, and other related issues to ensure that the nature of the reported crime is consistently expressed in writing and to the survivor. Similarly, patrol officers should be given modeled vocabulary and scenario-based training to ensure they are appropriately screening cases into the SAU. Police Academy staff should be increased to provide this scenario-based training.

2. Training should be provided and a protocol for assisting survivors with severe and persistent mental illnesses. A trauma specialist experienced in working with this population should be

contracted by the District to respond with the SAU and assist in interviews and in coordinating services for these survivors.

3. The Network for Victim Recovery of DC and MPD should engage in policy development together in a manner similar to a strategic planning session to arrive at a more practical, collaborative and victim-centered protocol for dispatching an advocate to the hospital to meet with a survivor. Statistics should also be kept over the upcoming year to determine any gaps in this system and NVRDC and MPD should review these together regularly.
4. SAVRAA should be amended to clarify the extent of advocate confidentiality using the language suggested in this report.
5. The case intake process, classification system, and case review process by supervisors should be maintained as model best practices to ensure that any report of sexual assault is fully investigated by skilled detectives.
6. The SAU should be ideally converted into a branch at MPD, and at a minimum staffed with 26 detectives, 4 sergeants, and an administrative staff person in addition to removing this unit or branch from all special details.
7. Vehicles should be provided to each pair of detectives to facilitate appropriate follow up investigations.
8. If staffing levels are increased, detectives should contact survivors in open cases to update them about the status of the case every 45 days.
9. If staffing levels are increased, one detective should be named as a liaison to each of the colleges and universities in the District to increase coordination of response and help provide outreach and education with the schools' respective Title IX staff and sexual assault advocates/counselors.
10. Aggregate data should be provided by the US Attorney's Office to the SART or via the mandated reporting requirements of SAVRAA to increase transparency in the process, particularly surrounding warrant approval, and to allow the coordinated community response to better address gaps in the system.

**The Sexual Assault Victims Rights Amendment Act of 2014 (SAVRAA)**

The Sexual Assault Victims' Rights Amendment Act of 2014 (SAVRAA) is the result of survivor and systems advocacy efforts to improve the District of Columbia's response to sexual assaults. The new law provides specific rights for survivors of sexual assault, victim-centered guidance and regulations for the Metropolitan Police Department (MPD) and other system actors, and defined a clear continuum of services for survivors of sexual assault. Specifically, SAVRAA provides victims with the right to a community-based victim advocate, to confidential communication with that advocate, and to have that advocate present at any interview with law enforcement.[13] Survivors of sexual assault also have a right to know the results of their toxicology and evidence kits after they are processed[14], to be notified of law enforcement's contact with the suspect[15], and to not be billed for forensic exams.[16] The law also defines and requires timely transport and processing of evidence kits taken during forensic examinations after an assault,[17] and new reporting requirements for law enforcement, as well as the structure and membership of the coordinated community response to sexual assault through the Sexual Assault Response Team (SART).[18] An Independent Expert Consultant was statutorily required to report on its implementation for a period not to exceed two years.[19]

Advocacy efforts surrounding SAVRAA focused heavily on individual stories that brought to light issues such as lost evidence kits, missing or misclassified reports, and insensitivity or failure to act on the part of law enforcement, as well as the impact of lacking advocacy and information for survivors. These individual stories brought home the impact the system itself can have – both positive and negative – on both a survivor's ability to heal after a sexual assault and the likelihood of holding an offender accountable. Survivor voices continue to be extremely important as we move forward and assess implementation of SAVRAA.

Equally important is robust and objective data about all aspects of the system itself such as the cases that were reported without a forensic exam or an advocacy response, and those reported by members of highly marginalized populations. Though seemingly tedious compared to more relatable individual stories, this data gives voice to more marginalized survivors who may not feel safe or empowered to speak publicly at a hearing. It also gives us a full and accurate picture of the actions of system actors such as detectives and prosecutors, as well as community-based organizations and advocates.

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**The Metropolitan Police Department's Implementation of SAVRAA**

The Sexual Assault Victims Rights Amendment Act of 2014 (SAVRAA) requires the Metropolitan Police Department to implement changes in protocol and process in accord with the letter of the law, as well as adopt a philosophical change to conform to its overall intent. Specifically, SAVRAA requires MPD to: (1) inform the sexual assault victim of the toxicology results and findings of his or her sexual assault forensic examination evidence kit; (2) make reasonable attempts to notify a sexual assault victim of MPD's intent to communicate with the suspect; and (3) allow advocates to accompany victims to all interviews with law enforcement. The new law also requires MPD to publish certain statistics about their sexual assault investigations annually, and to transport forensic evidence kits to the Department of Forensic Sciences (DFS) and the Office of the Chief Medical Examiner (OCME) within seven days of a forensic exam.

The review of the Independent Expert Consultant has found that the spirit and intent of the law were being implemented at MPD for at least a year before the law took effect, and that the department has fully implemented the letter of the law. Because SAVRAA became law so recently, the logistics of implementing some of the requirements remain a work in progress and will require more time to determine any problems that may exist. Where improvements, training and attention to logistical process are needed, MPD is making every effort to do so. Therefore the recommendations in this report describe these efforts and focus almost entirely on additional resources, process improvements, and training rather than any need for a change in philosophy or overall direction with regard to sexual assault investigations. This report also contains recommendations regarding issues outside of MPD's direct control that still greatly impact law enforcement's ability to successfully investigate sexual assault cases in a victim-centered manner or have a notably negative impact on the well-being of survivors who report to law enforcement.

**Methodology**

The Independent Expert Consultant was statutorily required to review the following and make recommendations as to any improvements needed: training for all personnel and advanced training for the SAU detectives; internal policies and procedures related to sexual assault including standard operating procedures and general orders; complaints and feedback from the public regarding sexual assault cases; and a random sample of MPD's case files to ensure that they are being fully investigated in a manner consistent with MPD's general orders and standard operating procedure as well as SAVRAA.[20]

[20] The Independent Expert Consultant was also required to determine whether MPD was compliant with the provision in SAVRAA that directs MPD to pick up forensic evidence kits within seven (7) days of an

Beyond the strict letter of the law, the advocacy around and reforms encapsulated in SAVRAA also require a survivor-centered approach throughout the continuum of services for sexual assault survivors from the point of seeking information about services, to obtaining medical care, advocacy and counseling, to reporting to law enforcement and the prosecution of the case. Research strongly demonstrates that the law enforcement response after an assault can severely compound the psychological harm to the survivor or provide a critical pathway to support and healing.[21] While some research indicates that procedural justice concerns, such as the perception of fairness and respect, being believed and fully heard, as well as being well-informed by law enforcement are more predictive of victim satisfaction and well-being than the actual case outcome[22], other studies indicate that the decision of law enforcement or prosecutors to drop a case exacerbates post-traumatic stress significantly even when procedural justice measures are high primarily because it speaks to whether or not they were believed.[23]

Attitudes from law enforcement, overt or subtle, can influence victim perceptions of accessibility of services, the fairness and respect within the process, and the underlying reasons for case outcomes. Studies have shown that law enforcement may make decisions about whether to pursue or drop cases based on extra-legal factors such as the victim's age, socioeconomic status, race, gender and history of alcohol and drug abuse.[24] Research has also demonstrated that often the mental maps used by law enforcement to determine the veracity of a case can mirror the myths about rape employed by the general public that say sexual assault should be taken seriously if the parties are strangers, a weapon or extreme force is used, and the victim is considered to be socially respectable by conventional measures.[25] One study indicated that officers do this in spite of intellectually knowing it is false as well as working under policies that prohibit such categorization.[26]

The remedy to the above-described issues is a victim-centered approach that represents a shift from case outcome-focused investigations to ones that place victim well-being at the center of policy and practice. Specific indicators of this preferred approach include: (1) interviewing survivors in a trauma-informed manner, including not interrogating or blaming them; (2) conducting a thorough investigation of all reported cases regardless survivor or suspect

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exam and deliver them to the Department of Forensic Sciences and/or the Office of the Chief Medical Examiner, as well as whether those cases were appropriately documented by MPD when reported. This evaluation is contained in the PERK Audit that accompanies this report.

[21] Campbell, R and Raja, S (1999). Secondary Victimization of Rape Victims: insights from Mental Health Professionals Who Treat Survivors of Violence. Violence and Victims, Vol. 14, No 3, 1999.

[22] Wemmers, J. and Cyr, K, (2006). What Fairness Means to Crime Victims: A Social Psychological Perspective on Victim-Offender Mediation. Applied Psychology in Criminal Justice, 2006 2(2).

[23] Campbell, et al. 2001.

[24] Brown, J., Hamilton, C., & O'neill, D. (2007). Characteristics associated with rape attrition and the role played by scepticism or legal rationality by investigators and prosecutors. *Psychology, Crime & Law, 13*(4), 355-370.

[25] Mont, J., Miller, K., & Myhr, T. (2003). The Role of "Real Rape" and "Real Victim" Stereotypes in the Police Reporting Practices of Sexually Assaulted Women. *Violence Against Women, 9*(4), 466-486.

[26] Venema, R. (2014). Police Officer Schema of Sexual Assault Reports: Real Rape, Ambiguous Cases, and False Reports. *Journal of Interpersonal Violence*. doi: 10.1177/0886260514556765.

identity; (3) giving the survivor control over how much or how little they participate in the process without judgment; (4) keeping survivors informed of the status of their case with safety as the central focus; and (5) working collaboratively with advocates, medical personnel, and other service providers to ensure that survivor's needs are met.[27]

After determining whether the letter of the law is being implemented, the goal of this review was to determine whether victim-centered behavior and policies are being followed as well using a procedural justice framework, i.e., one that focuses primarily, though not exclusively, on processes, communication and consistency, rather than outcomes. This review combined reading and analyzing randomly chosen investigative files, MPD's policies, procedures, training curricula and citizen complaints with extensive interviews with all Sexual Assault Unit detectives[28] and supervisors, MPD's Victim Services Unit personnel who work directly with sexual assault survivors, as well as 26 survivors of sexual assault who had reported to MPD after March, 2013. When survivors were interviewed, their cases were also reviewed in MPD's records management system to compare survivor perceptions and experiences of the law enforcement response to the detective's demeanor in the recorded interviews, statements and decisions about the case as well as the case outcome.

In addition to the cases of survivors who were interviewed, three hundred cases were chosen at random from more than 1800 total cases from March 2013 for review. MPD provided completely open access to these cases in their records management system and were also available to answer questions about specific cases. The criteria for this review were taken from the process outlined by the Women's Law Project[29] in their ongoing and nationally recognized review of the Philadelphia Police Department's sexual assault cases.

Cases were reviewed based on whether:

- Procedures were complaint with MPD's general order 304.06, the unit's standard operating procedures, and SAVRAA's requirements;
- All relevant witnesses were interviewed if available (and all reasonable efforts were made to contact said witnesses when they were not);
- All indicated forensic testing was requested and results returned;
- Victim interviews were conducted in a trauma-informed manner, without blame or interrogation;
- Case classification was consistent with MPD's General Order 304.06 Adult Sexual Assault Investigations, and General Order 304.01 ;

[27] Parsons, J. and Bergin, T. The Impact of Criminal Justice Involvement on Victims' Mental Health, *Journal of Traumatic Stress*, 23 (2), April 2010, pg. 183.
[28] Two detectives were unavailable due to extended leave or scheduling issues. They will be interviewed prior to the end of the project and their comments included in subsequent reports.
[29] Police Executive Research Forum, "Improving the Response to Sexual Assault," March 2012, pg. 38. Available at: http://www.policeforum.org/assets/docs/Critical_Issues_Series/improving%20the%20police%20response%20to%20sexual%20assault%202012.pdf.

- Probable cause determinations were consistent with the evidence collected.[30]

As of this writing, 215 cases have been reviewed based on these criteria and viewed through the lens of available research on best practices regarding law enforcement's response to sexual assault and trauma informed care. Basic demographic information and information about the circumstances of the assaults were also included. Recorded interviews of survivors and suspect as part of MPD's case files allowed a comparison of the case classification to the crime as reported by the victim, as well as the appropriateness of the conversation between the survivor and the detectives.

Twenty-six (26) survivors were interviewed in person or by telephone. They were recruited for this project through the Victim Assistance Network (VAN), individual sexual assault and mental health service providers, as well as those serving the homeless and other special populations. After being apprised of the confidential nature of the interview, all survivors were asked the same open ended questions, but were encouraged to share their experiences as they wished. The fact that the interview was entirely confidential was reviewed before the interview started. The questions that survivors were asked are:

- What prompted you to report to MPD and how did you go about making that report?
- What do you remember most about making that report and/or talking with MPD patrol officers or detectives?
- Beyond making the initial report, tell me about your experience with the rest of the process – was it good, bad, what worked or was helpful and what was not?
- What would have been more helpful or better for you in this process?

Survivors' experiences were extremely varied, but common themes and identified patterns and problems were used to guide the review of MPD cases as well as interviews with detectives and other personnel. They also informed additional research and data collection as needed.

All training curricula given to MPD personnel from 2013 to the present day were provided for review as well as the opportunity to observe a new recruit class as they learned about sexual assault laws in the DC Code at the Police Academy. MPD's Internal Affairs Division and the DC Office of Police Complaints provided copies of all complaints related to sexual assault cases from 2013 through 2014.[31]

Findings from the review of individual cases combined with interviews with detectives, survivors, advocates, and others, as well as citizen complaints and reviews of policies and training inform the recommendations that follow.

[30] The Women's Law Project included ensuring that no polygraphs were threatened or performed on victims. This is irrelevant to MPD's process and therefore was not part of the review.
[31] The DC Office of Police Complaints provided de-identified complaints to preserve the anonymity of those coming to their office for relief.

**Review of General Order 304.06 and Sexual Assault Unit Standard Operating Procedure**

As required by SAVRAA, MPD's General Order 304.06 Adult Sexual Assault Investigations and the accompanying Standard Operating Procedure (SOP) for the Sexual Assault Unit (SAU) were reviewed and compared to both the International Association of Chiefs of Police (IACP) Model Police on Sexual Assault[32] as well as national best practice models such as those promulgated by End Violence Against Women International (EVAWI), and the National Center for Trauma-Informed Care.

As the General Order and the Standard Operating Procedure currently exist, very few changes were recommended. Both policies provide clear procedural guidance detailed according to each responding member's level and area of responsibility, and clearly state MPD's appropriately victim-centered posture in sexual assault cases. The IACP's Model Policy emphasizes providing access to a victim advocate, waiting 48 hours or until the survivor has had two full sleep cycles to conduct a full interview, and not penalizing or judging victims for choosing not to go forward or being reluctant to divulge information. It also takes into account the impact of trauma on a victim's ability to provide a coherent account of what happened to them, and the need to work in coordination with advocates, forensic nurses, and others in the continuum of services to ensure that victims receive the support they need to participate in the criminal justice process or simply find healing and closure.

MPD's General Order 304.06 and the accompanying Standard Operating Procedure contain all of the elements described above. While minor changes will continue to be made over time, the policies at MPD almost identically reflect national best practices and are trauma informed. They not only respect the survivor's need for care and advocacy as a first priority, but are explicitly prohibit contradicting, judging or aggressively questioning survivors in any way. Survivors are given at least 48 hours and preferably 72 hours before a follow up interview is conducted. Both policies also contain instruction about all of the rights provided by SAVRAA for which MPD is responsible, specifically a survivor's right to have an advocate accompany them in interviews, [33] to be notified about toxicology and evidence kit results[34] as well as when detectives may have contact with the suspect.[35] Recommended changes were entirely for the sake of internal consistency, correcting names of programs and agencies, and ensuring that timelines are clear. There is no need to make any formal recommendations at this time.

Going beyond national best practices, the robust and systematic review process reflected in the SOP, though very burdensome from a human resources perspective, contributes to a high degree of procedural fairness and consistency, and also helps prevent case outcomes based on survivor or suspect identity or detectives' personally held ideas about what constitutes a "real" case or a "serious" crime.

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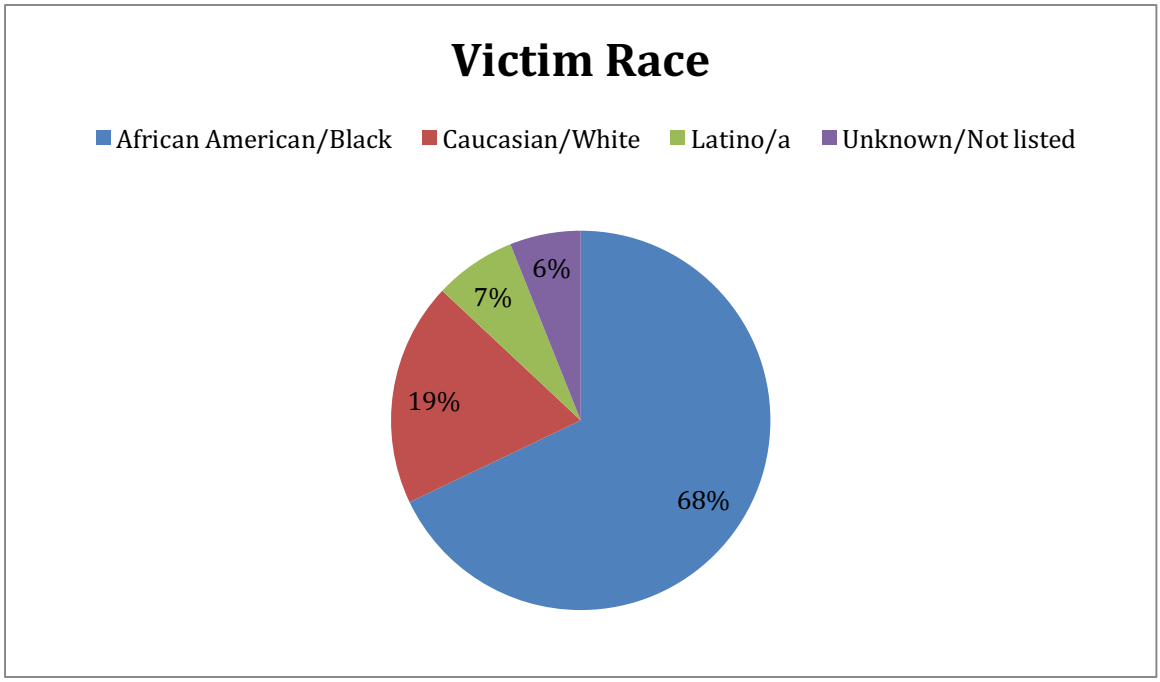
[32] International Association of Chiefs of Police, Model Policy on Investigating Sexual Assaults, 2005. http://www.djcs.wv.gov/grant-programs/all-general-programs/STOP%20VAWA/Documents/Publications/IACP%20Investigating%20Sexual%20Assaults%20Model%20Policy.pdf.
[33] MPD General Order 306.04 Adult Sexual Assault Investigations, pg. 4.
[34] MPD General Order 306.04 Adult Sexual Assault Investigations, pg. 10.
[35] MPD General Order 306.04 Adult Sexual Assault Investigations, pg. 11.

**Case Review Findings**

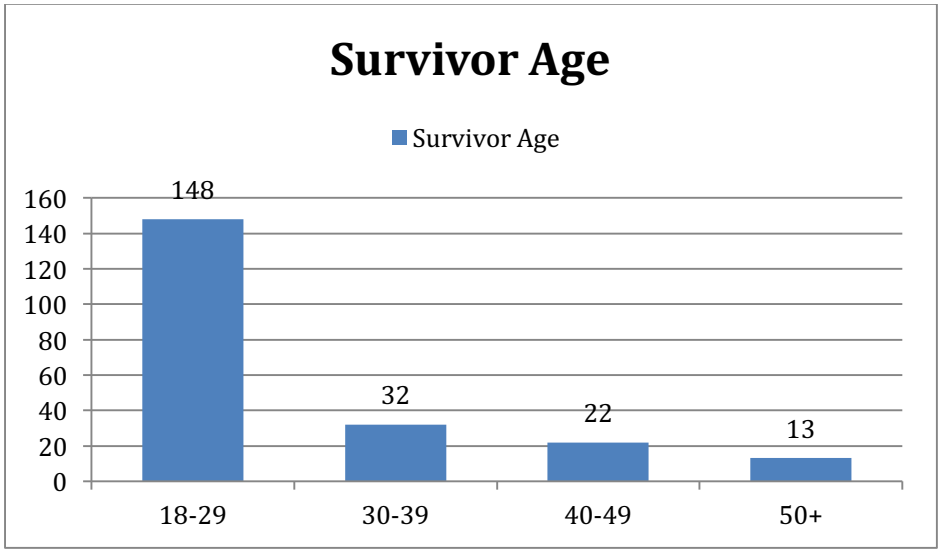
The findings that follow are based on an analysis of 215 randomly chosen sexual assault cases. Because record keeping changed so dramatically and was in a state of flux during 2013 due to changes to General Order 304.06 Adult Sexual Assault Investigations made in 2011, the review of individual cases focused primarily on cases beginning in January 2014. These cases were used to generate interview questions for detectives and survivors, and to pinpoint areas that could be improved with training, additional resources, and broader system change. Specific recommendations related to this case review are encapsulated in subsequent sections.

***Basic Demographics***

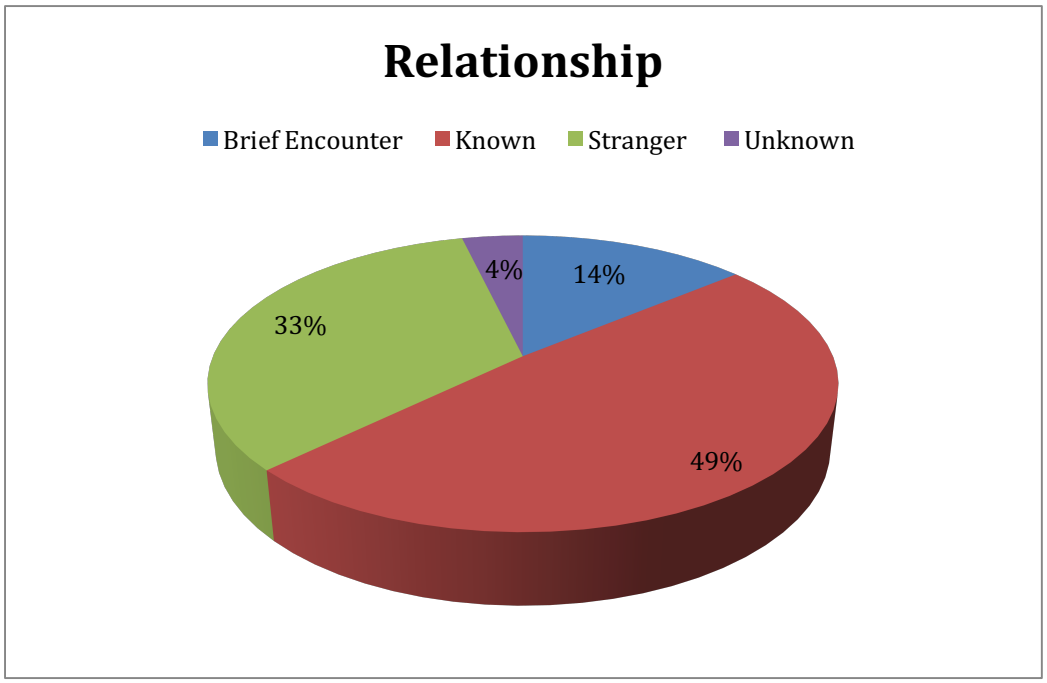
Of the 215 cases reviewed, 206 (96%) victims were female and nine (4%) were male while 215 (100%) of suspects were male and none were female. There were no transgendered victims or suspects in the 215 randomly chosen cases, but there were two transgendered survivors who reported cases to MPD's SAU during the period reviewed.




Sixty-eight percent (146) of survivors were African American or Black, 19% (41) were Caucasian or White, 7% (15) were Latino/a or Hispanic, and 6% were unknown or not listed.




The overwhelming majority of survivors (69%) in the cases reviewed were between the ages of 18 and 29, while 15% were ages 30 to 39, 10% were age 40 to 49 and 6% were over the age of 50. Additionally, twelve (6%) cases were reported by college students.




The relationships between the parties, i.e. the survivor and the suspect, were as follows: 33% (72) cases involved assault by a stranger; 49% (105) were committed by someone known to the victim in some way whether that is as an acquaintance, a partner, a coworker, etc., 14% (30) cases involved an assault by a brief encounter, i.e. by someone the survivor knows only through meeting them on that occasion usually having met them at a party, bar or club.

***Classification***

Classification of cases for investigation can indicate how much attention the case will receive and how seriously the case will be taken. Prior to SAVRAA, office information cases were used to table cases that did not clearly meet the level of a crime at the time of report, or were not going to be investigated for a variety of reasons. MPD's classification of sexual assault cases has changed to include only two categories: sexual assaults and sexual allegations. Unlike many police department classification systems that score cases or screen cases and only send those that appear on their face to be crimes to detectives for further investigation, MPD's system assumes that all cases have the potential to be successfully investigated and should be investigated until all leads are exhausted regardless of how they initially appear.

According to the SAU's Standard Operating Procedure, a sexual assault case is a complaint or report that contains elements of a sexual assault crime in the District and contains a sexual element. A sexual allegation case is a report of sexual assault or abuse that does not *yet* contain provable elements of a crime as defined in the DC Code.[36] This classification creates a case that may later be shown to be a sexual assault once it is fully investigated or once additional information comes to light at a later date. Of the 1102 complaints related to sexual assault filed in calendar year 2014, 613 were initially classified as "sexual assaults" and 489 were classified as "sexual allegations." Of the 489 cases initially classified as sexual allegations, 24 were upgraded to sexual assaults in 2014 after additional investigation. The current SOP explicitly prohibits classifying any cases as "miscellaneous" or as "office information" cases.[37] Based on the case review, no category has replaced these in function either.

A counter-intuitive pattern became apparent in the case review, in which 87 (40%) were sexual allegations. Sexual allegation cases not only underwent the same procedural and investigative process as cases in which the elements of a violation of the criminal law were immediately obvious, but they were given more time and attention on average in an attempt to prove a crime occurred and to ensure that all necessary steps were taken to make that determination. Detectives sought additional evidence and witnesses were actively pursued, though these cases were more difficult generally because they often lacked critical evidence as a starting point.

Case closure remains complicated by delayed forensic reports and the need for supervisor approval before a case can be formally closed in any way. Cases were closed, suspended or unfounded appropriately, though many cases were also awaiting formal closure designations in the records management system even though the investigation had ended. A case is suspended when all avenues for investigation have been exhausted and no resolution is yet possible. There was only one case officially unfounded, meaning that it was affirmatively proven that the assault did not take place and is therefore groundless, found in this review. That

[36]Metropolitan Police Department, Sexual Assault Unit Standard Operating Procedure, VIII, B, "Reporting Procedures in Sexual Assault Cases," pg. 25.
[37] Metropolitan Police Department, Sexual Assault Unit Standard Operating Procedure, VIII, B, page 25.

determination also was appropriate based on the available evidence and took place after significant additional supervisory review.

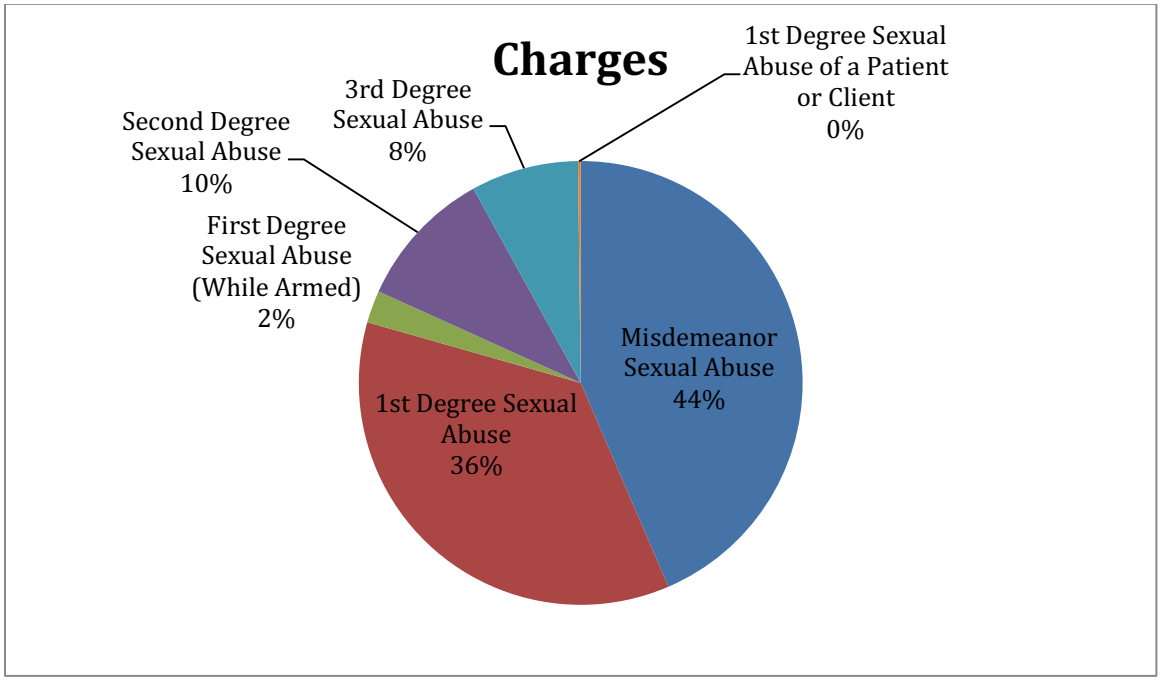
Cases were also appropriately classified according to the DC Code based on the elements of the crime articulated in interviews with the survivor and other witnesses and additional evidence available. Of the 215 reviewed, the following charges were applied at the investigation phase based on the facts and evidence presented. These charges also could change as the investigation progressed. The vast majority of cases (44%) were classified as misdemeanor sexual abuse.[38] Four cases (2%) were classified as First Degree Sexual Abuse and involved the use of a weapon. Thirty-six percent (77) of the cases reviewed were First Degree Sexual Abuse.[39] Ten percent (22) of the cases were Second Degree Sexual Abuse[40] and 8% (17) of cases were Third Degree Sexual Abuse.[41]

[38] DC Code §22-3006 "Whoever engages in a sexual act or sexual contact with another person and who should have knowledge or reason to know that the act was committed without that other person's permission, shall be imprisoned for not more than 180 days and, in addition, may be fined in an amount not more than the amount set forth in § 22-3571.01.

[39] DC Code §22-3002. A person shall be imprisoned for any term of years or for life, and in addition, may be fined not more than the amount set forth in § 22-3571.01, if that person engages in or causes another person to engage in or submit to a sexual act in the following manner: (1) By using force against that other person; (2) By threatening or placing that other person in reasonable fear that any person will be subjected to death, bodily injury, or kidnapping; (3) After rendering that other person unconscious; or (4) After administering to that other person by force or threat of force, or without the knowledge or permission of that other person, a drug, intoxicant, or other similar substance that substantially impairs the ability of that other person to appraise or control his or her conduct.

[40] DC Code §22-3003. A person shall be imprisoned for not more than 20 years and may be fined not more than the amount set forth in § 22-3571.01, if that person engages in or causes another person to engage in or submit to a sexual act in the following manner: (1) By threatening or placing that other person in reasonable fear (other than by threatening or placing that other person in reasonable fear that any person will be subjected to death, bodily injury, or kidnapping); or (2) Where the person knows or has reason to know that the other person is: (A) Incapable of appraising the nature of the conduct; (B) Incapable of declining participation in that sexual act; or (C) Incapable of communicating unwillingness to engage in that sexual act.

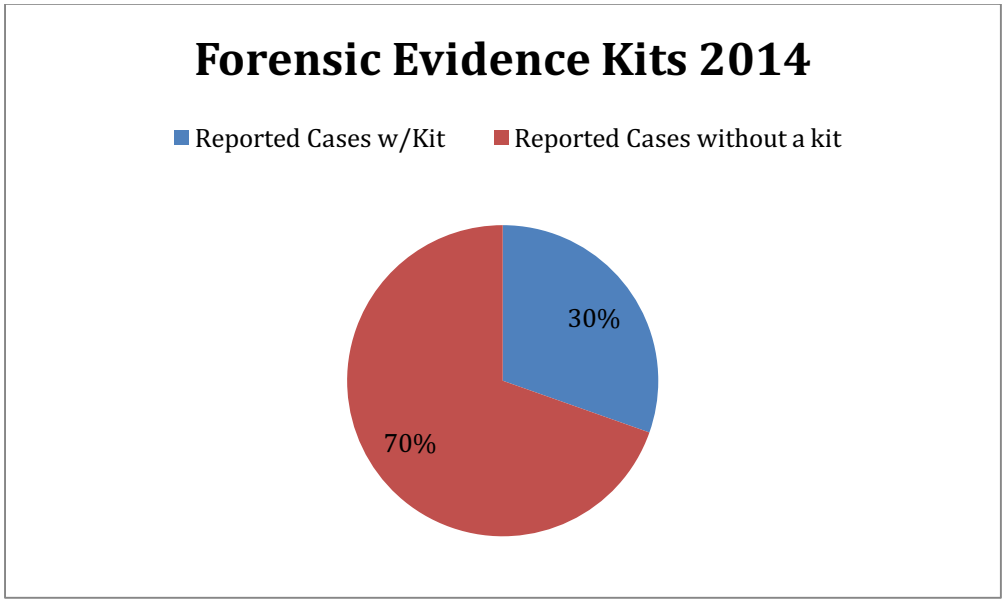
[41] DC Code §22-3004. A person shall be imprisoned for not more than 10 years and may be fined not more than the amount set forth in § 22-3571.01, if that person engages in or causes sexual contact with or by another person in the following manner: (1) By using force against that other person; (2) By threatening or placing that other person in reasonable fear that any person will be subjected to death, bodily injury, or kidnapping; (3) After rendering that person unconscious; or (4) After administering to that person by force or threat of force, or without the knowledge or permission of that other person, a drug, intoxicant, or similar substance that substantially impairs the ability of that other person to appraise or control his or her conduct.




***Forensic Evidence Gathered and Results Returned***

Forensic evidence in a sexual assault case is most often thought of as the forensic evidence kit or Physical Evidence Recovery Kit (PERK) gathered from the person of the survivor through a medical and forensic exam, though other evidence is of course relevant. These evidence kits are conducted in approximately one third of the cases filed every year. In 2014, of the 1102 cases filed, 335 involved a PERK as part of the evidence. DCFNE and NVRDC report that 415 forensic exams were done in calendar year 2014, that 282 (68%) were reported to law enforcement at the time of the exam and that 53, or 13% made a delayed report to law enforcement.[42] These delays are usually a matter of days or weeks, but a PERK is stored by DCFNE for one year after it is taken.[43] A PERK can only be taken 96 hours or approximately four days after an assault.

[42] DC Forensic Nurse Examiners (DCFNE), DC SANE Annual Report 2014, pages 1-2; DC SANE Mid-Year Report 2015, pages 1-2.
[43] Legally, PERKs must be stored for 90 days to allow survivors time to consider reporting to law enforcement at a later date, but DCFNE currently has the storage space to accommodate storing them for one year, after which time they are destroyed as biological waste by MedStar Washington Hospital Center.




Seventy-seven (36%) of the 215 cases analyzed had PERKs as evidence in addition to video, cell phone records, still photos, clothing or other physical evidence turned over to the detective independent of a PERK. While the PERK audit found that MPD was collecting this evidence in a timely way as part of the initial case intake, the Department of Forensic Sciences did not return results in a timely manner in a majority of these cases and in some cases had not tested the kit at all. These delays created a significant disruption in a detective's ability to investigate a case and keep a survivor informed, particularly if the determining evidence is the PERK. In these cases, survivors often became frustrated and imparted a lack of care or concern to the detective who may or may not be keeping them apprised of the status of the case regularly. Similarly, detectives reported feeling conflicted about constantly updating a survivor when they had nothing for them and possibly re-triggering their trauma for no productive reason. Delays also created a problem for detectives both in investigating and closing cases in a timely way and in managing their workload.

Recommendations about the PERK process and coordination are contained in the PERK Audit that accompanies this report. MPD is not only compliant with SAVRAA, but exceeds the seven-day requirement by picking up and dropping of evidence kits on average within 2.45 days of an exam at Washington Hospital Center and dropping them off at DFS and OCME. The delays and backlog are being aggressively remedied by DFS as detailed in the PERK Audit. MPD's SAU will also be able to improve its workload management and track evidence results more efficiently using the kit tracking database being created by the SART.

To the extent that case intake pressures allow on any given shift, detectives were diligent and extremely timely in canvassing and requesting video footage from clubs, hotels, and businesses where the assault either took place or where their cameras may have picked up the assault or the assailant. Often detectives sought video footage immediately after opening a case. Recovering and reviewing video is extremely labor intensive, sometimes requiring search warrants and subpoenas and many hours spent reviewing the footage.

**Witness Interviews**

Actual witnesses to sexual assaults are few and far between given the often private nature of the crime, but there are witnesses to events before and after, people the survivor and suspect spoke to about what happened, as well as some cases in which the assault was carried out in public or semi-private places. Witness names, where available, were thoroughly documented and these people were actively sought for interviews. In fact, it was striking the lengths detectives went to in order to find potential witnesses, including canvassing an entire construction site full of workers several days in a row located across from the crime scene, going to clubs immediately after an assault was reported at that location to speak with bartenders and patrons who may still be there and would otherwise be untraceable, and pursuing witness statements from co-workers, friends and family members.

Some witnesses were not interviewed in a timely way, and there were cases reviewed in which this was classified as an oversight or a clear omission, excepting cases in which the survivor had already decided they did not want additional police action to be taken. In cases where a witness was not interviewed, detectives were told by supervisors to find those witnesses if possible and interview them as part of the regular case review process, or sometimes part of the warrant review process. Issues also arose when witnesses were homeless or otherwise transient, did not have reliable contact information, or as in several cases reviewed, were also heavily intoxicated at the time in question. Because of staffing issues, detectives also have difficulty making appointments to speak with witnesses, and sometimes suspects, during follow up because they may be pulled away by new cases coming in, or may not be assured of a vehicle being available during that time if it is an in-person interview. These gaps became apparent in the case files as well.

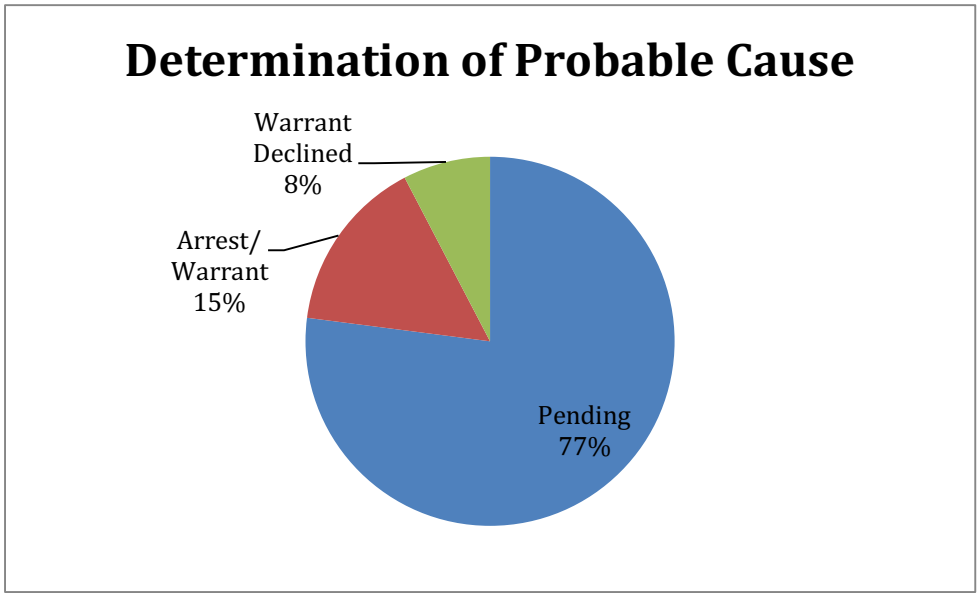
**Determination of Probable Cause Consistent with Evidence**

The ultimate determination of probable cause has to be consistent with the evidence gathered in the case over and above trauma-related inconsistencies, assumptions about a victim or suspect's identity or even competing motives they may be assumed to have for reporting such as a custody battle with the suspect, a contentious break up, or the victim's immigration status. Once a detective has probable cause, i.e., a reasonable belief based on articulable facts that a particular individual committed the alleged crime, by general order and standard operating procedure, he or she is required to present a warrant to the US Attorney's Office.

Determinations of probable cause were reasonable and appropriate in the cases reviewed. Warrants were presented to the US Attorney's Office in a timely manner after cases were approved by supervisors. Warrants were sometimes sent back for revision, or particular pieces of additional evidence were requested by supervisors before a warrant was approved for submission to prosecutors. These instructions were helpful and reasonable and also prevented cases from being presented before they were fully documented.

In cases where forensic evidence was not the lynchpin of the investigation, warrants were presented prior to obtaining the reports from DFS or OCME. Similarly, warrants were declined

by the US Attorney's Office prior to reviewing the forensics reports. There were also cases on hold entirely waiting for forensic evidence that was essential to the case. No cases in the review indicated that essential evidence was being overlooked where it would have decided a case, for example, in a case where both parties admit that sexual contact of some sort did happen and the case is decided by consent being withdrawn, it is concerning that the delays within the system have created a situation in which this happens at all. As the PERK processing system at DFS becomes more efficient this should not be happening regardless of the relevance of forensic evidence in the case.




Of the cases reviewed, 161 cases (71%) were pending cases being worked on by detectives or waiting for PERK evidence to be returned, review by a supervisor, or for contact with a party in the case to be made whether the victim, the suspect or a witness. These cases may also be functionally closed, but not officially due to the need to supervisor approval. Of the 48 that had a conclusive result that could be determined from the case notes, i.e. either an arrest had been made or a warrant signed or declined, 32 (66%) were cases that resulted in an on-scene arrest (2) or a signed warrant (30), and in 16 (34%) cases the warrant was declined. As discussed above, the number of cases pending will change dramatically once forensic results are available in a timely way.

It was difficult to discern why some warrants were declined, and some of these denials did not appear to be based on evidence in the file, but rather from viewing the case the way a jury or defense attorney would, i.e. being able to exploit the victim's alcohol consumption, inconsistent statements, text messages or voicemails sent before or after the assault, or a lack of witnesses. There is not enough documentation in the case files to make a definitive statement about why some cases that seemed to clearly meet the standard of probable cause based on the evidence presented were then declined by the US Attorney's Office. Some of reasons given include inconsistent statements, a survivor's drug-altered state at the time of the assault, that

the evidence did not demonstrate a lack of consent by the victim, insufficient evidence, and lack of corroborating evidence or witnesses. There may have been circumstances not apparent in the file, the cases were particularly difficult given the USAO's particular knowledge of defense attorney tactics, or the standard being used may be the ability to prove a case beyond a reasonable doubt based on the file exactly as presented. Without better documentation of why warrants are declined, these notes are left to stand on their own.

***Detectives' Interviews with Survivors***

By standard operating procedure, survivor interviews with detectives are recorded whenever possible and these recordings allowed almost first-hand knowledge of whether interviews are appropriate or not. These interviews often were then summarized in the running resume in the case file and provided an easy comparison between what the survivor was actually saying and how it was interpreted by the detective. Observing interviews with survivors revealed the following general findings:

1. Interviews are being conducted in a trauma informed manner. Detectives are not interrogating survivors or contradicting them to sort out inconsistencies in their recounting of events. Rather, they are mostly asking open-ended questions and allowing survivors to recount information in their own way.

2. The overwhelming majority of interviews showed a genuine concern for the survivor's well-being and knowledge about resources available to them.

3. Language around force and consent sometimes becomes confused, leading a survivor to believe the detective believed the encounter was consensual, when the case notes may actually indicate that this was not the case, i.e. that the detective believed the survivor and pursued the case appropriately. Language issues as described above most often presented themselves in cases involving excessive intoxication or cases where the only deciding issue was the existence or withdrawal of consent rather than a use of obvious force or coercion. This language makes its way into reports, something that can be damaging in court later and sends an unintended signal to survivors.

4. Detectives sometimes advised college students and particularly young women about their general safety in future social encounters. While these may be well intended and actually do not correlate with cases being dismissed, survivors can and sometimes did take these suggestions as blame for their current situation.

**Survivor Interview Findings**

As described above, 26 survivors were interviewed for this review specifically about their experience with law enforcement, though the discussion broadened to other related topics such as their experiences with prosecutors and other service providers in the continuum of services. Survivors were referred for interviews from a variety of other service providers in the community, some within the sexual assault continuum and some outside of it but providing supportive services such as help with immigration cases or assistance with homelessness. Of 26

interviewees, 16 were Caucasian/white, 7 were African American/Black, and 3 were Latina. All 26 survivors were females between the ages of 19 and 32 who had been assaulted by males.

To preserve confidentiality, survivor interviews were condensed into the following findings:

1. 20 (77%) survivors reported positive interaction with SAU detectives, particularly during the first interview(s). They indicated that they felt supported and believed and three said they felt the detectives were very empathetic.
2. 6 (23%) survivors were not positive in their descriptions of these interactions with SAU detectives, and were constructive about possible training remedies:
    a. One said they felt uncomfortable talking to a man about some parts of the assault;
    b. Three said the interaction felt rushed or abrupt, like the detective(s) didn't have time;
    c. One indicated she felt like the detective wasn't taking her seriously because she was drunk at the time of the assault.
3. 14 (54%) survivors interviewed said they would like more information about the progress of the case, and more information about the ultimate result regardless of the outcome. This was a primary focus and frustration.
4. Two survivors interviewed said, respectively, that the detective did not interview a key witness, and did not look at the nurse's report that indicated injuries before presenting the warrant to the USAO. Both of these cases involved extremely intoxicated victims assaulted by suspects whom they had just met that day/evening. In both of these cases, the warrant was sent back for additional investigation and the missing pieces of evidence were presented with the warrants. The USAO then declined each warrant.
5. Vocabulary used by detectives, patrol officers, and the US Attorney's Office around issues of consent, coercion, force and alcohol consumption sometimes felt like blame.
6. 16 survivors expressed intense frustration with the fact that warrants were declined without what the survivors felt were adequate explanations, or with explanations that were interpreted variously as making no sense, actually victim-blaming, or indicating that they believed the suspect or took his clearly contradictory statements at face value, particularly those related to alcohol consumption or brief, initially consensual encounters. In four instances, these decisions were explained by the US Attorney's Office staff themselves, and the other twelve in the group were informed that their warrants were declined by the detective in their case or their advocate.

Recommendations stemming from these interviews exist throughout this report but are located primarily in sections on Training and Staffing and Resources.

**Rights Created by SAVRAA**

***Right to an Advocate***

One of the most significant rights created by SAVRAA is the right of the survivor to have an independent community-based advocate present in interviews with law enforcement. Being informed of the right to an advocate and presented with an advocate on site to sit in on interviews and the forensic exam provides the survivor with access to a confidential resource

who can provide information about other rights they have in the process, explore their options with them, and begin to work through support and resource issues that may come up such as transportation, replacement clothing and access to counseling resources. The Network for Victim Recovery of DC (NVRDC) provides this advocacy free of charge for any survivor who wishes to avail themselves of these services.

The right to an advocate in the hospital setting as set forth in SAVRAA has been implemented by MPD and the Network for Victim Recovery of DC since SAVRAA became law on November 23, 2014. However, the practical application and exercise of this right continues to be a work in progress. Information gathering has been inconsistent thus far, but the statistics about advocate participation that we do have as well as interviews with NVRDC staff and MPD SAU detectives indicates that this process needs refinement.

Since October 2014 195 reports of sexual assault were made to law enforcement that resulted in a survivor seeking services at the hospital. From Jan. 1, 2015 to March 30, 2015 only 26 (22% of the total 114 reported to law enforcement in this period) resulted in an advocate sitting in on the police interview.[44] This number could be inordinately low given that some survivors have declined advocacy services, and some survivors were too intoxicated or traumatized to be interviewed at all at that point. These circumstances are not currently reflected in the statistics. Forty-two (37%) of those 114 interviews with detectives took place before the survivor arrived at the hospital making it impossible under the current system for an advocate to participate. There have been four (4) instances in which NVRDC was not contacted to participate in the interview at the hospital according to the established policies and procedures.

Upon SAVRAA becoming law, MPD's General Counsel's Office instructed the SAU Commander that detectives should not speak with survivors at all until an advocate arrives at the hospital to speak with them to ensure that there was no question about whether the detective had complied with the law, specifically section §23-1909(b).[45] While this seems like a direct implementation of §23-1909(b), this prong of SAVRAA and its strict interpretation creates unintended consequences for advocates, detectives and survivors.

By written policy, NVRDC advocates arrive at the hospital within an hour. This means detective and survivor must wait for an hour, not speaking with each other, and the survivor is simply sitting and waiting with his or her own thoughts and anxiety. Only once the advocate arrives and speaks with the survivor about their rights can the detective proceed with the interview. In practice, this means that the detective is unable to go to the crime scene to interview witnesses who may be unreachable later, work with crime scene technicians to retrieve relevant evidence and begin pulling video tape if necessary. Because of staffing issues, that detective may also be keeping other crime scenes from other sexual assault cases waiting as well.

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[44] NVRDC began collecting data about advocate involvement in law enforcement interviews in an organized manner on January 1, 2014.
[45] DC Code §23-1909(b) "Law enforcement shall ensure that a sexual assault victim advocate is present before the commencement of any in-person interview with the sexual assault victim."

Immediate safety issues in situations where the sexual assault is related to a domestic violence case where there are children in the home are also a concern with prohibiting a detective from speaking with the victim until an hour has passed since a report was made in an acute case. It also may incorrectly communicate to the survivor that there is something inherently suspect or not trustworthy about the detective, or that the detective does not care about them enough to engage with them meaningfully without being prompted by an advocate, when in fact this review has found the opposite to be true.

Recommendations

1. NVRDC and MPD should engage in policy development together in a manner similar to a strategic planning session to arrive at a more practical, collaborative and victim-centered protocol that *may* include the following:
    a) A telephone notification by the advocate to the survivor prior to their arrival at the hospital of their right to have an advocate present at any and all phases of the process, and a general overview of the process and other rights the survivor has within it;
    b) An estimated time of arrival notification to the detective by the advocate so that they can coordinate and make use of the time they have available on the crime scene;
    c) The need for any additional services such as interpreters, assistance and resources for survivors with disabilities, or severe intoxication that should be accounted for when planning resources and immediate interactions.[46]
2. Statistics about access to and use of advocates should be kept consistently and shared between MPD and NVRDC monthly to work out any issues that arise.[47] Those statistics should include how many:
    a) Cases were eligible for advocacy services at the time of report;
    b) Advocates spoke with the detective and the survivor prior to arrival at the hospital to advise the survivor of their rights and the process generally;
    c) Advocates participated in initial interviews with law enforcement;
    d) Survivors declined advocacy services entirely;
    e) Survivors declined advocate participation in the initial police interview;
    f) Cases exist where MPD did not contact NVRDC to participate either via phone or at the hospital.
    g) How long it took the advocate to get to the hospital after notification by the DCSANE hotline.[48]

[46] This possible component of the coordinated response is not meant to indicate that these things are not being provided currently. All evidence gathered indicates that they are. This is merely intended to provide additional coordination time for the advocates and the forensic nurse to put such resources in place to make the process more seamless for the victim.
[47] Eventually these statistics and any issues can be discussed in the Sexual Assault Response Team (SART) meetings, but it's important in early stages of this process to build the partnership between MPD's SAU and NVRDC and iron out any initial issues in one-on-one meetings.
[48] This time measure is intended to ascertain whether additional staffing is needed at particular times of the day or week, and whether a full time NVRDC presence at the hospital would be eventually warranted.

3. MPD and NVRDC should jointly submit their protocol to the SAVRAA Independent Expert Consultant to recommend amendment to the language surrounding the provision of a sexual assault victim advocate during the police interview.[49]
4. Amend the language surrounding confidentiality in SAVRAA, specifically §14-312(b)(3) to add the following:

> (4) The confidential nature of the communication is not waived by: the presence of a third person who is required for the response at the time of the communication; group counseling; or disclosure to a third person with the consent of the victim when reasonably necessary to accomplish the purpose for which the advocate is consulted.
>
> (5) Except as provided in this Act, no sexual assault victim advocate shall be examined as a witness in any civil or criminal proceeding as to any confidential communication without the written consent of the victim or the representative of the victim as provided in subparagraph (B).
>
> (6) The presence of a sexual assault victim's advocate or sexual assault counselor does not operate to defeat any privilege otherwise guaranteed by law.

***Right to Toxicology Evidence Kit Results and Notification of Law Enforcement Contact with the Suspect***

SAVRAA provides the victims the right to the results of their toxicology reports and evidence kit results upon request from MPD.[50] Because the law has only been in effect since November 2014, it is difficult to gauge whether this is being implemented successfully by MPD. Most survivors request this information through their advocate at NVRDC, and NVRDC reports no difficulty in obtaining this information from MPD or DCFNE as needed on their clients' behalf. There are only two cases in which this was noted out of those reviewed.

To allow survivors ample warning to make safety plans should law enforcement contact with the suspect spark a reaction either from the suspect or from people the survivor and the suspect know in common, SAVRAA requires law enforcement to make reasonable efforts to inform the survivor of their contact with the suspect where it does not compromise the investigation.[51] Like the right to information about toxicology and kit results, it may be too early to discern any patterns or problems with the implementation of this right. Preliminarily, notes do appear in MPD's case files indicating that survivors had been informed of the detective's intent to contact the suspect or that the suspect had already been contacted. Notes also appeared in cases reviewed indicating that the detective attempted to contact the survivor to inform them, and could not make contact after reasonable efforts. Reasonable efforts were defined as two attempts using whatever contact information was available to them in the file, or contacting the

[49] A meeting to start this discussion is scheduled for September 15, 2015.
[50] DC Code §23-1910(1).
[51] DC Code §23-1910 (2).

survivor's advocate if one was listed. In reviewed cases, these notes appeared in 36 (16.7%) cases, some prior to November 23, 2014.

Recommendations

It is recommended that:

1. These notations continue and that they are standardized so that compliance is easily determined and reported.
2. The unit discuss and think through possible acceptable instances in which these notifications might jeopardize a case with a bias towards providing the information if at all possible;
3. Supervisors include these rights as a standard part of their review of cases to ensure that they are observed in all cases where it would not jeopardize the case;
4. When this information is not provided, the reasons for declining the request should be clearly written in the file.

**Working With Survivors with Severe and Persistent Mental Illnesses**

One of the most striking observations about the cases reviewed and in interviews with SAU detectives was the prevalence and impact of survivors with severe and persistent mental illnesses. In fact, 38 (18%) of the cases reviewed showed blatant evidence that the survivor was likely severely and persistently mentally ill. That evidence consisted of highly disorganized thinking well beyond that caused by immediate trauma or intoxication alone, and usually a belief that physically impossible events had occurred or continued to occur on a regular basis. In fact, the case review corroborates detectives' collective perception that this population makes up at least 30% of the cases reported. Although unduplicated discrete individuals do not make up 30% of cases reported, there are often multiple reports made by the same person, some as often as weekly or monthly.

Severe and persistent mental illness (SPMI) is generally characterized by a pprolonged diagnosis of psychosis and of functional disability that affects social and occupational areas. SPMI often includes the following disorders: schizophrenia or schizoaffective disorder, major depression, bipolar disorder, and other non-specific psychotic disorders.[52] Further, severe and persistent mental illness can be exacerbated or brought on by a lifelong history of untreated trauma and abuse. A survivor's mental health status also makes them far more vulnerable to additional trauma and sexual assault, at rates 40% higher than non-SPMI individuals.[53] They are also far more likely to attempt suicide as a result of the assault.[54]

That a survivor is suffering from a severe and chronic mental illness is sometimes immediately apparent upon taking the report. This level of disorganized thinking is usually distinct from the impact of a severe immediate trauma such as sexual assault or that brought on by intoxication or drug use alone. A survivor with SPMI may report that an assault was committed by a perpetrator coming through the air conditioning vents, light fixtures above them, a light switch on the wall, by people who live in other parts of their bodies, or that the suspect assaulted them without ever touching them. In other instances, the survivor's mental health status becomes apparent as the investigation continues over time and the detective has multiple interactions with them.

None of these examples should be taken to mean that an assault did not take place. However, the confusion of time and place and an inability to identify or describe a specific person makes conducting an investigation extremely difficult if not impossible in some cases. Detectives have been extremely resourceful in trying to serve this population of survivors, even

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[52] Burlingame, G., Seaman, S., Johnson, J., Whipple, J., Richardson, E., Rees, F., O'neil, B. (2006). Sensitivity to change of the Brief Psychiatric Rating Scale-Extended (BPRS-E): An item and subscale analysis. *Psychological Services, 3*(3), 77-87.

[53] Khalifeh, H., Moran, P., Borschmann, R., Dean, K., Hart, C., Hogg, J., Howard, L. (2015). Domestic and sexual violence against patients with severe mental illness. *Psychological Medicine Psychol. Med., 45*, 875-886. This study compared male and female SMI patients with the non-SMI victim population. It is one of the only studies utilizing a direct control group to compare rates of victimization and reporting behavior. And generally, Teplin, L., Mcclelland, G., Abram, K., & Weiner, D. (2005). Crime Victimization in Adults With Severe Mental Illness. *Arch Gen Psychiatry Archives of General Psychiatry, 62*, 911-911.

[54] Khalifeh, et. al., 2015, pg. 883.

after it may become apparent that no assault took place that they can investigate. Detectives have secured homes, requested that the survivor be moved to a shelter with either more appropriate care or more secure living quarters, and requested resources from MPD's Victim Services Unit and the DC Department of Behavioral Health's CPEP Mobile Unit when acute psychological crisis is apparent. However, the lack of needed advanced training, direct resources and protocols to serve this population outside of acute crisis has been detrimental not only to the investigation, but to the reporting victim who may not feel heard or like anyone can help them because of their mental illness.

The District has multiple resources aimed at helping this population, but much like other jurisdictions[55], those responses are all designed for crisis intervention situations in which the mental health consumer is a danger to themselves or others in which they are in danger of being arrested, involuntarily committed, or harmed in some way. The Comprehensive Psychiatric Emergency Program (CPEP) Mobile Unit will respond when someone is a danger to themselves or others, and MPD's Crisis Intervention Officers (CIOs) are specially trained to defuse street-level situations involving mental health consumers in acute crisis. DC's Fire and Emergency Medical Services (FEMS) also has a protocol in which frequent 911 callers are identified and wraparound services are offered to address the underlying causes of a repeated crisis level situation prompting the 911 calls. While all three of these programs are extremely successful and highly useful in the situations for which they were designed, this response would need to be more nuanced to be applied to the SAU's population of severely and persistently mentally ill survivors.

Based on the extremely complex needs of this population and their increased likelihood of being sexually assaulted, it is imperative that they be empowered to participate in the investigation while also receiving additional supportive services. It is not necessary to distinguish between those who are reporting out of psychosis and those who are reporting actual assaults. Rather, the investigative process at MPD should and does remain the same for these cases.

Recommendation

The following should be undertaken to add to the SAU's available tools and resources:

1. A trauma specialist highly experienced in working specifically with those with severe and persistent mental illness should be contracted by the District of Columbia to work with MPD to provide the following for the SAU:

[55] Houston, Texas has a Chronic Consumer Stabilization Initiative (http://www.popcenter.org/library/awards/goldstein/2010/10-13(F).pdf) and Long Beach, CA has a Mental Evaluation Team (http://www.popcenter.org/library/awards/goldstein/1999/99-33.pdf) that each provide a multidisciplinary team approach to addressing the issue of repeated interactions with police by those with SPMI. These models have proven successful and have garnered praise from the Center for Problem-Oriented Policing, but focus primarily on material resources and medication management for potential criminal justice offenders rather than serving victims of crime.

   a) On-call, in person assistance with interviews for survivors who show a need for additional support beyond that which a community advocate or victim services specialist can provide;[56]
   b) Forensic interviews of survivors and consultation with detectives where needed;
   c) Assistance coordinating with the city's mental health system and the resources the survivor may already be accessing;
   d) Referral to a specialized trauma program at Community Connections or Green Door to begin to address what may be a lifelong trauma history and to help stabilize the survivor so that they can participate in their case more effectively.
2. Meet with relevant stakeholders to include Green Door, Community Connections, the CPEP Mobile Unit, and Fire and EMS Services (FEMS) to design this new position and bring together existing resources in a clear protocol for the SAU to employ when requesting assistance;
3. Develop training about mental illness, specifically SPMI, for the SAU and the Victim Services Unit so that they can communicate more easily with this population and utilize the new protocol correctly.
4. Similarly, training needs to include available resources and processes for handling crisis level situations such as suicidal intent or an extreme level of disorganization to such a degree that the individual may be a danger to themselves or others.

By employing this training, direct resources on the ground and a clear protocol governing their use, highly vulnerable survivors will receive a more meaningful and helpful response from MPD and be empowered to participate in their own cases.

[56] While MPD's Victim Services Unit can provide referrals for counseling and psychiatric care, and can also contact CPEP where appropriate, this issue is reported by them and shown in case responses to be beyond their capacity as well and should not be considered within their realm of sole responsibility.

**Citizen Complaints**

Copies of 24 citizen complaints filed between March 2013 and March 2015 were provided by MPD's Internal Affairs Department and the District's Office of Police Complaints in response to a request for any and all complaints filed in any manner, i.e. email, letter, PD-99 Citizen Complaint Form, or forwarded to MPD from the Office of Police Complaints.

Of 24 complaints provided, six were filed against SAU detectives.

1. One was related to a traffic stop the detective had conducted, and one was an allegation of theft by the suspect because of property held in evidence. These were not reviewed.
2. Two additional complaints involved persons who were severely and persistently mentally ill, who filed the same complaint repeatedly and were alleging things that were not practically possible. Both of these complaints were unfounded and the detectives exonerated, but full investigations were still conducted by supervisors and Internal Affairs.[57]
3. Two complaints related to sexual assault cases. Of the three charges alleged in the complaints – violating interview protocol, failing to gather required evidence and disrespectful behavior towards a survivor - the charge of disrespectful behavior towards the victim was sustained. These were appropriate results based on extensive interviews and documentation of the investigations.

One complaint was filed against the Youth Investigation Division, and the remaining 17 were filed against patrol officers but only eight of the remaining 17 were related sexual assault cases.

1. Almost all of the complaints alleged that officers were cited for failure to take a report or notify SAU appropriately.
2. Six were accused of demeaning and victim-blaming language about manner of dress and alcohol consumption. One officer was disciplined for arguably extreme violations of department policy including demeaning and victim-blaming statements regarding alcohol consumption and manner of dress of the reporting victim, as well as and interrogating her.
3. Two complaints against patrol officers were filed by individuals who could not identify an officer in particular and as with complaints against SAU detectives, showed indications of the complainant being severely and persistently mentally ill.

The relatively small number of complaints is encouraging, as is the fact that SAU detectives are rarely the subjects. However, the complaints about patrol officers raises the question as to whether all appropriate cases are being forwarded to the SAU, or if they are not being taken seriously or recognized as such by patrol. This concern is reflected in the in the recommendations about training. The complainants who appear to have mental health challenges also highlight the importance of the recommendation above regarding working with the mentally ill and of addressing the needs of this vulnerable population.

[57] Because there are so few complaints, no details about these complaints are being provided or discussed to avoid identifying the complainants.

Beyond the training outlined below to address issues raised specifically about patrol officers, the SAVRAA Task Force's detailed recommendation to create a SART-led complaint process for any and all organizations and agencies with which a survivor would interact should resolve any issues or question about whether all sexual assault-related complaints were found or identified by Internal Affairs, how they were resolved, and whether the complaints that were identified were actually properly related to sexual assault cases.[58] This new process will provide the SART with a way of making recommendations on an ongoing basis to address any patterns that arise in complaints filed. The Council is scheduled to receive this recommendation in final form by September 30, 2015.[59]

[58] The SAVRAA Task Force recommendation takes in to account the Fraternal Order of Police Union Agreement requirements under which MPD must function as well as local and federal employment and personnel laws.
[59] The draft recommendation can be found on the Office of Victim Services website at http://www.ovs.dc.gov.

**Training**

These training recommendations are the result of interviews with all Sexual Assault Unit detectives and with survivors who have reported to law enforcement since March 2013, as well as the above-described review and analysis of MPD's case files, and citizen complaints. The documentation of existing training and recommendations listed below are intended not only to address any shortcomings or problems that may have become apparent in the previous sections, and also to provide additional tools for the SAU to increase their already considerable professional skills as detectives.

**Training Previously Provided and Reviewed**

The current training on sexual assault was reviewed in December and January 2014 with the considerable assistance of the staff at MPD's Police Academy for both In-Service and New Recruit Training divisions. The trainings documented and reviewed for patrol officers and detectives are as follows:

New Recruits (each class)

- DC Code Crimes Against Persons 2014 (opportunity to observe pending)
- Domestic Violence 20 hour block (includes sexual assault as a component of domestic violence)

Patrol Officers

- Sexual Assault Training for First Responders (4 hours in person at MPA for all patrol officers - In-Service Training 2013).
  - Myths and Facts Explanations Seen by First Responders (30-45 min)
  - Adult SA Investigations G.O. 304.6 (1 hour)
  - Neurobiological Impact of Trauma as Seen by First Responders (1 hour)
  - Crime Scene Management in SA Cases (1 hour)

- Roll Call Briefing Scenarios for Patrol Officers (approx. 15 minutes during roll call briefings for patrol officers on the dates indicated in all MPD police districts for all shifts)

  - Investigate the Trouble — May 4,9,14,19,24,29, 2013
  - Suspicious Vehicle — March 2, 8, 14, 20, 26, 2013

Note: The titles of these roll call briefings do not immediately indicate a sexual assault topic. The exercise requires officers to identify the elements of sexual assault from a random situation, and then determine whether the SAU should be called to respond.

Detectives

- Investigating and Prosecuting Sexual Assaults: Beyond the Basics by Joanne Archambault 2-day training (March 2013)
- Understanding Crime Victims' Responses to Trauma and Resources (April and May 2014, and April 2015). Training provided by NVRDC.
- Cognitive Behavioral Interviewing (Need dates, who taught the course, who received the training, as well as the training materials.)
- SITEL Module (Web-based training module): General Order 306.04 Adult Sexual Assault Investigations (All personnel to date).

**Findings and Recommendations**

Curricula reflect the general order at the time the training was given and are victim centered and trauma informed, as well as relevant and technically correct. However, there is no consistent and increasingly advanced program of training about sexual assault investigations or trauma informed strategies. The training that exists is provided intermittently rather than what would ideally be provided as a consistent menu of ongoing and progressively advanced options.

Basic guidelines this recommended training program should follow to help law enforcement participate effectively within the coordinated community response are:

- Training should be provided by and/or with those working directly with survivors in partnership with law enforcement so that the relationship between them can be solidified and common vocabulary and cross-training is maximized.
- Tangible and practical tools, policies and protocols for officers and detectives should be provided and emphasized along with any data or theory provided.
- Voices and first hand perspectives of survivors themselves should be considered as part of the curriculum where possible.
- The curriculum should be relevant to the District even if a trainer has been brought in from another jurisdiction to discuss best practices.

Because the objectives and learning needs are drastically different for patrol officers and detectives, recommendations for training and the reasons for those recommendations are listed separately below.

*Patrol Level*

Patrol officers are required by General Order 304.06 to determine whether the reported crime has a sexual element and if so, to gather basic information, secure the scene and ensure victim safety, and call the Sexual Assault Unit. While this seems relatively simple, it is actually more challenging in application. The officer has to first determine whether what is being reported might fit into one of the categories provided to them in the DC Code Crimes Against Persons training and contain a sexual element, and then gather basic information, but no more than that, from a traumatized victim who may be intoxicated, drugged, angry, in a state of partial undress, and talking about things that may make that officer personally uncomfortable. The officer then has to cut that conversation off to contact the Sexual Assault Unit and indicate to the victim that he or she won't be discussing it further with them.

Interviews with Sexual Assault Unit detectives and supervisors as well as survivors, and reviewing citizen complaints, indicates that while officers are getting better about calling them for every potential sexual assault case they encounter, they still require additional training.[60] Interviews with survivors indicate that patrol officers were sometimes dismissive of a complaint. More often, survivors reported that officers were "visibly uncomfortable" and used vocabulary that indicated the encounter was consensual when it was not. Advocates for LGBT survivors and one LGBT survivor who were directly interviewed indicated that the officer seemed particularly uncomfortable and doubted the assertion that there was a sexual element at all to the assault when one was clearly present.

[60] Detectives also unanimously indicated that they would much rather be called for something that is not sexual assault and are happy to respond to those rather than miss a case that is a sexual assault because officers are being too conservative about calling them.

To provide patrol officers with the training they need to have these conversations and to provide them with tools to more effectively transition the investigation from patrol to the responding SAU, the following training should be provided to new recruits and patrol officers on a bi-annual basis. This training should be developed in collaboration with SAU detectives and NVRDC advocates to ensure that the team approach is instilled at all levels of the response.

New Recruits

*DC Code: Crimes Against Persons (2014):* This training needs to be updated as follows:

- Include active scenario based training that allows recruits to role play scenarios that are ambiguous or may be outside of their own cultural norms such as sexual assault as part of a domestic violence call, sexual assault of a sex worker, and sexual assault in a same sex relationship, etc. Recruits also need to be provided with scenario based training so that they can identify areas or issues they may have trouble talking about generally.
- Model vocabulary to avoid both overly sanitized language and judgmental statements when asking legitimate questions about the situation, and emphasize asking open-ended questions. An example of overly sanitized langue is the overt instruction given to new recruits in a handout telling them that it would be appropriate to ask "did the suspect engage in intercourse with you?" or "Did you engage in oral sex with the suspect?" While this sounds like a polite and gentler way to ask about a sensitive topic, to a victim of sexual assault it sounds like the officer is asking about entirely consensual sexual activity rather than an assault. Being able to ask basic questions in a sensitive manner requires that these situations be modeled in all of their potential complexity so that officers can develop their own organic way to speaking to survivors in a trauma-informed way. Deliberately judgmental statements and attitudes can also be addressed in this forum.
- Include a section on nonverbal and environmental clues that sexual assault may have occurred in scenarios where it may not be immediately obvious such as a burglary, family disturbance, or investigate the trouble call.

*Domestic Violence: 20 hour block*: This training can be left as is, though a stronger emphasis on the prevalence of sexual assault in violent relationships would be ideal.

Field Training Officers

Field Training Officers (FTOs) have a huge influence on whether a new recruit continues to behave as he or she was trained at the Academy or becomes acculturated to the norms of more experienced officers who may hold less victim-centered views. Therefore, all experienced and new FTOs should take part in the scenario based training for sexual assault for new recruits, as well as the portion about modeled vocabulary and how to identify sexual assault beyond a direct report.

Existing Patrol Officers[61]

*Training on the new General Order 304.06:* This component should be developed and provided in collaboration with SAU staff and the Network for Victim Recovery of DC and include an emphasis on the following:

- *Modeled vocabulary: What to say and how to say it*

[61] This includes FTOs.

This training would include a discussion about overly sanitized language discussed above and what to say instead. Scenario-based training and modeled conversations are essential for the success of this component. Deliberately judgmental attitudes and statements can be addressed through this module.

- *How to gather basic information without getting into details*
  This learning objective includes asking more open-ended questions to get enough information to know whether to call SAU.
- *Calling the SAU and what to expect/how to work with them.*
- *Transitioning the case over to SAU and communicating that to the victim.*

*Sexual Assault Cases within Special Populations: 2 hour block.* While this is entitled Special Populations, it is a catch-all category to address noticed and reported problem areas, and those requiring more specific cultural knowledge or awareness, such as cases involving sex workers, LGBT victims, victims with disabilities, college students, and intoxicated or drugged victims.

Relevant community service providers such as HIPS and Fair Girls (sex workers and human trafficking victims), SMYAL, Whitman Walker Health, and MPD's GLLU (LGBT victims), Project Peer (survivors with disabilities), and Men Can Stop Rape (campus culture and drug and alcohol facilitated sexual assault), can provide individual pieces of this training for the portion relevant to their service population.

*Trauma and the Neurobiology of Trauma:* This training should be provided as it has been, but it should be updated to include tools for talking with someone who is traumatized and managing them on a crime scene. The current curriculum is an excellent introduction to the concept, but does not operationalize the information sufficiently. NVRDC can provide this training.

Detectives

Existing SAU detectives have all received the trainings listed above, but they are lacking in the follow up information they need and desire in order to continue to improve their performance and operationalize this information. The following should be offered to all existing SAU detectives on a regular basis.

*Interviewing Sexual Assault Victims: 4-6 hours of instruction with a 2 hour follow up block provided by SAU supervisors about how the new training should be operationalized in documentation and warrants.* Detectives have received training on Cognitive Behavioral Interviewing (CBI) and report that the idea behind it is useful. However, the practical application takes too long to set up and is far more than a traumatized survivor, particularly someone with any challenges such as a mental illness, intellectual disability, or substance abuse issue, can truly utilize. Therefore its utility to detectives is limited. Instead of CBI, the unit should be trained in the Forensic Experiential Trauma Interviewing (FETI) technique, created by Russell Strand from the Army Military Policing Academy. Similar to CBI, but much more detective and victim-friendly, this technique allows the victim to provide what they can and gives the detective tools to fill in the trauma-created blanks more readily. It also naturally includes the tools for operationalizing the Neurobiology of Trauma training, and provides a gateway for a more naturally empathetic conversation.

In addition to the FETI technique, report writing and general vocabulary around assault, force and consent can be provided by Legal Momentum through a grant from the US Department of Justice. They have provided this curriculum for judges, prosecutors, detectives and police officers nationwide. The training focuses on shifting from the language we normally use to describe or categorize consensual sexual activity to that which describes a potential or verifiable

crime. Legal Momentum has indicated that they are willing to provide this technical assistance and training for MPD and the US Attorney's Office as one of their grantees.

*Trauma and Sexual Assault Victims: 2hr block.* This component should be Part II of the Neurobiology of Trauma, and like the segment provided to patrol officers, needs to be operationalized to alter speech, body language, vocabulary, and interview structure based on where the survivor is in terms of their level of trauma.

*Sexual Assault Cases within Special Populations: 2hr block (see description for patrol officers).* While this is entitled Special Populations, it is a catch-all category to address noticed and reported problem areas such as cases involving sex workers, LGBT victims, victims with disabilities, college students, and intoxicated or drugged victims. Based on survivor interviews and review of cases, the emphasis in these populations should be on college students and intoxicated and/or drugged victims.

*Working with Mentally Ill Survivors:* While we don't expect or want detectives to determine whether someone is mentally ill, sometimes it is apparent that the survivor has pre-existing challenges. This training focuses on the most likely symptoms, signs and disorders, as well as ways to determine what part of the narrative may be distorted by the mental illness, facilitate an easier discussion in spite of the victim's disorganized mental state, and when and how to get appropriate help for that victim either in the interview process or as an adjunct to it. The DC Department of Behavioral Health, Green Door and two private practitioners in the District have offered to collaborate to create and give this training on a regular basis and serve as ongoing resources to answer questions.

*Working with Your Partners: The Forensic Investigation, Forensic Nurse and Advocate Process:* This training is a collaborative effort with NVRDC, DFS, and DCFNE to allow the SAU and their partners to better define their respective roles and how those roles function as a whole. A better understanding of the forensic nurse process, the entire forensic investigation process including other items that can be useful from a crime scene beyond the kit and the victim's clothing, as well as how advocates work and how they can be useful as partners is essential to building a collaborative team approach to these cases. This training would be an ideal vehicle to increase teamwork between the forensic nurses, advocates, detectives and forensic analysts.

**Additional Recommendations:**

Scenario-based training for patrol and new recruits requires additional staff. The Police Academy currently does not have adequate to provide this essential form of training and would require at least 4 additional instructors per new recruit class as well as additional staff for any in-service curriculum provided to existing patrol.

Incoming SAU detectives go through a 30 day on the job training period where they shadow an experienced detective. They are then on their own. Within the first 90 days of their placement in the SAU, incoming detectives should receive, at minimum, the following, before they are on their own:

- *Trauma and Sexual Assault Victims*
- *Interviewing Sexual Assault Victims*
- *Working with Mentally Ill Survivors*

These recommendations have been provided to MPD, and work is ongoing to develop these trainings and bring in the recommended outside resources to accomplish more specialized components such as the FETI technique and the training regarding working with the mentally ill.

By providing this menu of trainings as a complete and recurring menu of options, MPD can point to a highly trained specialized unit that is constantly progressing with national best practices, as well as well-trained patrol officers employing best practices for victim centered policing. With these topics as a baseline, the department can also add various mini-topics to the menu as issues arise such as suspect typology and behavior, serial offenders and how to identify them, new strategies in drug facilitated sexual assault, or more mundane topics like report and warrant writing for particular kinds of sexual assault cases.

**Staffing and Resources**

Before discussing the issues related to staffing and resources that were made apparent in this review, it is critical to point out the high quality of staffing currently in the Sexual Assault Unit from supervisors to detectives to the officers who track and deliver PERKs to DFS and OCME.[62] Currently, this is an extremely dedicated group of people who are genuinely concerned for the welfare of survivors, and this dedication was apparent in all aspects of this review.

Having reviewed all of MPD's policies and procedures, read 215 cases, interviewed 26 survivors, as well as 17 SAU detectives and all supervisors, the most significant problem impacting MPD's response to sexual assault cases that is within MPD's direct control is the staffing and resources provided to the SAU. The unit is understaffed and under-resourced for the job with which it has been tasked under SAVRAA and MPD's general orders and standard operating procedures. Manpower is currently a problem department-wide and its impact on the SAU is significant.

Currently, there are 19 detectives assigned to the SAU's New Case Intake Unit, and two additional detectives assigned to the Cold Case Unit. There are three sergeants and one lieutenant dedicated to the unit and the unit shares a captain with all of the Criminal Investigation Division units. While this sounds like a robust allotment of resources, when compared to the consistent increase of cases reported, the way that the response itself is structured, the commendable review process required by the general order and the standard operating procedure, the requirements of SAVRAA, as well as the current special detail requirements for this staff group, the hours available for actual investigative work leaves detectives and supervisors working overtime on an almost daily basis.

Case review showed a pattern in which the new case intake process worked exceedingly well. Detectives do a tremendous amount of initial work to ensure that all evidence is gathered, and witnesses located and interviewed if at all possible. However, follow up and the continuation of these witness interviews and evidence gathering then becomes a significant logistical challenge. As detectives are following up on cases, they must also be on call to take in new cases as they come in, and are sometimes working a shift on their own, or responding to overlapping cases in one night. Staffing levels and resources impact a detective's ability to follow up with a victim and keep them informed, interview all available witnesses, follow up on evidence kit processing reports, and conduct non-custodial suspect interviews.

According to the Police Executive Resource Forum (PERF) the number of detectives should be based on the number of cases that a police department must investigate and the amount of time required to conduct a thorough investigation. A thorough investigation is defined by PERF as "one that results in a case that is prepared for prosecution, or one in which all leads have been followed and exhausted."[63]

[62] The Sexual Assault Unit has experienced an 89% staff turnover since 2012.
[63] Police Executive Forum (PERF), Anchorage Staffing and Deployment Study, August 2010, pg. 11.

Two factors not mentioned by PERF must also be taken into account. First, the District of Columbia is a highly complex environment where survivors and suspects may be transient, homeless, or otherwise difficult to reach, where there are eight college campuses generating a particular type of complex report, and where tourists and others often come from all over the world producing unique challenges for following up on reports. Second, the case intake process mandated by department policy also drives staffing needs. In many jurisdictions, sergeants assign days old patrol reports to detectives and those cases are pre-screened for whether they can be successfully investigated or not and most units do not work 24 hours a day. In that kind of system, a case may be tabled before it has even truly started and victim needs may be secondary to the unit's work hours. In the District, patrol is making a telephone notification to a 24-hour a day unit that responds to the scene of the report or the crime within a few hours of that call at most to begin the investigation immediately with no scoring or pre-screening system.[64] By department policy, all cases are treated as possible successful investigations until all evidentiary leads are exhausted. This highly beneficial model should not be sacrificed for staffing efficiency purposes.

In one of the few staffing and deployment studies to address detective staffing levels in addition to patrol, the PERF determined that Anchorage, Alaska's Police Department's optimal level of staffing was eight detectives and two sergeants, and one administrative staff person to investigate 408 cases.[65] If we apply PERF's math to MPD's staffing and case numbers, the SAU is understaffed by comparison. When we consider that Anchorage is far less complex, has half the population size of the District and a unit only open during regular business hours, the comparison becomes even more weighted.

Reports of sexual assault are increasing annually. From 2013 to 2014, reports of sexual assault increased by 17% with 1102 cases filed in calendar year 2014 compared to 939 cases filed in 2013. While this could be attributed to a vastly improved system since 2012, the number of cases thus far in 2015 has already exceeded the number reported at this time in 2014.[66] This leaves 19 detectives to manage approximately 1250 cases, or 65 cases per year by the end of 2015. Each case requires an estimated 30 hours of work on average from start to finish according to this case review and the estimates used by PERF in their staffing and deployment studies. Initial intake requires 4 hours at minimum even if the case requires no additional investigative time. Using a 30-hour average for each case and 65 cases per year and an eight-hour shift, investigative time alone consumes 1,950 hours or 48 weeks each year on average, not including time spent in court, grand jury or warrant review.

[64] A range of staffing rates was found in a survey of special victims or sexual assault units in cities with population sizes similar to DC. Baltimore City Police investigate cases involving anyone age 16 and older and average 400-450 investigations a year with 12 detectives. Memphis Police Department investigates approximately adult 500 cases each year and has seven detectives, while El Paso, TX has 15 detectives and investigates approximately 200 cases each year. The definitions of units and sexual assault or abuse cases vary widely as to the ways in which these cases are handled.
[65] PERF, Anchorage Staffing and Deployment Study, August 2010, pg. 132-134.
[66] DCFNE, DC SANE Mid-Year Report, 2015, and MPD's SAU Case Records 2013-2015.

There are other factors which take up detective time not included in this calculation. Depending on the outcomes of their cases, detectives spend 1-2 days a week in court, getting search warrants and grand jury appearances. Like homicide detectives, SAU detectives are exempt from redeployment, but unlike homicide detectives they are required to do approximately 80 hours (2 weeks) or more every year of special details such as All Hands on Deck (AHOD) and others such as the Pope's upcoming visit.[67] Additionally, non-SAU related training also accounts for 60-80 hours (1.5-2 weeks) of time.

Leaving the SAU understaffed creates the following deficits:

1. Detectives may not have the time to speak to survivors in a fully present, trauma-informed manner or to set up interviews properly because of time constraints even though that is their clear intent.
2. Keeping survivors informed about their cases is extremely difficult as is proper workload management, though this will improve for 1/3 of the cases when forensic evidence reports are routinely returned appropriately within 90 days.
3. Non-custodial interviews and other follow up are difficult if not impossible to schedule proactively because case intake may come up during the scheduled time or a car may not be available.
4. Detectives may be responding alone and/or have more than one case reported during a shift. The most reported was four in a shift. This means that patrol is held up on the second or third scene of the crime, as is the survivor waiting for the detective to arrive there or at the hospital.
5. The potential for burnout for committed and skilled detectives is high, particularly given the nature of their work.
6. Case review by supervisors becomes stalled because cases are sent for review to too few sergeants and lieutenants.
7. Administrative tasks are often assigned to detectives and sergeants including vehicle maintenance, scheduling, and coordination of PERK transport further interfering with investigative time.

Recommendations

To ensure that this system and the new legal requirements are sustainable, ideally the Sexual Assault Unit would become a Branch under General Order 101.10, which defines a branch as a sub-element of an office or division that typically has two or more sections.[68] The Sexual Assault Unit arguably qualifies as a Branch because it has New Case Intake, Cold Case, the Sex Offender Registration Unit, and the Gun Owner Registration Unit (GORU) under its umbrella. Instead of sharing a captain with all other parts of CID, the Sexual Assault Unit would

[67] Cases are assigned to specific detectives. If something occurs in the case, or a victim has a question while the detective is on a detail, they have to answer these as they are available and cannot do the work required until they return.
[68] Metropolitan Police Department, General Order 101.10. Revising Organizations, Functions and Staffing, 1984.

have a captain dedicated solely to sexual assault and be able to command the resources and respect that the Homicide Branch currently does.[69]

Whether it becomes a branch or remains a unit in name, the minimum staffing that should be mandated for the SAU to adequately investigate sexual assaults in a truly victim-centered way and according to all protocols and processes is:

1. One dedicated captain for sexual assault cases only;
2. One dedicated lieutenant;
3. One sergeant assigned to the Sex Offender Registry Unit (SORU) and the Cold Case Unit;
4. One administrative sergeant or a civilian administrative staff person;
5. Three sergeants assigned to New Case Intake;
6. 24 detectives assigned to New Case Intake so they can operate in three shifts of eight;
7. Two detectives assigned to the Cold Case Unit;
8. Three SORU personnel, or exempt this unit from redeployment to provide consistent staffing;
9. Vehicles assigned to pairs of detectives, i.e. a minimum of 13 cars.

Finally, two additional recommendations depend on the implementation of the minimum staffing listed above, without which they are infeasible:

1. Detectives should contact survivors in open cases to update them about the status of the case every 30 days.
2. One detective should be named as a liaison to the each of the colleges and universities in the District to increase coordination of response and help provide outreach and education with the schools' respective Title IX staff and sexual assault advocates/counselors.

While this staffing recommendation may be a significant challenge for MPD currently given very real department-wide manpower issues and pressures, the SAU should be positioned as an elite unit that other detectives aspire to join only if they are suited for the unique skills it requires. Remaining victim-centered as caseloads increase will be a challenge without sacrificing some of the review protocol that makes the unit function so well now even under its current resource gaps and pressures. This review protocol is essential to ensuring that any biases that do exist, even those borne out of a need to prioritize what is currently an overwhelming workload, do not create disparate survivor experiences or case outcomes. Similarly, the immediate response from the SAU is critical to providing a highly trained and well-informed response almost from the first moment a survivor reports a sexual assault case.

As new staff is added, the SAU will likely need to move as they are currently lacking in adequate space for their offices and for survivor interviews. The physical location of the SAU is also not as victim-centered as it could be. Although it is located centrally in the city and the unit

[69] Currently, the Homicide Branch is staffed by 36 detectives and six sergeants, one dedicated captain, two lieutenants, and an administrative sergeant, as well as a dedicated vehicle maintenance officer and a TACIS clerk. Homicides are increasing and they require a significantly different investigation pattern than sexual assault cases, but the resourcing disparity remains large with 36 detectives investigating 105 homicides in 2014.

itself is secure on a restricted floor, its interview room is located across the hall from suspect interview rooms, which can create a situation in which the survivor is encountering their own or someone else's attacker, regardless of police supervision. It is also in a building co-located with Court Services and Offender Supervision Agency (CSOSA), i.e. the District's probation department where offenders meet with their Court Supervision Officers and come in to do drug testing. While there is nothing inherently suspect or problematic about people coming and going in a public building, this creates an environment where a highly traumatized victim may not feel entirely secure. Like staffing, space is at a premium, but it is an issue that should be reviewed and addressed if at all possible, either with additional smaller spaces to be used as satellite offices in other parts of the city, or relocating the unit to a more suitable space overall.

**Prosecution**

While this review focuses on MPD's response to sexual assault, a pattern emerged in survivor interviews as well as gaps in information available for this review that cannot be overlooked. Survivors whose cases were presented to the US Attorney's Office expressed frustration that eclipsed any they had about MPD's response. The details behind their frustration prompted a closer review of available data and documents provided by survivors from the US Attorney's Office, and a review of cases from the case review in which warrants had been declined. While the reason for declining a warrant may be that there is little chance of winning such a case, often the survivor is simply hearing that no one is willing to try and hold the offender accountable, and that they weren't believed.

Research about why survivors report cases and what they expect in that process shows that they have two primary concerns: being believed and therefore having their experience validated by the system, and preventing their assailant from harming others.[70] In interviews with survivors for this report, their primary expectations and concerns almost uniformly reflected the research results with 85% (22 of 26) of the survivors interviewed indicating in some that they viewed the system as a verdict on their credibility, and that they were extremely concerned about who else the suspect might harm if not stopped. One survivor expressed the issue in terms of losing their chance to be heard even if a jury ultimately might not convict the defendant.

By law, prosecutors have an enormous amount of discretion and often weigh what they know to be prevailing defense bar tactics and judge and jury attitudes in making the decision to go forward with a case. Defense attorneys are skilled at employing common societal myths about rape to cast doubt on the victim's credibility. Given the stress the court process places on the victim, anticipating this strategy as a primary screening tool may actually be a victim-centered strategy in some cases, but if taken too far it leaves the majority of survivors whose cases do not conform to society's idea of sexual assault without the redress they sought when the reported the case to police. Prosecutors also have an ethical obligation to only proceed with cases in which they truly believe there is probable cause that a crime was committed.[71]

To be clear, a high conviction rate should never be considered a sign of success any more than singling out arrest numbers or closure rates are considered appropriate measures of law enforcement success in sexual assault cases.[72] Those rates remain high if only clear cut first degree sexual assaults by a stranger in which force was obviously used against a socially unassailable victim were investigated and prosecuted.[73] There are also many victims who decide that they do not wish to proceed with a case, regardless of how strong it is or the detective or the prosecutor's desired course of action.

However, this admittedly very limited review found a lack of transparency about process, minimal communication about the reasoning behind decisions made, and some cases possibly being refused based on trauma-related contradictions or factors that might make a jury doubt

[70] Patterson, D. and Campbell, R. (2010). Why rape survivors participate in the criminal justice system. *Journal of Community Psychology*, 38(2), 191-205.
[71] Model Rules of Professional Conduct R.3.8(a) (Special Responsibilities of Prosecutors).
[72] AEquitas: The Prosecutors' Resource on Violence Against Women, Valuing Prosecutorial Performance Beyond Conviction Rates in Sexual Assault Cases: Summary of a Roundtable Discussion, 2014.
[73] Beichner, D. (2005). Prosecutorial Charging Decisions in Sexual Assault Cases: Examining the Impact of a Specialized Prosecution Unit. *Criminal Justice Policy Review, 16*, 461-498; and M. Elaine Nugent-Borakove & Lisa M. Budkilowicz, National District Attorney's Association, Do Lower Conviction Rates Mean Prosecutors' Offices are Performing Poorly? (2007).

the victim based on common societal myths. That said, for each case in which that seemed to be the reasoning, there are cases in which it is not, and indeed the USAO went forward with cases with very difficult sets of facts, such as an assault committed against a sex worker, or as part of a domestic violence case. The issue is not necessarily the decisions that are made themselves, but the lack of transparency around those decisions and that process as a whole, as well as the lack of communication that led survivors to attribute bias when there in fact very well may be none.

Looking into these reports and attempting to move beyond anecdotal evidence was extremely difficult. A previously filed Freedom of Information Act (FOIA) request to the US Attorney's Office for aggregate data was reviewed as part of this project. The request was declined for reasons of victim confidentiality. When data was directly requested for this review, the request was declined due to a lack of capacity to generate aggregate data reflecting the needed information. Therefore, the data that is available and used in this review does not come from the US Attorney's Office directly but rather from the Department of Forensic Sciences and MPD's respective records.[74] Based on those sources, the following was discernible: Of 331 cases filed in which a PERK was available as evidence, 88% (291) had not been charged as crimes by December 2014. Of the 40 (12%) that were charged, 9 (25% of the 40 that were filed) were dismissed, 17 (42.5%) were closed with a plea bargain, 2 (5%) were tried and the defendant found guilty, and 1 case was tried and the defendant acquitted.

This data is extremely attenuated because the remaining 291 cases may have been pending results from those kits that were delayed by DFS processing times or the backlog, cases for which the kit was entirely peripheral evidence, or they may be attached to cases that would and should never be presented as warrants by a detective. Even so, these are open questions and survivors who had forensic exams done are expecting a very different result. Therefore, increased communication and transparency about the thought process behind decisions as well as accurate aggregate data are essential to victims feeling confident that their case was taken seriously and they were believed even if a warrant was declined or a case dropped.

As with law enforcement, these survivor concerns can be remedied by focusing more explicitly on procedural justice measures – transparency and consistency in the process, and communicating openly in a trauma informed way - rather than focusing solely on case outcomes. The picture presented by this data and that provided in the section on probable cause determinations above may look entirely different once it is reviewed and explained.

Recommendations

Because detectives and advocates must explain case outcomes based on decisions made by the US Attorney's Office, and because the coordinated community response to sexual assault requires a high degree of teamwork, the US Attorney's Office Sex Offense and Domestic Violence Unit ideally should:

1. Develop the internal capacity to report aggregate data upon request to better facilitate the coordinated community response through the SART.

[74] As of this writing, the USAO is reviewing individual the cases that made up this data set. Their response and any corrections needed will be provided upon receipt. Currently, the total number of case outcomes does not match the number of cases charged because of gaps in the data as it was available or the case may be ongoing.

2. Participate in the SAVRAA reporting requirements applied to DFS, OCME, and MPD or alternatively, report this data to the SART. That data should include the number of warrants signed and declined, a categorization of reasons for declining warrants, grand juries convened and their outcomes, cases prosecuted and their outcomes, as well as the number of complaints received under the Crime Victim's Rights Act.
3. Obtain reports from all forensic evidence testing prior to declining or signing a warrant, offering a plea bargain, or dropping a case.[75] Again, this should be far easier to accomplish with appropriate processing times from DFS moving forward.
4. Attend and/or receive training with MPD's SAU on language use in sexual assault cases, overcoming a consent defense particularly those involving drugs and alcohol, and the Forensic Experiential Trauma Interview (FETI) technique so that this method can be applied throughout the criminal justice process and explained in the courtroom if needed.
5. Retain additional staff to review warrants: Currently there is only one AUSA available to review warrants for adult and juvenile sexual assault and all domestic violence cases. Supervisors can and do step in, but delays impact MPD already pressed staff hours.
6. Participate in staff-level cross-training and facilitated strategic planning with NVRDC's advocates and the USAO's Victim Witness Unit victim witness coordinators to better coordinate communication with and services for survivors.

Once more transparency exists and communication becomes more frequent, survivors' strongly expressed desire for greater attention to procedural justice measures at the warrant and prosecution phase may also help to shed light on patterns in outcomes far beyond conviction rates. These patterns in outcomes and aggregate data can help inform public education campaigns and therefore jury and judicial education efforts about sexual assault and consent.

[75] The reason(s) a warrant is declined is usually noted with more or less specificity, on the warrant or in the file, but there is a gap between those decisions and forensic evidence. Some of this disconnect is due to delays in processing by DFS, but plea bargains have been offered or cases dropped in at least 38 cases in 2014 before evidence was returned. That evidence may not be dispositive, or the survivor may have declined to go forward with the case making it moot and that is why testing was stopped. However, those things should be noted to increase transparency.

**Conclusion and Next Steps**

The goal of this review was to determine whether the Metropolitan Police Department has implemented the Sexual Assault Victim's Rights Amendment Act of 2014 (SAVRAA) according to the letter of the law, and to ensure that sexual assault investigations are being conducted in a victim-centered manner. Although logistically a work in progress, the ultimate conclusion is that they have implemented the new law and are operating from a victim-centered framework. However, the Sexual Assault Unit requires additional staff and an ongoing coordinated training program is needed to ensure that MPD has the capacity to meet the high standards that they have set themselves as well as those that have been set by the law, and to sustain this system with the increasing number reports of sexual assault in the District. With more appropriate processing times for forensic evidence, and the additional staff, training and resources recommended in this report, survivor experiences when reporting to law enforcement as well as case outcomes should improve yet further in the upcoming year.

Having determined that MPD is following the letter of the law and has implemented and is refining new processes required by SAVRAA, the next steps in this process will be to focus on logistical issues, additional training and resources and their impact on the process. Because MPD does not act alone in this coordinated response, additional focus should be placed on how information is shared and victims are served throughout the system, including prosecution and system and community-based victim advocacy. As this report itself demonstrates, it is difficult to gather consistent aggregate data about sexual assault as a case moves through the continuum of services and the criminal justice system because the system actors are just developing the ability to share this information with one another in a more coordinated and robust way. The Sexual Assault Response Team (SART) will be central to this effort and serves as an important vehicle for transparency and collaborative development of the response to sexual assault.

Specific areas for follow up review based on this report include: more explicitly pursuing interviewing survivors to include the experiences of special or vulnerable populations such as homeless, immigrant and LGBT survivors reporting sexual assault; implementation and success of the revised advocate protocol; whether a 24/7 advocacy presence is needed at MedStar Washington Hospital Center and whether that location or the medical entry point itself is a barrier to seeking services; the impact of improved processing times at DFS on investigations as well as the kit tracking database recommended in the PERK Audit; and any progress made with regard to staffing and resources provided to the Sexual Assault Unit.

Subsequent reports will include the following:

- Statutory changes that would positively impact sexual assault survivors and recommendations regarding sexual assault on college and university campuses (November 20, 2015)
- Findings and recommendations related to the SART Case Review Process and the continuum of services established by SAVRAA (November 20, 2015).
- SAVRAA Task Force Recommendations (January 31, 2016).

The Metropolitan Police Department has done a tremendous amount of work to create a process that is both transparent and consistent, and is moving forward using a victim-centered philosophy in which all cases are fully investigated by a group of detectives very committed to their work. The upcoming year's focus by MPD's SAU will further ensure that this process

continues and is integrated successfully into the continuum of services with MPD's partner agencies.

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## Addendum A: Updated Prosecution Data

The following represents revised data about prosecution of a specific group of cases for which the Independent Expert Consultant had preliminary data from other sources. This data constitutes the original list of cases for which the Department of Forensic Sciences had prosecution data as of June 2015. This list of cases has been reviewed and updated by the US Attorney's Office for the District of Columbia and will replace the data discussed on page 46 of the report entitled "The Metropolitan Police Department's Implementation of the Sexual Assault Victims' Rights Amendment Act of 2014."

Of 331 cases in which a PERK was done in calendar year 2014, as of November 20, 2015:

- 39 cases were charged. Of those 39 cases:
    - 21 resulted in a guilty plea.
    - 1 resulted in a trial with a guilty verdict
    - 1 resulted in a trial with an acquittal
    - 9 were dismissed
    - 6 cases are pending trial as of today
    - 1 case is listed as pending, but the defendant fled the country and a bench warrant exists should he ever return to the District.
    - 21 were cases in which the underlying relationship was domestic in nature, i.e. these were domestic violence cases in which a sexual assault occurred with or without other forms of violence.

It is important to note that these numbers do not indicate a prosecution rate per se for 2 reasons. First, they are an arbitrary pool of cases in which the crime was reported between January 2014 and December 2014 and that were charged between January 2014 and June 2015. Other cases may have been charged in the meantime as evidence kits were processed in large batches to resolve the backlog of cases noted in the PERK Audit. Second, the cases in which there are PERKs only represent approximately 30% of the cases reported to MPD each year. There are very likely many other cases that have been charged from among the entire pool of reports to police. These additional cases may alter the calculation considerably. Additionally, we don't yet know how many warrants MPD presented to the USAO stemming from 2014 reports and therefore we don't know what the total number of cases the USAO was drawing from when making decisions. As the forensic evidence becomes available from the backlog, there may be additional warrants presented from those cases as well.

Of the nine cases that were dismissed, five were the result of probable cause arrests in domestic violence cases that also had sexual assaults as part of the alleged offenses. This means the suspect was arrested on the scene of the crime based on the evidence available at that time rather than after a longer investigation by a detective who then seeks a warrant for hte suspect's arrest from the USAO. Therefore, because of the immediacy of the arrest, less information may have been available initially in these cases compared to cases that result from a more detailed police investigation before they reached the USAO. This may explain why some

were dismissed.  Similarly, in two of the cases, the record indicates that the victim did not wish to proceed with the case due to an existing relationship with the defendant.

Dynamic Strategies
Innovations for Social Change

# Audit of Physical Evidence Recovery Kits (PERKs)

By

Elisabeth Olds
SAVRAA Independent Expert Consultant

August 14, 2015

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## Executive Summary

The Sexual Assault Victims' Rights Amendment Act of 2014 (SAVRAA) is the result of survivor and systems advocacy efforts to improve the District of Columbia's response to sexual assaults. Among other important changes such as giving survivors the right to a confidential community-based advocate, the right to receive the results of toxicology and forensic evidence kit testing, and to receive a forensic exam free of charge, the law also defines timely transport and processing of forensic evidence kits, and creates new reporting requirements for the Metropolitan Police Department, the Department of Forensic Sciences (DFS) and the Office of the Chief Medical Examiner (OCME).[1] To ensure and facilitate implementation of SAVRAA, the DC Office of Victim Services was required to retain an Independent Expert Consultant for a period not to exceed two years. One of the specific tasks of the Independent Expert Consultant was to audit the process for delivering and processing the forensic evidence kits, or Physical Evidence Recovery Kits (PERKs), to ensure that these kits were being transported and processed according to the new requirements.[2] This document is the report from that audit.

Physical Evidence Recovery Kits (PERKs), also known as forensic evidence kits or sexual assault kits consist of evidence gathered during a medical and forensic examination performed at the request of a survivor of sexual assault to gather any evidence of sexual assault, document and address injuries from the assault, and also test for and treat any sexually transmitted infections including HIV. The DC Forensic Nurse Examiner (DCFNE) program conducts these exams free of charge for any adult in the District of Columbia who requests one with or without a report to law enforcement.[3] If the survivor wishes to report to law enforcement or has already done so and wishes to continue with that process, the kit is turned over to the Metropolitan Police Department's Sexual Assault Unit (SAU) as evidence. During the period reviewed, kits were picked up in batches by MPD from DCFNE at MedStar Washington Hospital Center twice a week, and delivered to the Department of Forensic Science (DFS) for processing by the Forensic Biology Unit, i.e. the DNA lab.[4] After processing the kit, DFS issues a report of its findings to MPD, and where prosecution has already begun, to the US Attorney's Office or the Office of the Attorney General for the District of Columbia. If DNA is recovered and the case meets certain legal criteria, that DNA profile is uploaded into the Combined DNA Index System (CODIS).

Any exams that were conducted in which drug facilitated sexual assault is suspected[5] also may include blood and/or urine samples that are delivered to the Office of the Chief Medical

[1] DC Code §4-561.02.
[2] DC Code §4-561.04.
[3] Under the Violence Against Women Act of 2005 and 2013, survivors of sexual assault are entitled to a medical and forensic examination free of charge and without being required to report the assault to law enforcement. The process in place in the District of Columbia for adult survivors is compliant with this requirement. 42 U.S.C.A § 3796gg-4(d)(1)(2005).
[4] The Department of Forensic Science's Forensic Biology Unit (FBU) is currently not testing kits in its lab, but outsourcing to private labs until the reorganization of the FBU that began in April 2015 is complete.
[5] The need to test for possible drug facilitated sexual assault (DFSA) is established by a short questionnaire administered by the nurse at the time of the exam.

Examiner (OCME) for testing in their Toxicology Unit. The results are transmitted via email to MPD and/or the USAO.

Under SAVRAA, MPD must retrieve the evidence kit from DCFNE no more than seven days after a police report is made[6] and requires that DFS and OCME process the forensic evidence kits and toxicology specimens, respectively, within 90 days of receiving them.[7] The law also requires that the Independent Expert Consultant verify that any survivor who received an exam and also wished to report to law enforcement had their case properly documented as a report of sexual assault by MPD.

This audit required answers to four questions: 1) were all of the cases in which a survivor had a forensic examination done and wished to report to police documented appropriately as reports to police; 2) were all of the evidence kits and toxicology specimens that were part those cases delivered to DFS and OCME; 3) were those kits and specimens delivered within the time frame required by SAVRAA and the Metropolitan Police Department (MPD)'s Standard Operating Procedure; 4) were those kits and toxicology specimens processed by DFS and OCME respectively within the required 90 days. The answers to these questions are presented in the findings below followed by recommendations for improvements to the system as a whole.

The bulk of the data reviewed and compared for this audit focuses on January 2014 through June 2015. Each agency in this process keeps its own spreadsheet with different tracking requirements. Ultimately, this audit required that these spreadsheets be compared to each other, and that the data also be reviewed in MPD's records management system in individual cases. The total number of cases was also compared across all record keeping systems to ensure that the totals were identical, or at least within an explainable range of each other depending on how records were kept and the point at which a case may have stopped progressing through the system.

The DC Forensic Nurse Examiners (DCFNE), the SANE nurses who conduct the medical and forensic exams, provided a list of all exams for which a report to law enforcement was made, whether immediately or later, from March 2013 through January 2015. This list contained the date of the exam, the patient's initials, whether a PERK, or evidence kit, or only a medical exam was provided, the case number if available, as well as the date the PERK was released to MPD for transfer to DFS and, if relevant, OCME. DFS then provided a list of kits received and the dates of receipt, as well as the corresponding processing times.

The findings from this audit indicate that 1) all of the cases in which a forensic exam was conducted and the survivor wished to report to law enforcement were properly documented by MPD; 2) all evidence kits from those reported cases were delivered to DFS and OCME; 3) the kits and toxicology specimens were delivered in the required timeframe of 7 days by MPD; and

[6] DC Code §4-561.02 (a) "Within 7 days after a sexual assault victim makes a report to the MPD, the MPD shall retrieve the kits and specimens and deliver: (1) the sexual assault forensic examination kit to DFS; and (2) the biological specimens for toxicology testing to the OCME."
[7] DC Code §4-561.02(b)(b) The DFS shall process all sexual assault forensic examination kits within 90 days from the date of receipt; and DC Code §4-561.02(c): The OCME shall process all biological specimens within 90 days from the date of receipt.

4) the majority of kits were *not* processed by DFS within the 90 days required by the statute but the toxicology specimens submitted *were* processed within 90 days by OCME.

## Summary List of Findings

1. Of the 426 cases listed by DCFNE as having been reported to law enforcement, all are documented appropriately by MPD.

2. All of the evidence kits were transported to DFS by MPD. Toxicology specimens are delivered to OCME in tandem with kits and all of those are accounted for as well.

3. The kits were delivered by MPD as required within an average time of 2.45 days of the exam being conducted as shown in the review of kits submitted in calendar year 2014 through February 2015.

4. The data showed a significant problem with processing times at the lab, but these problems are being resolved. Of the 363 cases that should have been tested within the required 90 days by July 1, 2015, 98 were tested within 90 days and 159 were tested but the processing times exceeded 90 days. The average processing time was 114 days, with the shortest at 16 days and the longest at 395 days. An additional 69 kits that should have already been tested by July 1, 2015 were not tested at all. These 69 untested kits constitute a backlog.

5. The 69 backlog cases have been sent to private labs on 15, 30, 45, 60, and 75-day turnaround contracts to ensure that the backlog is cleared up quickly and that it does not continue with incoming cases.

6. The data from the Office of the Chief Medical Examiner (OCME)'s Toxicology Unit showed that the processing times for toxicology specimens were taking place well within the statutory requirement.

7. Seventy-two kits were pulled from the testing queue for a variety of reasons before they were completed and therefore no results reported. There is a disparity in perception between MPD and DFS about what should and should not be tested, as well as a disparity between what victims are led to believe will happen with their kits and the possibility that results will never obtained.

## Summary List of Recommendations

1. OVS should fund two additional analysts to augment the two positions already funded for this project at DFS.

2. The Sexual Assault Response Team (SART) should create a shared database to track a kit from its inception with the survivor at DCFNE through processing at DFS and OCME, and assign a unique tracking number to each kit that will follow the kit through the process.

3. DFS and MPD should determine an adequate staffing level or back up staffing for to ensure that evidence can be submitted immediately when it is brought to the Central Evidence Unit.

4. DFS, MPD, the US Attorney's Office, and the Office of the Attorney General should continue to meet bi-weekly about prioritizing cases for testing and to discuss any logistical problems with testing that exist.

5. MPD, DFS and DCFNE should establish a more open dialogue about what can and cannot be tested in a given case so that realistic and clear expectations exist among themselves and are communicated to the survivor about the utility of the forensic exam.

6. DFS should submit monthly reports to the Independent Expert Consultant until such time as the backlog is resolved and DFS is processing cases within the 90-day time limit established by SAVRAA.

**The Sexual Assault Victim's Rights Amendment Act of 2014 (SAVRAA)**

The Sexual Assault Victims' Rights Amendment Act of 2014 (SAVRAA) is the result of survivor and systems advocacy efforts to improve the District of Columbia's response to sexual assaults. Effective November 23, 2014, this new law provides rights for survivors of sexual assault, victim-centered guidance and regulations for the Metropolitan Police Department (MPD) and other system actors, and defines a clear continuum of services for survivors of sexual assault. Specifically, SAVRAA gives survivors the right to a community-based victim advocate[8]to confidential communication with that advocate[9], and to have that advocate present at any interview with law enforcement[10]. Survivors also have a right to know the results of their toxicology and forensic evidence kits[11], as well as the right to not be billed for any expenses related to their forensic exams[12]. The law also defines timely transport and processing of forensic evidence kits[13], and creates new reporting requirements for MPD, the Department of Forensic Sciences (DFS) and the Office of the Chief Medical Examiner (OCME)[14], as well as the structure and membership of the coordinated community response to sexual assault through the Sexual Assault Response Team (SART).[15] Overall, SAVRAA is designed to implement nationally recognized models of victim advocacy and law enforcement in sexual assault cases.

To ensure and facilitate implementation, the DC Office of Victim Services was also required to retain an Independent Expert Consultant for a period not to exceed two years[16]. One of the specific tasks of the Independent Expert Consultant was to audit the process for delivering and processing the forensic evidence kits, or Physical Evidence Recovery Kits (PERKs), to ensure that these kits were being transported and processed according to the new requirements. This document is the report from that audit.

**Forensic Evidence Kit Process**

Physical Evidence Recovery Kits (PERKs), also known as forensic evidence kits or sexual assault kits consist of evidence gathered during a medical and forensic examination performed at the request of a survivor of sexual assault to gather any evidence of sexual assault, document and address injuries from the assault, and also test for and treat any sexually transmitted infections including HIV. The DC Forensic Nurse Examiner (DCFNE) program conducts these exams free of charge for any adult in the District of Columbia who requests one with or without a report to law enforcement.[17] After the exam, the forensic nurse seals the kit

[8] DC Code §23-1908.
[9] DC Code §14-312(b)-(d).
[10] DC Code §23-1908(1)-(2) and §23-1909.
[11] DC Code §23-1910.
[12] DC Code § 4-561.03.
[13] DC Code § 4-561.02.
[14] DC Code § 4-561.09-11.
[15] DC Code § 4-561.13.
[16] DC Code § 4-561.04.
[17] Under the Violence Against Women Act of 2005 and 2013, survivors of sexual assault are entitled to a medical and forensic examination free of charge and without being required to report the assault to law enforcement. The process in place in the District of Columbia for adult survivors is compliant with this requirement. 42 U.S.C.A § 3796gg-4(d)(1)(2005).

and affixes the nurse's report which contains information about injuries and a basic description of the physical findings to the outside of the kit. The kit is assigned a number by DCFNE and placed in a locked storage unit at MedStar Washington Hospital Center.[18]

If the survivor wishes to report to law enforcement or has already done so and wishes to continue with that process, the kit is turned over to the Metropolitan Police Department's Sexual Assault Unit as evidence. During the period reviewed, kits were picked up in batches by MPD from DCFNE at MedStar Washington Hospital Center twice a week, and delivered to the DFS for processing by the Forensic Biology Unit, i.e. the DNA lab.[19] After processing the kit, DFS issues a report of its findings to MPD, and where prosecution has already begun, to the US Attorney's Office for the District of Columbia (USAO) or the Office of the Attorney General for the District of Columbia (OAG). If DNA is recovered and the case meets certain legal criteria, that DNA profile is uploaded into the Combined DNA Index System (CODIS). The DNA profiles obtained from the testing of the kit may be uploaded to CODIS for searches against the national DNA database which may result in a match to a putative perpetrator or aid in the identification of serial offenders increasing overall public safety.[20]

Any exams that were conducted in which drug facilitated sexual assault is suspected[21] also may include blood and/or urine samples that are delivered to OCME for testing in their Toxicology Unit. The results are transmitted via email to MPD and/or the USAO.

**New Requirements under SAVRAA**

SAVRAA promulgated specific requirements for the transport and processing of PERKs to prevent undue delay, untested or lost kits so that survivors receive the answers they seek about their assault and so that offender accountability through the criminal justice system is enhanced. Under SAVRAA, MPD must retrieve the evidence kit from DCFNE no more than seven days after a police report is made.[22] SAVRAA also requires that the DFS and OCME process the forensic evidence kits and toxicology specimens, respectively, within 90 days of receiving

[18] The majority of medical and forensic examinations are performed at MedStar Washington Hospital Center but if a survivor presents at another hospital and does not wish to go to MedStar, DCFNE and the accompanying advocate from the Network for Victim Recovery will also go to other area hospitals as needed. This process will be discussed in greater detail in the final Independent Expert Consultant's report issued in October 2015.
[19] The Department of Forensic Science's Forensic Biology Unit (FBU) is currently not testing kits in its lab, but outsourcing to private labs until the reorganization of the FBU begun in April 2015 is complete.
[20] A study by David Lisak at the University of Massachusetts showed that 60% of undetected rapes are perpetrated by repeat offenders. Lisak, D.& Miller, P. (2002). Repeat Rape and Multiple Offending Among Undetected Rapists. *Violence and Victims, 17*, 73-84. Retrieved March 13, 2015, from http://www.wcsap.org/sites/www.wcsap.org/files/uploads/webinars/SV on Campus/Repeat Rape.pdf
[21] The need to test for possible drug facilitated sexual assault (DFSA) is established by a short questionnaire administered by the nurse at the time of the exam.
[22] DC Code §4-561.02 (a) Within 7 days after a sexual assault victim makes a report to the MPD, the MPD shall retrieve the kits and specimens and deliver: (1) the sexual assault forensic examination kit to DFS; and (2) the biological specimens for toxicology testing to the OCME.

them.[23] The law also requires that the Independent Expert Consultant verify that any survivor who received an exam and also wished to report to law enforcement had their case properly documented as a report of sexual assault by MPD.

This audit required answers to four questions:

1) were all of the cases in which a survivor had a forensic examination done and wished to report to police documented appropriately by MPD;

2) were all of the evidence kits and toxicology specimens that were part those cases delivered to DFS and OCME;

3) were those kits and specimens delivered within the time frame required by SAVRAA and MPD's Standard Operating Procedure;

4) were those kits and toxicology specimens processed by DFS and OCME respectively within the required 90 days.

The answers to these questions are presented in the findings below followed by recommendations for improvements to the system as a whole.

**Audit Methodology**

The process of gathering information for this report was particularly challenging given that this process changed dramatically during 2013 and only began to function in its current form in January 2014. Therefore the bulk of the data reviewed and compared for this audit focuses on January 2014 through June 2015.

Each agency in this process (DCFNE, MPD, DFS, and OCME) keeps its own spreadsheet with different tracking requirements. Ultimately, this audit required that these spreadsheets be compared to each other, and that the data also be reviewed in MPD's records management system in individual cases. The total number of cases was also compared across all record keeping systems to ensure that they were identical, or at least within an explainable range of each other depending on how records were kept and the point at which a case may have stopped progressing through the system.

DCFNE provided a list of all exams for which a report to law enforcement was made, whether immediately or later, from March 2013 through January 2015. This list contained the date of the exam, the patient's initials, whether a PERK or only a medical exam was provided, the case number if available, as well as the date the PERK was released to MPD for transfer to DFS and, if relevant, OCME. DFS then provided a list of kits received and the dates of receipt.

In DCFNE's records, a significant number of cases were missing case numbers and were therefore untraceable without access to MPD's files. Of the 426 cases listed by DCFNE in

[23] DC Code §4-561.02(b): The DFS shall process all sexual assault forensic examination kits within 90 days from the date of receipt; and DC Code §4-561.02(c): The OCME shall process all biological specimens within 90 days from the date of receipt.

which a PERK was done, 82 (19%) did not have case numbers. The fact that the cases did not have case numbers is not the fault of DCFNE or MPD, nor is it a flaw in the system per se. Rather, it indicates that case numbers were assigned after the exam was completed. The date of the exam and the patient's initials were used to locate the MPD case number in MPD's Sexual Assault Unit spreadsheet. Using MPD's Sexual Assault Unit spreadsheet to identify all cases in which MPD had a record of a kit being done, and removing the cases that already had case numbers in DCFNE's spreadsheet accounted for the remaining cases.

MPD's records management system, iLEADS, was also used to randomly verify DCFNE and DFS' list of dates of release and receipt of kits respectively. In the randomly selected 75 cases verified in MPD's system, no significant discrepancies were found with DCFNE or DFS' records. This indicates that MPD is recording the transport of kits accurately internally as well.

A list of cases was then provided to DFS to obtain processing times for these kits measured from the date the kit is received in their Central Evidence Unit (CEU) to the date a report is sent to MPD and/or the US Attorney's Office.

**Findings**

The current system for providing, transporting and processing PERKs is highly coordinated in some ways, but still a work in progress in others. Overall, kits are accounted for, law enforcement is documenting reported assaults appropriately, and this process is being taken extremely seriously by all involved. However, processing times for PERKs were beyond the statutory limit, and a backlog of untested kits was discovered. Most issues that are noted below are the result of resource and coordination issues rather than deliberate indifference, and they are being aggressively addressed by all parties. .

1. Of the 426 cases listed by DCFNE as having been reported to law enforcement, all are documented by MPD and classified according to MPD's newer classification system as either a sexual assault or a sexual allegation.

2. All of the evidence kits were transported to DFS by MPD. Sixteen kits required additional research to locate and thought to be misplaced. However, they have all been located and accounted for in the correct location, meaning these were documentation issues rather than actual lost kits. Toxicology specimens are delivered to OCME in tandem with kits and those are accounted for as well.

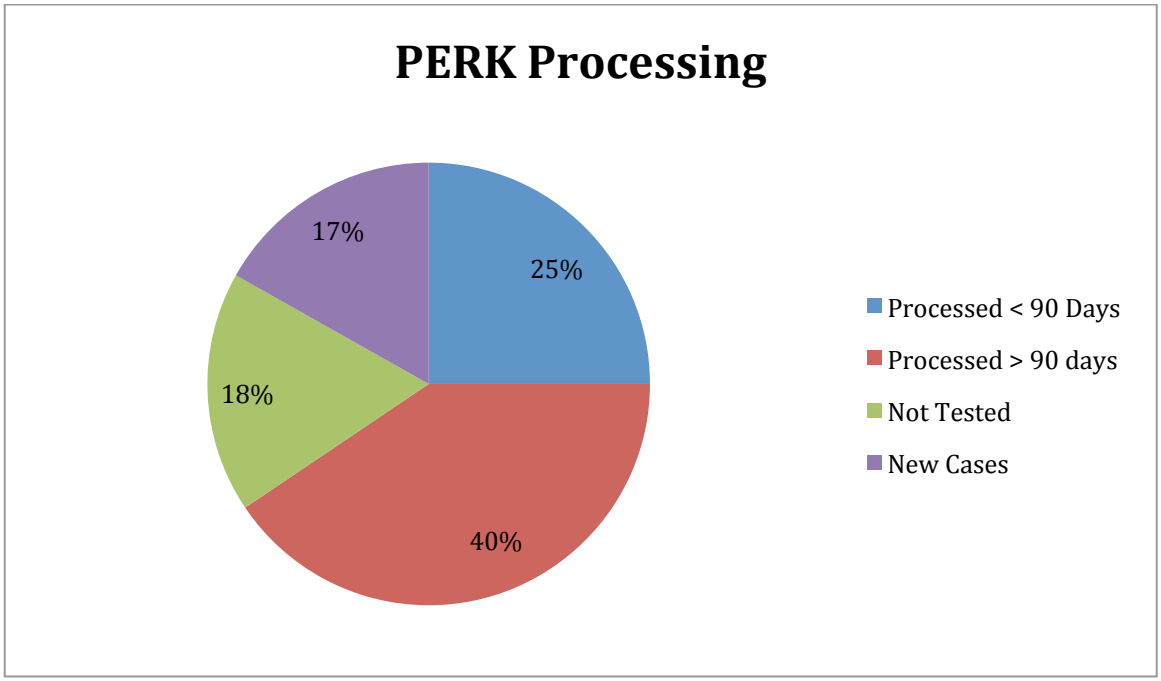
3. The kits were delivered by MPD as required within an average time of 2.45 days of the exam being conducted in the review of kits submitted in calendar year 2014 through February 2015. Although the timeline in from March, 2013 to December, 2013 was five days, and outside of MPD's standard operating procedure requirement of four days, they still are compliant with the seven day timeline required by SAVRAA. For delayed reports or so called conversion cases[24], MPD is also picking them up and delivering them to DFS and

[24] Conversion cases are those that start out as requests for SANE exams and medical care without a report to law enforcement and later get reported to law enforcement by the survivor based on their own personal choice. Currently, 40% of the exams conducted by DCFNE are non-reports and 60% are

OCME within seven days of a report to law enforcement. All delivery timelines were well within the seven days required by SAVRAA.

4. The data showed a significant problem with processing times at the lab that was also apparent in the review of MPD's case files and in interviews with survivors. Processing times were provided by DFS for 429 cases dating from January 2014 through July 1, 2015. This time frame was chosen because the tracking mechanism for kits did not begin until January, 2014 and the two analysts dedicated solely to processing kits began in February and June 2014. Of 429 cases, 66 (15%) were considered new cases, meaning they were less than 90 days old and therefore they are not considered backlog nor out of compliance if they haven't been tested or if they are still being tested.

   Of the 363 cases remaining that should have been tested within the required 90 days by July 1, 2015, 98 were tested within 90 days and 159 were tested but their processing times exceeded 90 days. The average processing time was 114 days, with the shortest at 16 days and the longest at 395 days. It should also be noted that SAVRAA did not become law until November 23, 2014 and therefore these processing times are not all out of strict legal compliance with the statute. An additional 69 kits that should have already been tested by July 1, 2015 were not tested at all.[25] These 69 untested kits constitute a backlog.




immediate reports to law enforcement. Approximately 13% of the non-reports eventually convert to reports to law enforcement.

[25] These untested kits date as early as January 8, 2014 and are from random dates throughout the year and reflect the triage process that was occurring at the FBU prior to its reorganization that began in April 2015.

These problems are now being aggressively addressed by DFS and the backlog is almost resolved. The 66 new cases and 69 backlog cases have been sent to private labs on 15, 30, 45, 60, and 75-day turnaround contracts to ensure that the backlog is cleared up quickly and that it does not continue with incoming cases. From May 1-July 1, 111 cases have been sent to BODE, of which reports have been received for 70 cases. Two cases were pulled from testing by the USAO. There are 39 cases which have been sent to Bode for testing for which DFS has not received a report to date. MPD also reports having received a large number of reports the week of August 3rd, 2015 corresponding to backlogged cases.

Although DFS is working to remedy this situation, the systemic and survivor-related ramifications of these delays cannot be overstated. Based on my review of 215 of MPD's case files as well as interviews with Sexual Assault Unit detectives, investigators usually finish the bulk of their investigation within four to six weeks of receiving a report even while being incredibly thorough. They and the survivor then must wait for the kit to be processed.

This wait has a significant impact on survivor participation and satisfaction with the process. During this time, the victim may come to believe that the detective is not investigating their case, or the detective may lose touch with the victim during this long wait period. Victim dissatisfaction with the overall process mounts as the delays continue and can seriously impact their decision to continue to participate in the process should the case go to trial.

Waiting for results can also impact the ability of law enforcement to follow through on their mandate. Given the volume of cases MPD is presented with, these delays also produce an inordinate number of open cases making workload management and case tracking extremely difficult. This backlog also requires the US Attorney's Office to make warrant and charging decisions sometimes without benefit of a DNA report in hand. They will request these reports to ultimately present their case in court, but the timelines do not initially coincide in the way the system intends.[26]

5. The data from the Office of the Chief Medical Examiner (OCME)'s Toxicology Unit showed that the processing times for toxicology specimens were taking place well within the statutory requirement. For the 92 cases received in 2013, the average processing time was 62 days and for the 80 cases received in 2014, the average processing time was 68 days. For the 90 cases not reported to MPD where DFSA was suspected, the average processing time was 54.1 days in 2013 and 75.6 days in 2014. It should be noted, however, that these processing times are averages that may exceed 90 days soon in individual cases if not the mean.

6. Two related issues that arose in both processing the data, reviewing MPD case files and interviewing detectives are kits being pulled out of the queue and testing discontinued entirely for a variety of reasons, and the disparity in perception between MPD and DFS regarding what can be tested and who should make those decisions.

[26] The use of these results by the US Attorney's Office and MPD in the overall context of investigation and prosecution is discussed in the larger report about MPD's implementation of SAVRAA.

Seventy-two kits were pulled from the testing queue before they were completed and therefore no results reported. Those reasons and the agencies making those decisions are reflected in the chart below.

| **Requesting Agency and/or Reason for Discontinuing Testing** | **Number of Cases** |
|---|---|
| US Attorney's Office for the District of Columbia | 32 |
| DFS Forensic Biology Unit (lack of probative evidence)[27] | 18 |
| Metropolitan Police Department | 7 |
| Office of the Attorney General for the District of Columbia | 3 |
| Significant delay between assault and time of exam too great | 2 |
| Lack of jurisdiction over the crime (reporting jurisdiction takes responsibility for testing) | 2 |
| No biological evidence in kit to test | 2 |
| Kits sent to DFS in error – no police report made | 3 |
| No Further Information Provided | 3 |

Based on MPD's case files, interviews with detectives, as well as a discussion with DFS about the 18 cases DFS removed from the testing queue and the reasons for those decisions, it is clear that a disparity exists between DFS and MPD about who should make the determination about what constitutes useful evidence in any given case.

E-mail correspondence exists in MPD's case files between DFS and MPD SAU supervisors in which DFS declines to test particular items that a detective believes may have evidence to assist his or her case. These determinations by DFS may be because the appropriate body swabs were not collected, i.e. they were either declined by the survivor or not collected by DCFNE, and all other evidence collected may have been from areas of the body that were not involved in the assault. Additionally, DFS may determine that there is no reliable way to test for a digital assault, or that the time frame between the assault and the evidence collection was too long to provide reliable results.

However, there are instances in which the detective may believe that there is useful evidence available to answer or rule out certain portions of their case. Interviews with survivors and advocates revealed that survivors place an enormous emphasis on the results of the kit because it can validate their experience in empirical terms. They have also been

[27] In this context, the term "probative" is used to denote that there was no scientific basis for testing to be performed.

led to believe that having a kit done will add to the criminal justice process in some way and may also provide them with additional information about what happened to them. A lack of closure in this regard was particularly troubling to many of those interviewed, and was taken as an indication that they weren't believed or taken seriously by the system as a whole.

6. Delays have also been reported in the process of dropping off kits. There have been instances where detectives or the officer dropping off kits or other pieces of evidence to be tested must wait an inordinately long time because the appropriate staff is not available or there to receive the evidence. The process currently requires DFS' CEU staff to notify the MPD CSID Sergeant on duty that evidence is being submitted and that sergeant assigns an officer to take the evidence. If an officer is in the building, they will respond immediately, but this is not possible if an officer is not in the building because they may be out on a homicide case or are short staffed for other reasons.

   There have also been instances in which this situation arises and the detective must continue to hold the evidence for several days because they have been told no one is available to accept the evidence at DFS.

**Recommendations**

As the findings above demonstrate, the kits are being picked up and dropped off well within the time frame required and being delivered to DFS and OCME promptly by MPD. However, there are changes recommended that would make this process more transparent and efficient, and would clarify who has decision-making authority regarding testing. Beyond mere efficiency and accuracy, these recommendations are also intended to create an environment in which each player does their part to ensure that the process moves quickly and correctly so that survivors receive both information and case resolution as quickly as possible. While DFS must remain impartial and independent, the law enforcement members of the process have a responsibility to ensure that the system functions in a way that increases offender accountability overall.

**1. OVS should fund two additional analysts to augment the two positions already funded for this project at DFS.**

Cases reported to MPD have increased by nearly 17% per year from 2013 to 2014, and there will likely be a demonstrable increase in 2015.[28] DCFNE reports a nearly 17% increase over the past five years in the number of requests for forensic exams in 2015, with or without a report to law enforcement as well.[29] This staffing increase is required to resolve the existing backlog, process cases in a timely but thorough and accurate way, and allow the Forensic Biology Unit to keep up with this ever-increasing workload. Additionally, it allows staff to go on allowable vacation, sick leave, and testify in court as needed, without compromising the lab's ability to test kits in a timely way. Although the processing times for OCME's Toxicology Unit are within the 90-day limit, the average processing time is creeping closer to that limit. As caseloads increase,

[28]Metropolitan Police Department Sexual Assault Unit records showing 939 cases filed in 2013 and 1102 filed in 2014..
[29] DC Forensic Nurse Examiners (DCFNE), Mid-Year SANE Report, April 2015.

additional staff will be needed to maintain legal compliance. An additional analyst is also needed for the Office of the Chief Medical Examiner's Toxicology Unit to ensure they have the capacity to remain in statutory compliance as caseloads increase, but this need is less urgent than the pressing need for staff in the FBU.

**2. The Sexual Assault Response Team (SART) should create a shared database to track a kit from its inception with the survivor at DCFNE through processing at DFS and OCME, and assign a unique tracking number to each kit that will follow the kit through the process.**

Evidence kits need to be tracked through the system from beginning to end to ensure that each kit was picked up and received by DFS and toxicology specimens received by OCME. Currently, without a survivor, an advocate or a detective raising a question or a complaint about a missing kit, or an independent consultant conducting an audit such as this one, theoretically, no one would know that a kit was missing or had not been dropped off or processed. DCFNE keeps an electronic form signed by MPD for each kit to indicate when MPD has picked it up. MPD keeps a record of each case in both a large spreadsheet that tracks evidence kits among other data, as well as its own records management system in which dates of pick up and drop off are noted in each individual case. DFS and OCME each keep yet another spreadsheet with their own matrices for evidence kit processing that indicates when they received a kit and when results were processed and notification made to MPD and the USAO. An enormous amount of data is being kept by all four agencies, but they are completely separate and therefore never compared. When cases are documented and handled this many times the potential for data error also increases.

Because this is a critical part of the sexual assault response in terms of medical care, investigation and prosecution, it is imperative that a system exists in which kits are universally accountable if only for purposes of assuring victims and the general public that the system is efficient and documenting legal compliance with SAVRAA.

A secure database that is shared among DCFNE, MPD, the USAO, DFS and OCME would resolve this problem and is strongly recommended. The information shared in this database should be purely procedural, i.e. drop off and pick up dates, as well as the date on which results are available and notification made to MPD and the US Attorney's Office if applicable. No actual substantive results, case or survivor information would be shared.

Ideally, the database would also have the ability to send notifications when an item is complete or requires attention, and allow for search and aggregate data analysis to ensure compliance with the statute easily. Reports from the database can be used to inform the SART on a monthly basis. A group of staff from DFS, OCME, DCFNE, MPD, the US Attorney's Office, and the Office of Victim Services is currently creating this database. It is their hope that this project will be completed by the first quarter of fiscal year 2016.

The most significant challenge experienced in this audit was the lack of police report numbers attached to evidence kits originally, and the possibility that a simple typo could render a kit untraceable. Nineteen percent19%) of the evidence kits listed did not have a report number

initially. Kits should be tracked by the kit number assigned by DCFNE when the exam is performed. DCFNE would enter kits into the system based on that number and MPD would add in their case number when a case is opened and a kit is picked up. Any other numbers assigned in the process, such as MCL numbers at DFS and any OCME tracking numbers, could be added, but the cases would be tracked by the original DCFNE generated kit number across the system.

**3. DFS and MPD's CSID should determine an adequate staffing level or back up staffing for the CSID to ensure that evidence can be submitted when it is brought to the Central Evidence Unit.**

While this is not a chronic issue overall, it is a periodic problem that can have ramifications for an already over-taxed Sexual Assault Unit, as well as create a deterrent to dropping off evidence as soon as it is in hand. There should be enough CSID staff available to take in evidence in a timely way when requested by CEU staff. The solution to this problem may be as simple as providing a back-up officer assigned to the schedule and providing authorization and training for the MPD personnel who normally drop off evidence to be able to draw MCL numbers themselves.

**4. DFS, MPD, the US Attorney's Office, and the Office of the Attorney General should continue to meet bi-weekly about prioritizing cases for testing and to discuss any problems with testing that exist.**

These meetings are currently occurring as a way to work through DFS' restructuring and the halt of DNA testing at the Forensic Biology Unit. They have proven useful and should continue beyond DFS' reorganization to catch problems early in the process and maintain a dialogue about what is and is not being tested and possible reasons for that. These meetings will also ensure that questions about particular cases are answered in a timely way if questions arise after the kit or specimens are dropped off.

**5. MPD, DFS and DCFNE need to establish a more open dialogue about issues related to what can and cannot be tested in a given case so that the expectation communicated among themselves and to the survivor about the utility of the forensic exam in a particular case is realistic.**

The results of testing a kit or an item may not be dispositive of the entire case, but it may rule out or bolter a theory that the detective or the prosecution has about a case or a suspect. Similarly, while MPD personnel should receive training about the science of DNA to know what is and is not reasonable to request, DFS is the designated expert regarding what is scientifically possible. DFS should attempt to test any and all kits and items sent by MPD where it is scientifically possible to obtain a reliable profile of any kind. These issues should be discussed at the bi-weekly meetings. Clear documentation of kits or specimens, as well as other physical evidence not tested, the reason for this decision, and which agency made the decision should appear in the kit-tracking database. These explanations will help prevent confusion about why a kit was not tested, and help refine the system so that expectations and limitations may be understood proactively by all involved, including the survivor.

Beyond each agency contributing its own expertise to the process, the kits should be tested as submitted where at all feasible, i.e. scientifically possible, to provide closure for the survivor. While each case is different and each forensic evidence kit may yield different levels of new information, the survivor went through an extremely invasive examination with the understanding that the kit would be tested as originally described. Survivors are often very focused on the results of the kit, particularly when they are unclear exactly what happened to them in an assault or how extensive the assault was. All of these disparate expectations– from the SAU detectives to DFS to survivors themselves - were significant enough to warrant future dialogue and agreement on both process and communicating with survivors. The guiding principle should err on the side of testing what has been submitted unless it is scientifically impossible to obtain a result.

**6. DFS should submit monthly reports to the Independent Expert Consultant until such time as the backlog is resolved and DFS is processing cases within the 90-day time limit established by SAVRAA.**

As discussed above, previous issues with triaging cases and lengthy processing times are being aggressively addressed by DFS. The FBU is currently submitting these reports to the Independent Consultant and meeting with her regularly. DFS and the FBU have been extremely forthcoming, helpful and available in this process. Once kits are being tested in a timely way, i.e. within the 90-day limit at DFS rather than being outsourced, any outstanding issues can be discussed at the SART meetings as needed using the kit-tracking database.

**Conclusion and Next Steps**

The delayed kit results experienced over the last year and a half have had a serious impact on MPD's ability to investigate and close cases in a timely manner where the case hinged on the contents of the kit. These delays, as well as failure to test kits at all and other agencies pulling kits from testing before results were reported, also create victim dissatisfaction with the process. However, parts of the system are working extremely well. During the period reviewed, MPD was well within the statutorily required seven-day time limit for transporting kits to DFS and OCME, as well as their own four-day window for picking up kits and dropping them off outlined in the Sexual Assault Unit's Standard Operating Procedure. However, the overall system itself needs to be unified and appropriately resourced with additional staff both for purposes of transparency and accountability as well as ease of use by MPD, and DFS and OCME personnel alike.

The Department of Forensic Sciences is working aggressively to remedy the issues identified in this report as part of their overall reorganization, and based their efforts thus far these delays will be a thing of the past. Further, the relationships needed to ensure that a victim-centered team approach exists from the point at which an exam is conducted and an assault reported to law enforcement to the point where that evidence is used in law enforcement decision-making and subsequently in court are also present and improving.

The SART has formed a subcommittee made up of relevant staff from the agencies and organizations listed in this report to create the aforementioned kit tracking database. This

database will increase accountability and transparency in the process for all system actors and alert the SART early on if delays, backlogs or excessive discontinuation of testing arise again. The work of the subcommittee should be completed by the end of the first quarter of fiscal year 2016. An update will be provided to the Committee on the Judiciary in October 2016 as to its progress as part of the report on the SART case review process.


# The District of Columbia Sexual Assault Response Team (SART) and The System of Care for Sexual Assault Survivors

By

Elisabeth Olds

SAVRAA Independent Expert Consultant

November 30, 2015

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**Executive Summary**

The Sexual Assault Victim's Rights Amendment Act of 2013 (SAVRAA) requires the Independent Expert Consultant to formally evaluate the Sexual Assault Response Team (SART) with a particular focus on the new statutorily enacted case review process. The Sexual Assault Response Team (SART) and its case review process is inextricable from the SART's overarching goal of coordinating a victim-centered system of care for survivors of sexual assault in the District, particularly as it is defined by SAVRAA. Therefore, this evaluation necessarily included robust discussions of that system and includes findings and recommendations from those conversations with survivors, service providers, and other peripheral community stakeholders. These findings are particularly relevant given the lack of a unified, functional sexual assault coalition in the District for sexual assault services providers and survivors alike, and the SART's role as the current de facto coalition forum.

The information gathered about the continuum of services also bears discussing because the requirements of SAVRAA and the system of care it mandates represent a departure from the manner in which advocacy services were provided in the past. Therefore, illuminating those services as much as possible, i.e. what those services are, and who is being served, how and by whom, is necessary. Further, based on interviews and observations both with survivors and service providers, these changes have had consequences within the service provider community that need to be resolved to maintain and expand the high quality city-wide services envisioned by SAVRAA.

The methodology used to evaluate the SART, the case review process, and the system of care to then arrive at these recommendations included interviews with 26 survivors of sexual assault who utilized the services discussed, all service providers and SART members, as well as other community stakeholders such as multi-faceted social service organizations who make referrals to the sexual assault system of care in some way or have reason encounter the issue of sexual assault among their service population. All available aggregate data and specific documentation of services provided, policies and procedures manuals, handbooks and written complaints were reviewed and compared. The SAVRAA Independent Expert Consultant also attended four meetings of the full SART and three Case Review Meetings over the course of one year to observe discussions and information sharing, details and process of the case review itself, as well as group dynamics as a whole.

This report covered many disparate topics, from the statutory requirements of the SART to specific case review process to the broad issue of coalition representation for SAVRAA's system of care to gaps in services. Ultimately the SART is well on its way to being a highly

effective SART even by national standards, and the case review process is functioning beyond its mere legal requirements to identify patterns and find solutions to systemic problems. However, as discussed in the section about the system of care, there are gaps in services such as the mobility and overall capacity of the DC SANE Program to meet geographically scattered and non-hospital based requests for services as well as the current capacity of DCRCC's much needed hotline. In order for survivors to receive clear and correct information about where to go to receive the services they seek and to have knowledge of all of the available choices, transparency and coordination across the entire system of care is imperative. Ultimately, the SART is burdened by coalition activities and conflicts that should be undertaken by a more functional and inclusive coalition separate from direct service provision. By making this change, the SART can focus on its more formal system response while the badly needed rape crisis center model and philosophy embodied by DCRCC can continue to thrive as well.

**Recommendations**

1. Implement the Step-by-Step Practitioner Toolkit for Evaluating the Work of Sexual Assault Nurse Examiner (SANE) Programs in the Criminal Justice System written by Megan R. Greeson, Rebecca Campbell and Shannon Kobes[1]. This toolkit is disseminated by the National Institutes of Justice to establish clear and mutually agreed upon measurable outcomes for the SART. The SART Case Review Subcommittee has agreed to implement the toolkit, and it should begin immediately.

2. Establish a method of information entry for members using the SART website portal so that complete statistical information is provided in a way that can be recorded and disseminated prior to SART meetings. Entering data in this manner increases members' ability to participate fully in the Toolkit and allows for considered discussion at SART meetings. The SART has developed its own website and is creating a method by which members can enter data into the website prior to meetings.

3. Area colleges and universities should be represented by one representative on the SART as is currently the case. However, that representative should be the explicit link between the University Leadership Initiative and any other advocacy groups or regular forums for campus advocates rather than just representing their institution.

4. OVS should provide funding for a full time staff person for the SART. This individual should have higher-level knowledge of sexual assault services and answer to the SART as a whole through the SART Chair.

5. An FTE for an additional staff person at OVS should be provided and fully funded to work with the SART, continue to work with any aspect of the DC SANE Program, both of which OVS is also statutorily responsible, and to continue to manage ongoing work with all area colleges and universities, as well as the ASK and UASK Apps that OVS has so successfully

[1] Greeson, M, Campbell, R and Kobes, S (2008). Step-by-Step Practitioner Toolkit for Evaluating the Work of Sexual Assault Nurse Examiner (SANE) Programs in the Criminal Justice System. https://www.ncjrs.gov/pdffiles1/nij/grants/240917.pdf.

developed and launched. This person would also be OVS' designee on the SART representing the office's director.

6. The SART should undertake either an annual retreat or other organized member cross training that occurs *at the staff level* annually to ensure that each member is fully acquainted with the services provided by their partners.

7. A public SART presentation should be agreed upon by the entire group to describe access points, the DC SANE Process and the law enforcement reporting process including the option of converting a non-report case later into a report to law enforcement. Education about sexual assault and consent generally can be included in this presentation to address misconceptions about what is and is not considered sexual assault or abuse. This presentation and locating opportunities for providing it should be a priority to mitigate existing misperceptions, particularly given the changes brought by SAVRAA.

8. Cases to be reviewed bi-monthly should be provided to case review participants two weeks in advance of each Case Review Subcommittee meeting to allow participating organizations and agencies time to research the cases and arrive prepared to have a deeper discussion. Ultimately a full-time SART Coordinator should be hired as described in the recommendation on page 8, and this would be one of the duties assigned to that staff person.

9. MPD and/or the USAO should present cases that did not entail a SANE Program response to allow the group to identify resources to help those who did not need or wish to engage a hospital-based response. These cases can be made anonymous because those survivors did not sign the SART release of information for case review. Alternatively, MPD or the USAO could obtain that release as part of their initial meeting with a survivor.

10. Non-report cases, i.e. those for which no police involvement was requested but the DCSANE Program was engaged in some way and an evidence kit was collected, should also be presented and reviewed at case review meetings to identify resource gaps for this population. Anecdotal information should be provided by mental health service providers and other long-term service providers about survivors they serve who did not engage the DC SANE Program or report to law enforcement at all.

11. When cases are chosen that involve college or university students, advocates and department of public safety officials and/or Title IX coordinators from that university should be invited as guests for that particular case's discussion to the case review to provide crucial information about the interaction between the campus response and the District-level response.

12. The DC SANE Program should undertake a three year strategic plan for expansion to determine whether a more mobile model, a 24-hour presence at one hospital, or a combination of the two can be integrated with a broader non-hospital case response over a period of time.

13. The Network for Victim Recovery of DC (NVRDC), the Victim Witness Unit at the US Attorney's Office and the Victim Services Unit at MPD should engage in cross training and strategic coordination meetings facilitated by the Independent Expert Consultant to bridge the significant gap in communication, information sharing and services referrals.

14. Training for all staff as described above should be provided annually about the different confidentiality laws that govern the roles of each, as well as updated information and training regarding the federal Crime Victims' Rights Act, and the DC Crime Victim Bill of Rights.

15. DCRCC's hotline should be improved upon to provide referrals to other organizations for both acute and longer-term services, including but not limited to the DC SANE hotline for acute care and advocacy, a clear description of the DC SANE Program and process and reporting options as approved and provided by the SART, mental health resources, and support groups and individuals counseling for adult survivors of childhood sexual abuse and others.

16. Mental health services should be funded and built out by the Office of Victim Services to establish a wider network of trauma-informed providers than currently exists, with a specific focus on increasing the capacity to serve adult survivors of childhood sexual abuse, the severely and persistently mentally ill, and marginalized populations who may be more reluctant to report sexual assault through more formalized processes.

17. Establish a functional sexual assault coalition for the District that includes all organizations whose primary mission explicitly includes serving sexual assault survivors and therefore the survivors those organizations serve. Any sexual assault coalition that is created or altered should contain a strong survivor advisory board or council, and contain survivor representation at all levels from the board of directors to staff and volunteers.

18. This coalition, however ultimately configured, should be entirely separate from any direct service provision for sexual assault survivors to facilitate transparency and avoid any apparent conflict of interest in funding and legislative advocacy efforts as well as overall philosophical orientation.

Each section of this report discusses any statutory requirements and related compliance, describes the current state of the issue and any findings, and then provides recommendations for improvement. The vocabulary used in this report is also worthy of note. While the term "survivor" is viewed by many as preferable to "victim" because it connotes empowerment, this report uses the terms interchangeably because the term "victim" is used in the DC Code and in accompanying policies and procedures.

## I. Introduction

The Sexual Assault Victim's Rights Amendment Act of 2013 (SAVRAA) requires the Independent Expert Consultant to formally evaluate the Sexual Assault Response Team (SART) with a particular focus on the new statutorily enacted case review process. The Sexual Assault Response Team (SART) and its case review process is inextricable from the SART's overarching goal of coordinating a victim-centered system of care for survivors of sexual assault in the District, particularly as it is defined by SAVRAA. Therefore, this evaluation necessarily included robust discussions of that system and includes findings and recommendations from those conversations with survivors, service providers, and other peripheral community stakeholders. These findings are particularly relevant given the lack of a unified, functional sexual assault coalition in the District for sexual assault services providers and survivors alike, and the SART's role as the current de facto coalition forum.

The information gathered about the continuum of services also bears discussing because the requirements of SAVRAA and the system of care it mandates represent a departure from the manner in which advocacy services were provided in the past. Therefore, illuminating those services as much as possible, i.e. what those services are, and who is being served, how and by whom, is necessary. Further, based on interviews and observations both with survivors and service providers, these changes have had consequences within the service provider community that need to be resolved to maintain and expand the high quality city-wide services envisioned by SAVRAA.

The methodology used to evaluate the SART, the case review process, and the system of care to then arrive at these recommendations included interviews with 26 survivors of sexual assault who utilized the services discussed, all service providers and SART members, as well as other community stakeholders such as multi-faceted social service organizations who make referrals to the sexual assault system of care in some way or have reason encounter the issue of sexual assault among their service population. All available aggregate data and specific documentation of services provided, policies and procedures manuals, handbooks and written complaints were reviewed and compared. The SAVRAA Independent Expert Consultant also attended four meetings of the full SART and three Case Review Meetings over the course of one year to observe discussions and information sharing, details and process of the case review itself, as well as group dynamics as a whole.

Each section of this report discusses any statutory requirements and related compliance, describes the current state of the issue and any findings, and then provides recommendations for improvement. The vocabulary used in this report is also worthy of note. While the term

"survivor" is viewed by many as preferable to "victim" because it connotes empowerment, this report uses the terms interchangeably because the term "victim" is used in the DC Code and in accompanying policies and procedures.

## II. The SART Model

The Sexual Assault Response Team (SART) model is a nationally recognized multidisciplinary approach to coordinating services for survivors of sexual assault that combines a victim-centered approach with the needs of the criminal justice system.[1] While there is often an inherent tension between being victim-centered and the less flexible requirements of the criminal justice system's adversarial process for holding offenders accountable, the SART model seeks to overcome this gap through coordination and collaboration, and ultimately by keeping the needs of survivors at the center of its mission and actions.[2] SARTs are typically comprised of victim advocates, police, prosecutors, forensic nurse examiners, and forensic scientists who meet regularly to formalize processes, discuss issues that have arisen with particular cases, or and improve the system as a whole.[3] Successful SARTs promote honest feedback and member accountability and increase the system's capacity as a whole. SARTs can also tackle broader systemic gaps and issues in acute service provision, reconcile issues regarding the prosecutability of criminal cases, as well as guide and contribute to general public education about sexual assault, consent and how and where to get respectful and effective assistance when needed.[4]

## III. The District of Columbia Sexual Assault Response Team (SART)

### A. Statutory Requirements

Although the District's SART existed in some form prior to the Sexual Assault Victims' Rights Amendment Act (SAVRAA) of 2013, the new law formally established the District of Colombia Sexual Assault Response Team (SART) as the coordinating body for the District's coordinated response to sexual assault, and also clarified the system and standard of care required by the District for survivors. Specifically, SAVRAA established required membership,

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[1] National Sexual Violence Resource Center, Sexual Assault Response Team Development: A Guide for Victim Service Providers, 2011, page 1.

[2] Campbell, R and Raja, S (1999). Secondary Victimization of Rape Victims: insights from Mental Health Professionals Who Treat Survivors of Violence. Violence and Victims, Vol. 14, No 3, 1999 and 70 Patterson, D. and Campbell, R. (2010). Why rape survivors participate in the criminal justice system. *Journal of Community Psychology*, 38(2), 191-205.

[3] National Sexual Violence Resource Center, Sexual Assault Response Team Development: A Guide for Victim Service Providers, 2011, page 1.

[4] Campbell, R, Greeson, M, Bybee, D, and Watling Neal (2011). Sexual Assault Response Team (SART) Implementation and Collaborative Process: What Works Best for the Criminal Justice System? Pg. vii. https://www.ncjrs.gov/pdffiles1/nij/grants/243829.pdf.

staffing, meetings, and specific duties for the full SART as well as the SART Case Review Subcommittee.

Required members of the SART are as follows: the Director of the DC Office of Victim Service (OVS) or his or her designee; the SART Coordinator; the Chief of Police for the Metropolitan Police Department (MPD) or his or her designee provided that the designee is a member of the Sexual Assault Unit with the rank of Captain or above; a representative from MPD's Victim Services Unit; the United States Attorney for the District of Columbia (USAO) or his or her designee provided that the designee is an attorney assigned to the Sex Offense and Domestic Violence Unit; a representative from the USAO Victim Witness Assistance Unit; a representative from the US Park Police; the director or his or her designee of a private non-profit entity providing medical forensic care through the DCSANE Program provided that the designee is a forensic nurse; the director or his or her designee of a community-based advocacy organization providing services through the DC SANE Program; a representative selected by OVS from a community-based organization that is providing post-assault mental health services; the District's designated sexual assault coalition; the director of the Department of Forensic Sciences (DFS) or his or her designee provided that the designee is a qualified forensic scientist; the Chief Medical Examiner (OCME) or his or her designee; and a representative from a District area college or university.[5]

A SART Chair is required to be elected by a simple majority of the membership. That chair can only be from a non-profit member rather than from any of the government agency members. The SART is also mandated to meet at least 6 times per year after its initial meeting.[6]

As described in SAVRAA, the SART's functions are to improve the coordination and functioning of victim services, medical forensic care, investigations and prosecutions available to survivors of sexual assault; and to conduct regular case reviews of all parties involved in sexual assault responses including a review of sexual assault reports and investigations by MPD and cases reported to any member of the SART through the Case Review Subcommittee also established by SAVRAA.[7] As part of incorporating feedback from the Case Review Subcommittee, the SART was also required through SAVRAA to develop a protocol to ensure feedback and recommendations from the SART Case Review Subcommittee are incorporated

[5] DC Code § 4-561.12(c).
[6] DC Code § 4-561.12(d) and § 4-561.12 (e).
[7] DC Code § 4-561.13.

into SART member agencies' policies and procedures, practices, training and decisions to re-examine investigations when applicable.[8]

## B. Current State and Findings

### *i. Statutory Compliance*

The current membership and attendance of the SART is statutorily compliant, with one required seat temporarily vacant. The SART members are: MPD's Chief of Police represented by the Captain of the Criminal Investigation Division that contains the Sexual Assault Unit (SAU); the Chief of the Sex Offense and Domestic Violence Unit at the United States Attorney's Office; the Executive Director of the DC Forensic Nurse Examiners (DCFNE) under the DC SANE Program; the Executive Director of the Network for Victim Recovery (NVRDC) representing the advocates under the DC SANE Program; the DC Rape Crisis Center (DCRCC) as the District's designated sexual assault coalition; the director or deputy director of the USAO Victim Witness Unit; the director of MPD's Victim Services Unit; the executive director of the Wendt Center for Loss and Healing as the OVS-designated community-based organization providing post-assault mental health services; the Chief Toxicologist for the Office of the Chief Medical Examiner; the Victim Witness Coordinator for the US Park Police; a representative from an area college or university (currently vacant); and the SART Coordinator provided by OVS.

Given its previous sometimes contentious history and the enormous changes the system of care has experienced in the last two years, the SART's functionality should be evaluated as a work in progress. The first necessary step in that progression is trust and relationship building among the SART members to solidify a more collegial culture, and the establishment of agreed upon internal governing processes. The second step involves clarifying roles and vocabulary among the members and uniform information sharing, leading to a third step of actual strategic planning to address broader systemic issues, differing perspectives, and gaps in services. These steps can certainly overlap, but it is important to lay a solid foundation so that the mission and vision can be clearly implemented over time regardless of the individuals at the table.

Overall, the SART is extremely well organized and is adhering to the duties assigned by SAVRAA. The SART is organized through a Memorandum of Agreement that outlines the mission and vision of the SART, as well as its guiding principles to enact that mission to which all members must agree and adhere. All SART members except for MPD's Chief of Police have signed the MOA, though changes in member leadership will require new signatures at the beginning of 2016.[9]

[8] DC Code § 4-561.13.
[9] District of Columbia Sexual Assault Response Team Memorandum of Agreement, 2015.

The SART's mission statement is clear and encompasses the duties described by SAVRAA and listed above. That mission is: "to ensure consistent, sensitive services for adults who have been sexually assaulted; identify and remedy gaps in services; increase engagement in the criminal justice system; improve forensic evidence collection and processing of results; and improve investigations and the prosecutability of cases." The Sexual Assault Response Team Handbook, developed in the past year by the SART Chair and agreed to by the members, also details the SART's mission, vision and goals as well as operating processes and bylaws. The Handbook also contains a detailed DC SANE Program response protocol for all cases presenting to a hospital with or without a report to law enforcement, and for those that originate with law enforcement but also require a DC SANE Program response. At each meeting information is exchanged about aggregate data and member activities as a way to approach analyzing the efficacy of the system and adherence to the protocols described in the Handbook. Issues encountered with any portion of this response are addressed, as are more benign issues such as outreach opportunities or ongoing education and training. Other issues regarding accessibility, survivor satisfaction with services, and the perceptions or needs expressed by various groups and individuals are also discussed as they arise. The full SART meets at least bi-monthly and case review meetings are held bi-monthly alternating with full SART meetings.

*ii. Information Sharing*

Currently, an extremely high value is being placed on relationship building among SART members and, where possible, overcoming previous tensions exacerbated by the changes mandated by SAVRAA. As mentioned above, the SART appropriately shares aggregate data at each meeting through member updates. This information sharing is still in an early stage and requires increased transparency both of the definition of terms and what services were provided. Thus far, this data and the way it is presented are very confusing because it does not illustrate a continuous or connected system of care or speak to specific issues with a common vocabulary. For example, what population a member agency or organization is reporting on is not clear, and the services provided or referenced are not entirely clear. Therefore, when a member says they did 45 "intakes" in a particular month, what that intake functionally contains or to whom the services were provided is not clear to the group and therefore gaps in services are not yet clear. Some organizations and agencies also do not have staffing or time to gather this information in advance of every SART meeting. Important metrics that agencies do actually keep, such as response times to the hospital by advocates or whether warrants were approved or declined, are also being glossed over or not provided at all because agencies are providing general statistics rather than those that would speak to a particular more pointed issue.

Improving prosecutability and survivors' experiences of the response itself requires defining terms and outcome measures very clearly and being thorough about what is reported.

*Information Sharing Recommendations*

1. Implement the Step-by-Step Practitioner Toolkit for Evaluating the Work of Sexual Assault Nurse Examiner (SANE) Programs in the Criminal Justice System written by Megan R. Greeson, Rebecca Campbell and Shannon Kobes[10]. This toolkit is disseminated by the National Institutes of Justice to establish clear and mutually agreed upon measurable outcomes for the SART. The toolkit provides a standard process for determining the data the SART will track, and will also provide a neutral structure that everyone can adhere to rather than having to agree with one member or another in determining process or methodology. The SART Case Review Subcommittee has agreed to implement the toolkit, and it should begin immediately.

2. Establish a method of information entry for members using the SART website portal so that complete statistical information is provided in a way that can be recorded and disseminated prior to SART meetings. Entering data in this manner increases members' ability to participate fully in the Toolkit and allows for considered discussion at SART meetings. The SART has developed its own website and is creating a method by which members can enter data into the website prior to meetings. This method of data entry will allow any metrics that are decided upon via the toolkit to be reported as a normal part of SART participation, and a report can be provided at each meeting to facilitate deeper discussion of that data rather than the oral report that is provided currently and reflected in the meeting minutes later.

3. Amend the SART Handbook to reflect the statistics that are to be entered by each member and any definitions needed to ensure a common vocabulary among SART members.

4. A distinction should be made in all reporting between number of survivor contacts and unduplicated individual survivors served within any given time period so that the SART, and ultimately the District, can determine how many people the system is serving and what they are choosing to access, and what they are receiving as a result.

### *iii. Campus Sexual Assault Representation on the SART*

The designated representative for an area college or university is now open and the SART is actively seeking a replacement, which provides an opportunity for a structural change. It is notable that of 450 survivors seeking services at the DC SANE Program in 2015, 23% (102) were college or university students at the time of the assault.[11] The current SART structure and expectation for this representation is lacking. Interviews with college and university students and their advocates indicated a huge variety of understanding levels and, in two instances, outright

[10] Greeson, M, Campbell, R and Kobes, S (2008). Step-by-Step Practitioner Toolkit for Evaluating the Work of Sexual Assault Nurse Examiner (SANE) Programs in the Criminal Justice System. https://www.ncjrs.gov/pdffiles1/nij/grants/240917.pdf.

[11] DC SANE Program Annual Report, 2015, pg. 12. While the single largest category of colleges and universities where these students are enrolled is listed as "other," meaning that they are not from one of the eight District-area colleges and universities but were students visiting the District for a variety of reasons, students from George Washington (17), American (15), Howard (10), Georgetown (10), Catholic (5), Gallaudet (4), UDC (4), and from other universities outside the DC area (36) received services through the DC SANE Program in 2015.

misinformation received about the DC SANE Program. Similarly, there are vast differences in how each campus responds to sexual assault for various reasons, some of them cultural. The District is also in an unusual position compared to other jurisdictions due to the sheer number of colleges and universities in the city in addition to the large number of students that travel to the District both for entertainment, vacation and educational purposes. These factors may inflate the percentage of the total reported cases that are reported by college students, but they also speak to the urgent need for coordination and transparency in the efforts surrounding sexual assault on college campuses and how they interact with the SART system of services.

Additionally, the DC Coalition Against Domestic Violence coordinates the University Leadership Initiative (ULI), which is a forum for monthly campus advocates to meet and discuss issues related to sexual assault, dating violence and stalking on campus, and quarterly meets with university presidents to discuss policies and reporting of crime statistics. The DC Rape Crisis Center participates in the ULI as an advisor, but little is brought back to the SART. The other direct service providers on the SART are also not privy to the ULI, though the advocates meeting to discuss issues are necessarily interacting with the DC SANE Program at a minimum by referring students. These loops of information and coordination can be chaotic and contradictory based on campus representatives various perceptions and understandings of the SANE process.

*Campus Sexual Assault Representation Recommendations*

1. Area colleges and universities should be represented by one representative on the SART as is currently the case. However, that representative should be the explicit link between the University Leadership Initiative and any other advocacy groups or regular forums for campus advocates rather than just representing their institution.

2. MPD should also report to the SART about its monthly meetings with campus departments of public safety attended by the supervising sergeant of the Sexual Assault Unit, and convey any needs or concerns expressed by that group regarding sexual assault investigations on campus.

3. Alternatively, a campus public safety representative should be directly added to the SART's membership to speak to this separate need and function on college campuses. That public safety representative would have to coordinate with his or her peers on other campuses to ensure they're speaking to issues more broadly than those on their own campus.

*iv. Staffing*

Dr. Heather DeVore, Executive Director of DCFNE and Medical Director of the DC SANE Program, was elected Chair of the SART in 2014 and is serving the first of two possible three-year terms under the bylaws of the SART.[12] As Chair, Dr. DeVore guides meetings, sets the agenda, and ensures that member organizations and agencies follow the bylaws and other agreed upon regulations. She also selects the cases to be reviewed in case reviews. The Office of Victim Services also provides a SART Coordinator as required by SAVRAA. The SART Coordinator attends SART and Case Review Subcommittee meetings and provides logistical support including keeping SART records and minutes, as well as speaking for the Director of the Office of Victim Services on the SART when needed. While the SART Chair and the SART Coordinator make every attempt to provide what is currently needed and do an excellent job, the SART is not their full time job by any means.[13]

This capacity limitation has a large impact on how the SART functions. For example, case review names are provided sometimes the day before case review meetings, and statistics and other required research for meeting discussion is almost impossible to provide in a timely way. The requirements of the SART both through SAVRAA and as proposed in the SAVRAA Task Force Recommendations which include a robust complaint process located within the SART as well as added reporting requirements and coordination with other systems such as the Multidisciplinary Team which serves minor survivors of sexual assault, and increased opportunities for public outreach and education will require a full time staff person for the SART. OVS is appropriately statutorily responsible for providing a coordinator and for participating in the SART, but some members have expressed concerns about regarding the *potential* ramifications of OVS' dual role as a funder, as well as concerns about the potential for ongoing changes as the office has recently experienced two leadership changes in a short period of time.

Similarly, the work surrounding sexual assault policy and monitoring within the victim services community has been appropriately assigned to the Office of Victim Services. This workload is significant and will continue to increase. This includes working with colleges and universities to address campus sexual assault, requests for additional program development and funding related to sexual assault, tracking and updating the ASK and UASK apps recently

[12] District of Columbia Sexual Assault Response Team Handbook 2015, page 8.

[13] Dr. Heather DeVore is physician at Washington Hospital Center's Emergency Department working the night shift three nights a week, and is the unpaid Executive Director of the DC Forensic Nurse Examiners (DCFNE). Kelley Dillon, the current SART Coordinator, is a grant manager to OVS who has a full assignment of grantees to oversee in addition to the SART and the SAVRAA Task Force.

re-launched by OVS, and most significantly, partially managing the DC SANE Program.

*Staffing Recommendations*

1. OVS should provide funding for a full time staff person for the SART. This individual should have higher-level knowledge of sexual assault services and answer to the SART as a whole through the SART Chair, rather than as an employee of the Office of Victim Services. Insulating this position in this way, as a nonprofit or for-profit contractor using a fiscal sponsorship model, answering to the SART itself preserves the SART's sustainability insofar as funding for this position allows.

2. An FTE for an additional staff person at OVS should be provided and fully funded to work with the SART, continue to work with any aspect of the DC SANE Program, both of which OVS is also statutorily responsible, to manage ongoing work with all area colleges and universities, the SAVRAA Task Force recommended credentialing process RFA and its implementation, the juvenile process changes, as well as the ASK and UASK Apps that OVS has so successfully developed and launched. This person would also be OVS' designee on the SART representing the office's director.

### *v. Outreach and Education*

One of the SART's explicit goals is to engage in outreach and education to encourage reporting and help seeking by the affected public and to increase public awareness of sexual assault generally. These outreach goals and activities are detailed on page 28 of the SART Handbook and are extremely detailed, appropriate and clear. However, conducting outreach for services prior to ensuring that all SART members are willing and able to represent the actual continuum of services accurately and clearly may create a situation where survivors receive conflicting information. Based on complaints about incorrect referrals and misconceptions, as well as incorrect information provided to certain populations such as sex workers and advocates working with college students about how the DCSANE Program works, reporting requirements to law enforcement, and accessibility issues for survivors with disabilities and those with limited English proficiency, the SART's outreach and training process should include adhering to the following recommendations.

*Outreach and Education Recommendations*

1. The SART should undertake either an annual retreat or other organized member cross training that occurs *at the staff level* annually to ensure that each member is fully acquainted with the services provided by their partners, how to utilize the DCSANE Program, reporting requirements and limits to confidentiality, accessibility issues, and how to refer survivors to other providers in the system. Staff level cross training also increases relationship building across sectors, which benefits the survivors receiving those services.

2. A public SART presentation should be agreed upon by the entire group to describe access points, the DC SANE Process and the law enforcement reporting process including the option of converting a non-report case later into a report to law enforcement and the length of time non-reported kits are kept. Education about sexual assault and consent generally

can be included in this presentation to address misconceptions about what is and is not considered sexual assault or abuse. This presentation and locating opportunities for providing it should be a priority to mitigate existing misperceptions, particularly given the changes brought by SAVRAA.

3. Create boilerplate referral instructions agreed upon by the SART for receiving help with any sexual assault issue with an explanation of available services to distribute to the general public. This language or small presentation can to also provide to organizations that may serve sexual assault survivors as part of their service population, and the SART can encourage them to include this information in their public outreach and education presentations or on their websites. This information can then be tailored to specific populations that an organization serves.

Additional recommendations for the full SART are included in the section entitled "Additional Issues: Gaps in Services and the Role of the SART" beginning on page 16.

## IV. The SART Case Review Subcommittee

Much like the larger SART, SAVRAA also established statutory requirements for the Case Review Subcommittee including membership, meeting frequency, and duties. Specifically, SAVRAA requires that Case Review Subcommittee consist of the following: the director or his or her designee of a private non-profit entity providing medical forensic care through the DCSANE Program provided that the designee is a forensic nurse (currently the DC Forensic Nurse Examiners, DCFNE); the director or his or her designee of a community-based advocacy organization providing services through the DC SANE Program (currently the Network for Victim Recovery of DC, NVRDC); a representative selected by OVS from a community-based organization that is providing post-assault mental health services; the SART Coordinator; the Commander of MPD's Sexual Assault Unit or his or her designee provided that person is at a level of Captain or above; the director of DFS or his or her designee provided that person is a qualified forensic scientist.[14]

The subcommittee is statutorily charged with reviewing cases randomly selected from investigations involving sexual assault, specific cases as requested by members of the SART or the Case Review Subcommittee, and as requested by the Independent Expert Consultant.[15] To perform these reviews, the subcommittee was also required develop a protocol including a standard review form and adequate protections for survivor confidentiality under federal and District law. Further, the Subcommittee has to examine at a minimum whether each agency and service provider involved in the response followed current best practices for each case reviewed, including but not limited to whether police waited at least 48 hours before conducting

[14] D.C. Code § 4-561.14(b) (2015)
[15] D.C. Code § 4-561.14(c) (2015)

a follow up interview, whether the victim's request for information about toxicology and/or DNA results was accommodated as required under SAVRAA, any prosecutorial actions taken, and whether evidence testing complied with timing requirements of SAVRAA. The Subcommittee is also expected to track and discuss the use of forensic evidence in the investigation and prosecution of the case. The subcommittee is then required to submit any feedback or recommendations to the larger SART for their consideration and action when concerns or problems are identified.[16]

### A. Findings

The Independent Expert Consultant observed three case review meetings from December 2014 until October 2015, and was able to determined that the Case Review Subcommittee is statutorily compliant and that the process, while a work in progress, is occurring as intended. The Case Review Subcommittee membership is compliant with SAVRAA and comprised of the following: the co-executive directors of NVRDC and DCFNE representing the DC SANE Program advocates and forensic nurses respectively; the Commander of the Criminal Investigation Division and thus also the Sexual Assault Unit at MPD; the Division Chief of the USAO's Sexual Offenses and Domestic Violence Unit; and the Executive Director of the Wendt Center for Loss and Healing. An addition has also been made to the core group of Subcommittee members. At the last SART meeting, the Director of the Toxicology Unit at OCME was also invited to participate on the Case Review Subcommittee and will be attending beginning in December 2015.

The only discrepancy in membership that currently exists is that of the Department of Forensic Sciences (DFS). DFS' General Counsel had been attending Case Review meetings as DFS' Interim Director and continued to do so during DFS' recent reorganization. Although he was extremely helpful, informed and engaged, either the current Director of DFS or a qualified forensic scientist should be present. As DFS Forensic Biology Unit returns to full functionality, this problem will likely be remedied quickly.

Policies and forms have been created which adequately protect survivor confidentiality and the Subcommittee is following those policies routinely. Case review participants sign a confidentiality form at the beginning of each meeting indicating that no case specific information will leave the room or be communicated beyond the case review in any way. The SART Coordinator keeps a copy on file with participants' signatures for each case review meeting. A time-limited informed consent and release of information form explaining the SART and the case review process is offered to each patient to sign as part of the intake forms for the DC

[16] D.C. Code § 4-561.14(d) (2015).

SANE Program. The survivor can then consent to their case information being released to the Subcommittee and sign the form, or simply not sign the form to opt out. Survivors may also opt out after signing the form at any point, orally or in writing, by contacting their advocate at NVRDC or the follow up nurse at DCFNE and requesting to change their form. The survivor chooses the time limitation for the release of information as well, which is consistent with best practices nationally and the requirements of the Violence Against Women Act.[17]

As of its October 2015 meeting, the SART has reviewed 23 cases randomly chosen by the SART Chair from among the cases that originated in the DC SANE Program and were reported to police. Case review is conducted based on a detailed list of questions tailored to each member agency's function in the process. The case review questions provide information about each of the survivor's rights provided by SAVRAA as well as tracking forensic evidence processing times, and asks detailed questions about what was helpful and what may have gone wrong within the process for each agency. The SART Chair maintains a spreadsheet of reviewed cases and the information provided about each so that aggregate data can be reported as required of the SART's annual report to the DC City Council, and so that patterns can be seen in the cases reviewed and action recommended. The spreadsheet also allows the Subcommittee to follow up on cases previously reviewed to accommodate the fact that cases are in fact constantly progressing and changing as time goes on, and to also allow tracking of noted issues retroactively.

In spite of being a work in progress making continual adjustments, the Subcommittee is working extremely well, and has already begun to systematically address patterns apparent in the cases reviewed thus far. One issue that became extremely clear to the Case Review Subcommittee is the prevalence of survivors presenting with severe and persistent mental illnesses. Although the obvious response would be to simply refer these survivors back to their community service agency for help with their mental health concerns, this solution did not address what the group identified as a real and immediate need at the hospital on a 24-hour basis for more crisis intervention level mental health care. Upon identifying this need from

[17] Section 3 of the U.S. Violence Against Women and Department of Justice Reauthorization Act of 2005 (VAWA 2005) provides, in relevant part: (A) IN GENERAL. In order to ensure the safety of adult, youth, and child victims of domestic violence, dating violence, sexual assault, or stalking, and their families, grantees and subgrantees under this title shall protect the confidentiality and privacy of persons receiving services. (B) NONDISCLOSURE.—Subject to subparagraphs (C) and (D), grantees and subgrantees shall not (i) disclose any personally identifying information or individual information collected in connection with services requested, utilized, or denied through grantees' and subgrantees' programs; or (ii) reveal individual client information without the informed, written, reasonably time-limited consent of the person (or in the case of an unemancipated minor, the minor and the parent or guardian or in the case of persons with disabilities, the guardian) about whom information is sought, whether for this program or any other Federal, State, tribal, or territorial grant program, except that consent for release may not be given by the abuser of the minor, person with disabilities, or the abuser of the other parent of the minor.

among the pool of cases at that time, the subcommittee agreed to track the issue for another two months and reported back to the full SART. As a result, a subcommittee of the SART has been formed to address this issue and partner with the DC Behavioral Health Association, a group that has devoted two members to pursuing a solution with the SART for this vulnerable subpopulation of clients. This would not have been possible without a systematic case review and is an example of how this process should proceed.

The Subcommittee also correctly identified the extreme delays in forensic results from DFS, albeit in a less direct manner. Unlike the mental health issue, this issue was harder to pinpoint and identify due to lack of initial focus on the timeline for specific cases as well as a lack of information about those cases from DFS as a representative was rarely sent to case review. Another factor in this conversation may have also been the fact that it is a strict accountability point with a SART partner, making it awkward to address directly in an environment currently focused on relationship-building. In fact, when questions were asked in a case review meeting, the Independent Expert Consultant had to pointedly state that the Subcommittee's perceptions of delayed results were verifiable and not merely a result of missing information in spite of the fact that some at the table clearly knew the extent of the problem. While this may be an advantage of temporarily having an Independent Expert Consultant to state uncomfortable facts directly without fear of damaging a relationship, the use of clear data points and a review of the aggregate information on a regular basis by the Case Review Subcommittee will remove this sort of relationship based conflict because the group will already have agreed on the information shared and what it may reveal about any one of them at any given time. That kind of data sharing is a second phase of the development of this group and not a failing thus far, and the group has done well with the first necessary step of creating a collegial and therefore functional environment. It is also worth noting that the Subcommittee members are explicitly people from the agencies and organizations who do not directly handle cases themselves to reduce any defensiveness that may otherwise create.

As described above, cases to be reviewed are chosen from those that go directly through the DC SANE or SART process, from a forensic exam with an advocate assigned and present with a police report that may or may not result in a warrant and prosecution. They may also have been referred for counseling at the Wendt Center for Loss and Healing. This means that all of the Case Review Subcommittee partners are engaged in the discussion, and therefore creates an easier starting point for the Subcommittee. However, restricting case

review to this particular pool of cases leaves out approximately 60% of cases reported to MPD[18] as well as 31% of those served by the DC SANE Program who do not make a report to law enforcement.

For example, MPD received 1102 reports of sexual assault in 2014, and the DC SANE Program provided care for 415 survivors in 2014, of which 283 (68%) made a report to MPD.[19] This means that in 2014, out of 1102 cases reported to police, the Case Review Subcommittee would only be choosing cases from a pool of 283, all of whom had a forensic exam, the benefit of an advocate, and were at least comfortable enough with law enforcement to report. There is a great deal we can learn from those who choose not to report to law enforcement and from cases in which a forensic exam or hospital response was either deliberately refused or not appropriate due to the nature of the assault.

Similarly, the Case Review Subcommittee is also lacking the perspective of those who chose not to engage the system that has been set up even if their assault was acute enough to trigger that response.[20] Individuals who do not engage any formal assistance other than counseling or perhaps a church or community group after an assault may be more marginalized than those who do seek help, or they may have inaccurate ideas or have actively been given incorrect information about resources and reporting. Often conversations about highly marginalized groups and those who may refuse the more formal part of the system of care are framed as a report to the SART without adequate detail as to how this problem arose or even presented itself and without constructive solutions thus leaving the SART with little way to actually address the source of the barrier or the misinformation being provided.

The pool of case review eligible cases have been chosen thus far based on those for which a release of information is possible for the entire group. For non-report cases served by the DC SANE Program, law enforcement and prosecution should not know their identity or the details of their assault by virtue of the survivor's initial decision not to report to police. Similarly, cases only reported to MPD could not be shared with the rest of the group. Cases that were reported to no one but a hotline or a mental health professional would face the same confidentiality barriers. There may be ways around these hurdles both by using de-identified survivors' cases to review where this is a concern, and by implementing a broader informed consent and release of information process for the SART. However, to change this focus the SART will have to explicitly determine whether its mission is limited to those cases that availed

[18]Metropolitan Police Department, Sexual Assault Unit, 2014.
[19] DCSANE Annual Report, 2014, pages 2-3.
[20] Acute cases are those that have occurred within the previous 96 hours making a forensic exam appropriate, and triggering crisis intervention level response. It is not intended to indicate that other assaults are less traumatizing or less in need of a response.

themselves of the hospital response and engaged law enforcement, or if the group sees itself as actively working on the entire system of care for survivors of sexual assault regardless of what part of the system they engaged.

While the process and case review questions are extremely helpful and case reviews are occurring regularly and with the full intention of the group to engage in the process, the process itself remains relatively perfunctory, sometimes leaving out key pieces due to the absence of one or more parties such as the Department of Forensic Science. This surface-level discussion is less a shortcoming than it is the result of an evolving process that the Subcommittee is now learning as well as the resources currently available to the group. The primary reason the discussion is not as in-depth as it should be or could be is the fact that cases are distributed a day or two before the meeting, and participants are too busy with the rest of their respective jobs to do in-depth case research at the last minute. This lack of preparation is understandable given that the SART is something conducted as an addition to the Chair and to the SART Coordinator's full time jobs, and can be remedied by the staffing recommendations for the full SART. The recommendations below specifically address these issues.

### B. Recommendations

1. Cases to be reviewed bi-monthly should be provided to case review participants two weeks in advance of each Case Review Subcommittee meeting to allow participating organizations and agencies time to research the cases and arrive prepared to have a deeper discussion. Ultimately a full-time SART Coordinator should be hired as described in the recommendation on page 8, and this would be one of the duties assigned to that staff person.

2. A recommendations log should be maintained as part of case review and presented to the larger SART at each meeting. The log should capture recommendations such as the need to follow up on a particular data point, or to educate the community in a particular way so that problems with referrals are resolved, develop strategies to help a particular population, or to simply document a particular issue to facilitate program development and advocacy efforts in the future. This will help the Subcommittee ensure that they are following up on each issue and communicating that to the full SART.

3. MPD and/or the USAO should present cases that did not entail a SANE Program response to allow the group to identify resources to help those who did not need or wish to engage a hospital-based response. These cases can be made anonymous because those survivors did not sign the SART release of information for case review. Alternatively, MPD or the USAO could obtain that release as part of their initial meeting with a survivor. This pool of cases in particular may help identify access issues, including misinformation among the general public and on college campuses, for the DCSANE Program to tailor program development and outreach efforts.

4. Non-report cases, i.e. those for which no police involvement was requested but the DCSANE Program was engaged in some way and an evidence kit was collected, should also be presented and reviewed at case review meetings to identify resource gaps for this

population, any myths or real access issues related to law enforcement reporting, should they exist, as well as mistakes made by MedStar that result in law enforcement responding to cases in which the survivor has already indicated that they do not want police involvement.

5. Anecdotal information should be provided by mental health service providers and other long-term service providers about survivors they serve who did not engage the DC SANE Program or report to law enforcement at all. This information from other service providers on an anonymous but case-specific basis, rather than as a report about a population as a whole in general terms, will help SART members identify any barriers to services experienced by survivors in underserved or marginalized populations as well as any misconceptions about the reporting process.

6. When cases are chosen that involve college or university students, advocates and department of public safety officials and/or Title IX coordinators from that university should be invited as guests for that particular case's discussion to the case review to provide crucial information about the interaction between the campus response and the District-level response.

7. A representative from OCME's toxicology unit should be assigned to participate in case review and a series of relevant case review questions should be devised for OCME's report to the group on each case.

8. Case review questions should be followed more closely during each case review, and amended as follows:

    a. MedStar's dispatch response should be routinely included in case review reports. Specifically, the case review should ask and track any problems that occurred in the dispatch of a nurse, detective or an advocate through MedStar.
    b. The NVRDC advocate should report specifically about language access issues. While they do report on this as needed, it should be specifically reflected in the questions so that this continues regardless of NVRDC's Subcommittee representation.
    c. NVRDC should report whether an advocate accompanied the survivor for the law enforcement interview, and if not, whether the survivor declined an advocate in the interview with them.
    d. MPD should report the reason that an advocate was not present for the law enforcement interview, i.e. what exigent circumstances, survivor request, etc., existed from their perspective which prevented them from conducting the interview with the advocate present. Pursuant to a legislative and policy change, for any survivors who opted out of the advocacy process, MPD should provide verification of the required signed form.
    e. DCFNE should report on the total time the patient was at the hospital rather than only reporting on any significant delays, which is an extremely subjective measure.
    f. The US Attorney's Office should report on whether a grand jury was convened and if the grand jury was polled for a decision, or if the Assistant US Attorney declined to request an indictment.
    g. Whether the survivor started their request for assistance at a hospital other than MedStar Washington Hospital Center and were then transported or referred to WHC for a forensic exam, and which hospital that was and if there were any logistical issues reported.

## V. Additional Issues: Gaps in Services and the Role of the SART

The newly formalized system of care described by SAVRAA necessarily focuses on the DC SANE Program as it relates to the right to an advocate during a free medical and forensic examination and/or a law enforcement interview. SAVRAA provides that a sexual assault survivor has a legal right to an advocate, statutorily designated as provided by the Network for Victim Recovery of DC (NVRDC), during any medical, evidentiary or forensic examination, initial interview at the hospital, subsequent in-person interviews with law enforcement related to the sexual assault and at any point during a the hospital visit; and a right to a free medical and forensic examination, designated as provided by the DC Forensic Nurse Examiners (DCFNE).[21] Because the SART is currently serving as the de facto coalition for the District coordinating these services, and because its membership contains far more members than just those involved in the acute hospital response, the system of care itself necessarily became a topic of discussion in interviews for this evaluation. The information provided illuminated a system that was becoming highly organized and effective in terms of providing acute services and referrals to longer-term care. However, gaps in services also became clear as survivors and service providers asked questions, shared complaints about existing services, and indicated highly disparate understandings of what services were available and under what conditions. In addition to gaps in services, specific problem areas exist around role confusion within the current system, ongoing pressure on the DC SANE Program to change and expand response beyond its existing model and capacity, a lack of transparency and inclusivity in official sexual assault coalition activities, as well as significant outreach and messaging discrepancies. In some instances these conflicts have prevented appropriate referrals and progress for survivors that have been reported as complaints to the Independent Expert Consultant.

A note about this section of the report is warranted. The District is a very small community in many ways, and therefore the discussion of and recommendations to remedy these issues will maintain the confidentiality of the interview sources where at all possible, though maintaining that confidentiality may require vagueness or assertion of fact without explicit attribution more often than is normally advisable. This route was strategically chosen to avoid exacerbating any existing tensions or divisions that might impede constructive dialogue and therefore collaborative solutions. Further, while there are many parts of any continuum of services, organizations, and issues within them, the issues discussed in this report are limited to those

[21] DC Code §23-1908.

that have a direct impact on how survivors understand and experience the options available to them.

### A. The DC SANE Program

Under SAVRAA, the DC SANE Program is comprised of the DC Forensic Nurses Examiners (DCFNE), and the Network for Victim Recovery of DC (NVRDC) to provide a forensic nurse examiner and a victim advocate to support survivors seeking medical and forensic care up to 96 hours after an assault.[22] If police involvement is desired by the survivor, law enforcement will be notified by MedStar's dispatch service as well and meet the survivor, the forensic nurse, and the advocate at Washington Hospital Center. Sexual Assault Unit Detectives also may transport a survivor from a crime scene to the hospital for an exam and to meet with an advocate as well. Forensic exams are performed almost exclusively at MedStar Washington Hospital Center. NVRDC Advocates respond to the hospital 24-hours a day, 7 days a week to work with survivors to provide information about their legal options, emotional support, and social services referrals as well as ongoing case management and advocacy for the duration of their case regardless of its legal outcome or status. The DC SANE Program also provides a 24-hour call center for survivors to speak with an on-call victim advocate and obtain information and transportation to MedStar Washington Hospital Center for purposes of obtaining a medical forensic examination and can also link survivors to a forensic nurse to answer medically-related questions.

In Fiscal Year 2015, the DC SANE Program conducted medical forensic exams and provided advocacy services for 450 cases, an 8% increase in the number of examinations conducted in 2014 and a 19% increase in the average number of cases presenting over the previous five years.[23] Of those 450 cases, 274 (61%) were reported to law enforcement and 174 (39%) were non-reports.[24] In both report and non-report cases, toxicology specimens are tested for potential drug facilitated sexual assault by the Office of the Chief Medical Examiner. Results for non-report cases are provided to DCFNE to convey to the survivor as with any other medical test result. In cases reported to law enforcement, those results become part of the evidence in the case, and under SAVRAA, the survivor has a right to know the results upon request as well.[25] NVRDC provided 265 safe rides for survivors to MedStar Washington Hospital Center

[22] Ninety-six hours, or four days, is the maximum time after an assault that forensic evidence can reliably be gathered.

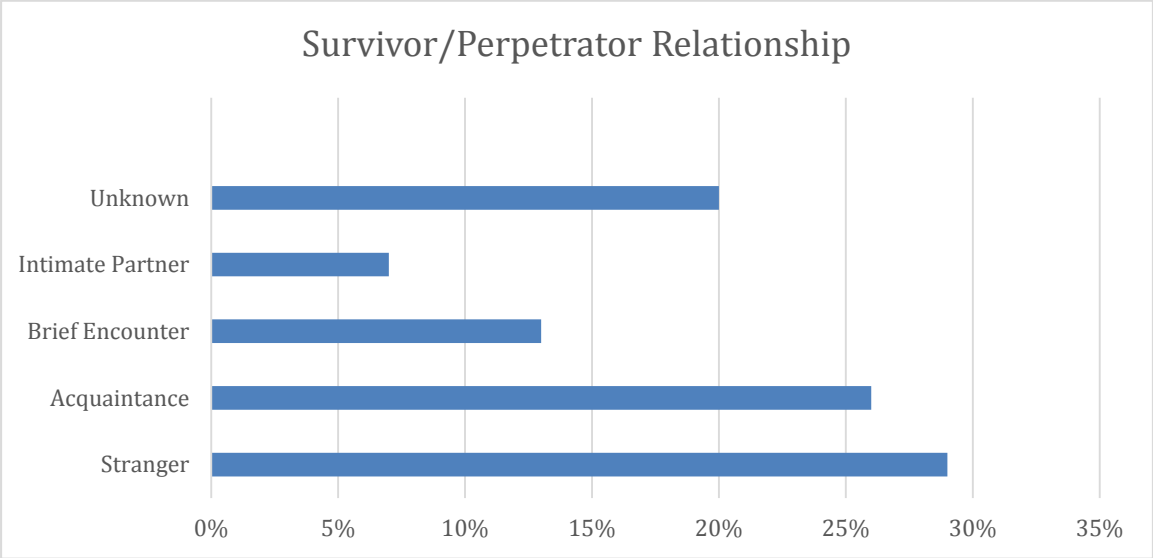
[23] DC SANE Program Annual Report 2015, pages 1-2.

[24] Non-report means that the Physical Evidence Recovery Kit (PERK) is stored by DCFNE for one year and then destroyed by MedStar Washington Hospital Center as biological waste unless the survivor wishes to make a report to law enforcement during that time.

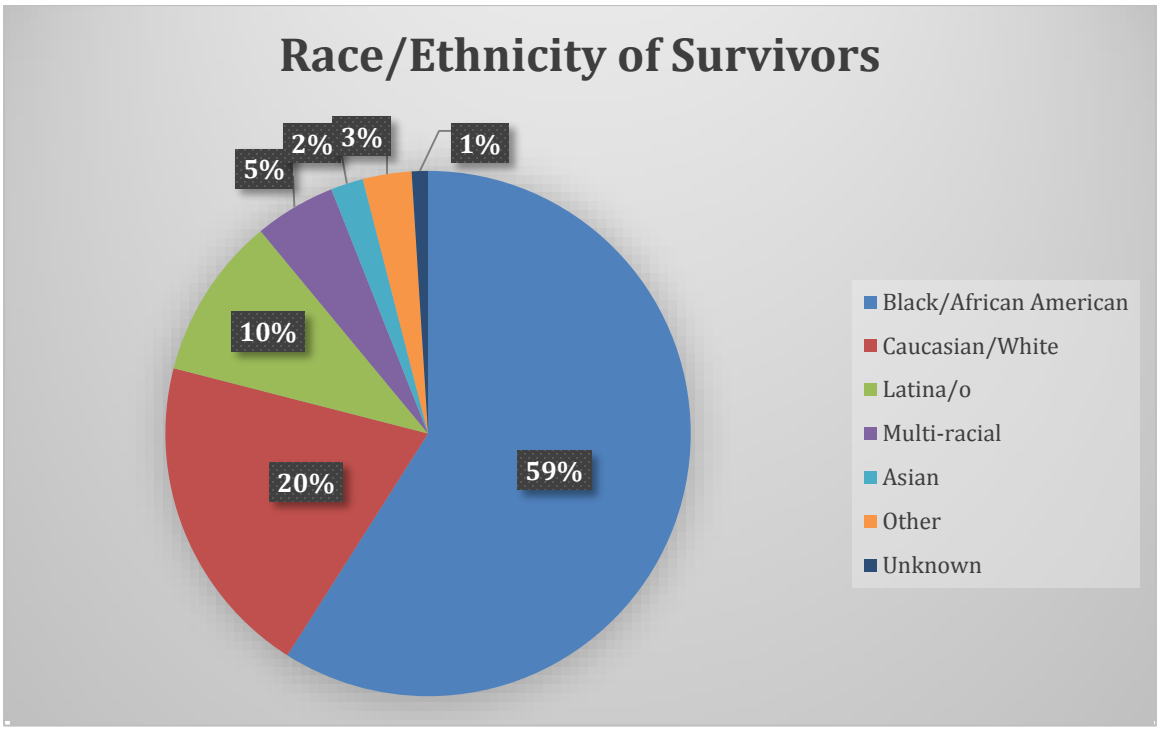
[25] DC Code §23-1910.

and to a safe location after their exam through a contract with Uber in FY15.

Advocates accompany survivors to law enforcement interviews, including the initial brief interview at the hospital. In FY15, NVRDC advocates were present for only 25% of police interviews. This percentage is far too low. MPD and NVRDC are currently working on an amended protocol that would significantly raise the number of interviews in which an advocate is present because it works more smoothly with the process of an actual crime scene initiated investigation. This issue will be addressed in an accompanying memo describing these recommended changes, both procedural and statutory, as well as in the section below regarding increasing the mobility of the DC SANE Program response.




In FY15, the self-identified gender of patients entering the DC SANE Program was 91% female, 8% male and 1% transgender (male to female). The relationship between the survivor and the perpetrator of the assault was as follows: stranger (29%), acquaintance (26%), brief encounter (13%), intimate partner (7%), and unknown (20%).




The self-identified race and ethnicity of DC SANE Program clients are: African-American (59%), Caucasian/white (20%), Latina/o (10%), Multi-racial (5%), Asian (2%), Other (3%), and unknown (1%). The interpreter bank was utilized for foreign language interpretation services for 13 survivors with limited English proficiency: Spanish (7); American Sign Language (3); and Amharic (3).

*i. Growth and Expansion of DC SANE and Community-Based Advocacy Services*

The process for obtaining a SANE exam and advocacy services requires that the survivor be willing to go to MedStar Washington Hospital Center either themselves, or brought in by the police or ambulance, or via transportation provided by NVRDC, usually an Uber driver. The DC SANE Program forensic nurse and the advocate will respond to other area hospitals only if the patient is not medically or psychologically stable enough to be transported to MedStar. In FY2015, of the 450 cases, the DC SANE Program responded to the following area hospitals other than MedStar Washington Hospital Center: Providence Hospital (2), Georgetown University Medical Center (2), United Medical Center (1), Howard University Hospital (1), and George Washington University Hospital (3) for a total of nine mobile responses.

Inquiries have been made repeatedly as to why there are not more mobile responses. This inquiry has been made specifically in reference to historically underserved populations who may

not feel welcome or comfortable at MedStar for any reason, as well as college students who may not want to venture too far from their zone of familiarity on campus. Similarly, inquiries have been made from advocates at Howard University and George Washington University as to why their respective universities do not have their own SANE Programs as they have their own hospitals. DCFNE and NVRDC met with George Washington University advocates to discuss this issue and OVS, DCFNE and NVRDC met in 2014 with Howard University advocates as well, but these issues have not necessarily been resolved and similar requests continue.

Another area of expansion requested is for the advocacy response to become more mobile and respond to cases where a report has been made to law enforcement but no hospital response was required. In 2014, MPD received 1102 reports of sexual assault and approximately one third of those survivors also had a SANE exam and therefore received advocacy services from NVRDC. The SAVRAA Task Force has undertaken this question as part of one of its statutorily assigned inquiries into whether there is a need for additional advocates and under what qualifications and circumstances should those be provided. To determine the need for additional advocates, the Task Force has recommended that NVRDC and MPD gather data for one year regarding the survivors presenting outside of the DC SANE Program response. Once this needs assessment is complete, a more targeted and effective response program can be created to provide credentialed community-based advocates for survivors reporting to police without contact with the hospital response.

Similarly, as discussed above, NVRDC advocates are participating in relatively few law enforcement interviews, primarily because detectives are interviewing survivors at the scene of the crime before they either do or do not go to the hospital. While the statute and the process are being amended to improve advocate participation and the overall logistics of the response from the perspectives of all parties, including survivors, this discrepancy also speaks to a possible need for more mobile advocates or advocates who are available at the hospital on an around-the-clock basis to accommodate the timeline needed by the survivor and by law enforcement. It should be noted that the model in Austin, Texas on which the advocacy response/model is based utilizes on-scene advocates in addition to those at the hospital thus avoiding this problem. Currently, the advocate response as structured by SAVRAA and therefore the SART places a tremendous emphasis on the hospital or medical response as the gateway to resources and advocacy, and thus pressures detectives to organize their investigations around bringing a survivor to the hospital. It also assumes that the survivor wishes to or even deems it necessary to go to the hospital at all, regardless of the evidence collection and medical care that they could get and may ideally need. These considerations and

possible solutions should all be included in both the needs assessment mentioned above and any strategic planning undertaken by the DC SANE Program and ultimately OVS.

With regard to the system as it currently exists, logistical issues have been reported regarding MedStar's dispatch system. Detectives have been dispatched to respond to the hospital for survivors who have already stated they do not wish to report to law enforcement. Additionally, MedStar sometimes gets information about survivors wrong, or provides the wrong name to the responding nurse or advocate. None of these errors are due to the DC SANE Program or MPD, but rather are located with MedStar. Similarly, area hospitals receive training to refer survivors presenting at their emergency departments to MedStar Washington Hospital Center, but this is not without delay or occasional error, and differences in hospitals' responses have been reported.

The pressures on the program to grow beyond its current capacity are many, and the high demand for services speaks well to the quality of and need for the services provided thus far. Rather than responding to these concerns repeatedly and/or individually, or possibly create haphazard and potentially less coordinated solutions, the DC SANE Program and the SART should address these issues systematically with needs assessments to document the issues and then issue a strategic plan to either address the issues or possibly explain why there is no need to do so.

**Recommendations**

1. Area hospitals should receive clear instructions and regular training from the DCSANE Program to ensure that survivors presenting at hospitals other than MedStar Washington Hospital Center receive a swift and clear response.

2. MedStar should receive clear instructions and regular training from the DCSANE Program to address problems with the dispatch process. Any such problems should be documented and presented at each SART meeting as well as any case-specific information presented at case review meetings. This compiled information should be used for both training purposes and to ensure accountability to the Office of Victim Services for MedStar's annual funding.

3. The needs assessment recommended by the SAVRAA Task Force to assess the specific need for community-based advocacy for survivors who do not engage the DCSANE Program is a sound recommendation and should be implemented as soon as possible so that this population of survivors receives equal access to resources as ultimately found and directed by the upcoming needs assessment.

4. A needs assessment should also be conducted by the DCSANE Program and the Independent Expert Consultant to determine the need for a more mobile advocacy response, SANE nurse response, or both in response to patients who present at other area hospital locations and would prefer to remain at those locations for care, as well as other solutions to increasing the participation of advocates in law enforcement interviews.

5. The DC SANE Annual Report should include the number of times an advocate was present for a law enforcement interview, the number of times a survivor declined the presence of an advocate either at the crime scene or the hospital, and the number of times law enforcement did not conduct the interview at the hospital and why that decision was made.

6. The DC SANE Program should undertake a three year strategic plan for expansion to determine whether a more mobile model, a 24-hour presence at one hospital, or a combination of the two can be integrated with a broader non-hospital case response over a period of time.

*ii. Role Confusion*

The current services provided by NVRDC advocates and those provided by MPD's Victim Services Unit and the USAO's Victim Witness Unit suffer from significant role confusion with one another, something that is currently creating confusion for survivors who may have more than four or five individuals attempting to interact with them and providing differing pieces of information, while other survivors have no support at all based on how they entered the system. The distinctions in services provided by each are very real and clear, though a survivor can get some of the same resources and referrals from any of the three as they move through the legal process. NVRDC is a community based organization that has a confidential relationship with each survivor they serve, almost exactly like that of an attorney with their client.[26] They also provide advocacy services using a model of vertical advocacy, meaning that once the NVRDC advocate begins working with a survivor, they work with that person throughout all of their expressed needs from the beginning to the end of a criminal case and well beyond that point if the survivor so desires. Even if a criminal case is dropped early on, advocacy can continue indefinitely as needed.

System-based victim services, i.e. those coordinators and victim services personnel employed within the criminal justice system by either law enforcement or prosecutors provide extremely valuable support, some of which cannot be duplicated by non-system actors, but under different terms. MPD's Victim Services Unit provides support in terms of crisis intervention, referrals to needed resources, and act as a link to detectives to provide information about the status of their case. They begin working with a survivor when a police report is filed, and that relationship ends for the most part when the case ends or it is handed off to the USAO for prosecution.

Similarly, the USAO's Victim Witness Unit provides crisis intervention, referrals to other resources with special attention paid to mental health needs, support surrounding the prosecution process, support during a trial, and act as a link to the prosecutor in the case. They

[26] D.C. Code §14-312 (2015).

also sit in on interviews with prosecutors to provide support to the survivor. Neither MPD nor USAO victim services has a confidential relationship with the survivor, meaning that they are legally required to inform the detective or the prosecutor of any information they learn about or from the survivor. Their mandate also involves ensuring that victim participation in a case is facilitated by empowering the victim with the services, support and information they provide, which is an entirely laudable and needed function to ensure that the criminal justice system is more victim centered overall.

This tension between community-based advocates and system-based victim witness coordinators is not unique to the District at all. In fact, such is the pervasiveness of the divide that there are conference seminars provided at the national level about how to get these two types of service providers to work together. A tremendous amount of the tension comes from the system-based providers feeling as though they are being disrespected or even entirely duplicated by community-based advocates, while community-based advocates allege that system-based service providers do not recognize the limits of their roles in terms of confidentiality and their obligation to the criminal justice system in addition to the survivor. The reality is that the two have distinct and equally valuable and crucial roles in the system of care for survivors.

In interviews with MPD detectives, survivors who had reported to MPD, and Victim Services Coordinators themselves, it became apparent that a large disconnect clearly exists between MPD's Victim Services Unit and NVRDC's advocates and attorneys. NVRDC advocates and case managers indicate that they are unclear as to precisely what the Victim Services Unit provides and has very little interaction with them. However, the survivor's experience may be very different, possibly receiving various communications from both. This isn't to say that survivors are dissatisfied with one over the other, but rather that there is a gulf that needs to be bridged with each performing their specific roles appropriately and in coordination with the other.

Conversely, the relationship between the USAO Victim Witness Unit and NVRDC's advocates and attorneys involves a great deal more contact, particularly in meetings with survivors at which both are present. As recently as December 2015, a survivor reported that the hostility of the USAO Victim Witness Coordinator was noticeable and made her uncomfortable, while that USAO Victim Witness Coordinator reported the NVRDC advocate to her supervisor for what she believed were inappropriate facial expressions. With the upcoming SAVRAA Task Force recommendation to include of prosecutorial interviews in the mandate for a community-based advocate as a right for all survivors, this contact and likely the tension that exists will only increase without thoughtful intervention.

**Recommendations:**

1. The Network for Victim Recovery of DC (NVRDC), the Victim Witness Unit at the US Attorney's Office and the Victim Services Unit at MPD should engage in cross training and strategic coordination meetings facilitated by the Independent Expert Consultant to bridge the significant gap in communication, information sharing and services referrals.
2. Training for all staff as described above should be provided annually about the different confidentiality laws that govern the roles of each, as well as updated information and training regarding the federal Crime Victims Rights Act, and the DC Crime Victim Bill of Rights.
3. SAVRAA should be amended to clarify confidentiality language related to the provision of a community-based advocate (DC Code §14-312) and their presence in meetings with prosecutors and system-based victim witness coordinators. This is necessary to ensure that there is maximum confidentiality provided to the survivor regardless of who they do or do not wish to have in their meetings with prosecutors or law enforcement, and so that everyone in the process can be reassured regarding the advocate's presence and the full integrity of a criminal case. See accompanying memo regarding statutory changes.

### *B. The DCRCC Hotline*

Perhaps the broadest and most important access point for service delivery for individuals who do not contact the DC SANE Program or report to police is the DC Rape Crisis Center's anonymous 24-hour hotline. The hotline receives approximately 275 calls per month.[27] In 2015, DCRCC referred 9 callers to the DC SANE Program Call Center for acute services. Though this number is shockingly low, according to DCRCC's Executive Director, callers to DCRCC's hotline are typically individuals who do not have an acute assault to report but rather were assaulted either as children, or in the recent or distant past and may not wish to report the assault or engage with anyone other than the hotline call taker or eventually a counselor or support group. According to DCRCC, this hotline has shifted recently from a counseling line on which callers could expect to talk for several hours to one that is geared more towards crisis intervention and referrals.

The hotline is not without significant problems and warrants improvement if it is to serve its full important function. The most significant issue noted through interviews with survivors who have utilized the hotline as well as other service providers and DCRCC leadership is the distinct separation and apparent lack of coordination with other service providers in the continuum of care. The Independent Expert Consultant also received three complaints about DCRCC's hotline's inappropriate information or lack of referrals to the DC SANE Program within the past year, two of which were instances in which the DC SANE Program was entirely appropriate for the caller and the callers were told that the forensic exam the caller was requesting was not an

[27] These are anonymous callers and therefore there is no way to know how many of those callers are unduplicated individuals rather than repeat calls from a smaller group of people.

option for them. In one of those two instances, the caller was incorrectly told that because her assault, which had occurred less than 24 hours prior, did not involve actual penetration, there was no reason to engage the SANE Program. Further, the Independent Expert Consultant has received 13 complaints from survivors directly and via sexual assault as well as domestic violence advocates because the hotline went unanswered. As of September 2015, the hotline only had one line. If the call taker is speaking with someone, other callers get a busy signal or a recorded message that says the call taker is busy helping another survivor and to call back later. The line then hangs up on the caller. Survivors calling after a recent assault or survivors having an acute crisis related to a past assault receiving this response may experience extreme distress at being disconnected in this manner.

DCRCC reports that their callers are from more marginalized portions of the District's population such as sex workers, transgendered survivors, immigrant survivors and teens. As such, they may not wish to go to a hospital or engage in a more formal system for fear of being reported to police themselves or otherwise not treated respectfully, as the response they receive from formal systems may have done more harm than good in the past. While this is entirely plausible and should be taken at face value, it is also the case that when specific numbers were requested for these populations to address DCRCC's concerns about the enormous needs they presented, as well as the number of adult survivors of child sexual abuse to verify the hotline's population, DCRCC cited the fact that callers are anonymous and therefore they don't have any way to know who is calling. This lack of specific information about what about the response is inadequate or about what the gaps are in a case-by-case manner makes it difficult for the SART to address them constructively. The hotline is a vital resource for very vulnerable populations and its capacity should only increase in the ways described below.

**Recommendations**

1. The hotline should be improved upon so that it provides robust referrals to other organizations for both acute and longer-term services, including but not limited to the DC SANE hotline for acute care and advocacy, a clear description of the DC SANE Program and process and reporting options as approved and provided by the SART, mental health resources, and support groups and individuals counseling for adult survivors of childhood sexual abuse. This hotline should be the primary entry point to the system of care.

2. The capacity of the hotline should be increased both through additional staffing, funding, training and improved technology to ensure that each call is answered. Until then, at a minimum a voicemail box should be set up so that callers are not disconnected when the line is busy.

3. Though acute cases are numerically rare among hotline callers according to DCRCC, cross training for hotline staff with the DC SANE Program should occur regularly so that

correct referrals are made, and so that any programmatic changes in the DC SANE Program and accessibility issues encountered by hotline callers can be shared.

### *C. Mental Health Services for Survivors of Sexual Assault*

There are three primary mental health service providers for sexual assault survivors: The Wendt Center for Loss and Healing, The Women's Center and The DC Rape Crisis Center (DCRCC), all of whom provide trauma-informed counseling services free of charge. The need for these services cannot be overstated; the Wendt Center often has a wait list for counseling services, as does the Women's Center, though DCRCC generally does not. The specific remedy to this problem involves increasing the capacity of these three organizations to address this need, while at the same time bringing in other service providers who focus on sexual assault and trauma informed care as portions of their service provision and educating other service providers in both issues of sexual assault and practicing trauma informed mental healthcare to expand the District's city-wide capacity and give survivors additional choices.

Through interviews with survivors and service providers, as well as analyzing MPD's data and observing case review subcommittee meetings, two gaps in mental health services became apparent. First, adult survivors of childhood sexual abuse are without a clearly designated service provider capable of providing ongoing support. This population often has acute lifelong needs and requires ongoing support. Three survivors interviewed indicated that, while they had been attending groups at DCRCC in prior years, they had been told that there were no groups for them as an ongoing matter. As of this writing, DCRCC does currently have a group for African American women who were victimized as children and may be starting more groups for adult survivors of child sexual abuse. This represents excellent progress in filling this gap, but the need is vast. The Wendt Center does not currently have a support group for this population, but the Women's Center does hold one periodically in Vienna, Virginia.

The second issue, discussed in the Case Review Subcommittee section on page X, is the high percentage of survivors with severe and persistent mental illnesses. The SART is currently working on increasing not only their capacity to serve this population more appropriate to the need expressed, but also to ensure that the capacity of mental health service providers engaged in this process outside of the SART are better equipped to work with sexual assault survivors overall.

**Recommendations**

1. Mental health services should be funded and built out by the Office of Victim Services and the SART to establish a wider network of trauma-informed providers than currently exists, with a specific focus on increasing the capacity to serve adult survivors of childhood sexual

abuse, the severely and persistently mentally ill, and marginalized populations who may be more reluctant to report sexual assault through more formalized processes.

2. Proof of current licenses for counselors, psychologists, social workers, etc. should be required by OVS as a condition of grant funding for any counseling activities. This includes appropriate supervision of interns by a licensed professional.

3. Services for adult survivors of child sexual abuse should be prioritized so that this unfortunately large population can receive the services they desperately need and want. This includes support groups such as those provided by DCRCC currently as well as individual counseling with an emphasis on clear information about accessing these services.

### *D. Sexual Assault Coalition Activities and the SART*

After careful review and interviewing of all parties concerned, including a total of 5 hours of interviews with DCRCC leadership, it is clear that there is no functioning sexual assault coalition in the District that encompasses both the more radical grassroots history of the DC Rape Crisis Center and its current leadership and the more system-oriented, SAVRAA-mandated service providers and process for sexual assault embodied by the DC SANE Program and the majority of the SART members. As mentioned in the discussion about the SART's statutorily required membership, DCRCC is the District's designated sexual assault coalition[28] and is also a direct services provider with important hotline and counseling services. While the DC Rape Crisis Center provides important and badly needed support for survivors of sexual assault both through their direct services and their outreach and education programming, their orientation towards a rape crisis center model over and above acting as a sexual assault coalition as described by both OVW and the National Sexual Assault Resource Sharing Project, necessitates that another organization perform the coalition functions the community so badly needs and desires. The District is currently without an inclusive functional coalition to speak for and benefit all sexual assault survivors and the service providers working with them every day. This coalition would of course include the DC Rape Crisis Center.

The definition of a sexual assault coalition provided by the Office on Violence Against Women (OVW) which provides specific funding for CDC-designated state sexual assault and domestic violence coalitions is: "Statewide sexual assault coalitions provide direct support to member rape crisis centers through funding, training and technical assistance, public awareness activities, and public policy advocacy (e.g. state coalitions might work with law enforcement, prosecution, and community organizations to enhance their responses to victims

[28] State sexual assault coalitions are designated by the Centers for Disease Control and are not assigned by local or state entities.

of sexual assault)."[29] Relatedly, the National Sexual Assault Coalition Resource Sharing Project defines a sexual assault coalition as follows: "S*exual assault coalitions* often serve as membership associations for local services providers, and also often advocate for improvements in laws, services, and resources for survivors of sexual violence and their service providers. State sexual assault coalitions coordinate statewide work and provide training and technical assistance to member rape crisis centers. State coalitions function as public policy advisors and provide guidance to organizations assisting sexual assault victims; additionally, some manage contracts or pass funding through to local rape crisis centers." [30] The District is relatively unique in that the local rape crisis center, defined by the National Sexual Assault Coalition Resource Sharing Project as an agency "whose major purpose is providing victim advocacy and support services to sexual violence survivors.[31]

Based on OVW's definition as the funder of sexual assault coalitions, the support and coordination of services is not forthcoming as of this writing, and in fact a philosophical discomfort with the coordination and public policy work required by the community through SAVRAA has been apparent in multiple meetings and interviews with DCRCC. Their more grassroots perspective is consistent with the history of the anti-rape movement, one embodied by rape crisis centers nationwide that sometimes function in opposition to system actors and other organizations who are viewed as sometimes needed but also part of an inherently oppressive culture badly in need of broad-based change.[32] This perspective is of course valid

[29] United States Department of Justice, Office on Violence Against Women, Fiscal Year 2015, State and Territorial Sexual Assault and Domestic Violence Coalitions Program, 2015, page 6. April 3, 2016. OMB Number: 1122-0020 http://www.justice.gov/sites/default/files/ovw/pages/attachments/2015/04/08/finals_coalitions_fy2015_4_2_15.pdf.

[30] National Sexual Assault Coalition Resource Sharing Project, Core Services and Core Services and Characteristics of Rape Crisis Centers: A Review of State Service Standards, pg. 2. Available at http://www.ccasa.org/wp-content/uploads/2014/01/Core-Services-and-Characteristics-of-Rape-Crisis-Centers.pdf.

[31] Ibid, pg. 2.

[32] See also generally Byington DB, Martin PY, DiNitto DM, Maxwell MS (1991). Organizational affiliation and effectiveness: the case of rape crisis centers. Administration in Social Work 15(3): 83-103; Campbell R, Baker CK, Mazurek TL (1998) Remaining radical? Organizational predictors of rape crisis centers' social change initiatives. American Journal of Community Psychology 26(3): 457-83; and Poskin, P, "A Brief History of the Anti-Rape Movement," September 2006 (presented by DCRCC's executive director at a public meeting on December 14, 2015).

and desperately needed in any community, most especially those with many historically marginalized communities, populations and even subgroups with specific needs and perspectives within those populations. However, it is also a philosophy more rooted in being a rape crisis center and not a philosophy that allows this particular state coalition to work well with the system that the community indicated it needed through SAVRAA and its mandate of highly coordinated and formalized services. The two perspectives are not mutually exclusive by any means, and only function in opposition if one or both parties approach the work in that manner, but based on interviews and observations of interactions, as well as review of written materials indicate strongly that these two portions of the anti-rape movement cannot coexist constructively in the current configuration where the city's rape crisis center is also serving as the state coalition while also providing direct services.

Based on community need and strong advocacy by DCRCC and other related community activists and survivors, SAVRAA was created to address not only the way police handled sexual assault reports and investigations, but to alter and formalize the advocacy and forensic evidence collection process associated with those investigations. The SAVRAA Task Force was established to explore expanding that mandate beyond law enforcement investigations and the adult survivor population. The system of care and the advocacy model endorsed by SAVRAA, though always a work in progress, was and is a reflection of a dire community need for more formalized and highly organized community-based organizations to advocate for survivors within the legal system, other formal systems and beyond.

A wealth of information was brought to the attention of the Independent Expert Consultant by survivors who noticed strained relationships between DCRCC and the other service providers, DCRCC leadership who defined coalition work exclusively and independently of the other newer service providers, as well as other service providers very concerned about a lack of coordinated voice for their organizations and the survivors they serve in policy matters. Throughout this evaluation, the Independent Expert Consultant also independently observed the highly chaotic and sometimes entirely contradictory outreach messages given to other, more peripheral service providers and the general public about how the DC SANE Program works and where to get help if one needs it. It is precisely these contradictions and their impact on survivors seeking care that prompted the inclusion of this highly divisive and controversial issue in this report.

Relevant Information related to the determination that the District is in need of a new configuration for its sexual assault coalition work is as follows:

- While outreach and technical assistance may have been occurring with other service providers, the only reports received by the SART from DCRCC were related to direct services even when questions about policy or coalition activities were asked.
- Coordination of services has been left entirely to the SART. The idea of a coordinated continuum of services and what it might contain had to be clarified by the SAVRAA Independent Expert Consultant to DCRCC's leadership on August 31, 2015 and again on October 20, 2015.
- On both occasions, DCRCC's leadership indicated that they spoke for survivors of sexual assault, and that their organizational agenda could not be shifted or diluted by other service providers who, in DCRCC's view as it was understood at those meetings, either did not speak on behalf of the survivors they served, or spoke on behalf of a privileged group of survivors who received the assistance of formal service providers.
- Unbeknownst to the service providers whose primary missions are to serve sexual assault survivors directly[33] and in some instances exclusively, policy advocacy and organization was outsourced to the DC Coalition Against Domestic Violence (DCCADV) at the request of the Office of Victim Services previous leadership through a Memorandum of Understanding between DCCADV and DCRCC. In spite of multiple direct requests, that MOU remained confidential until it was requested from OVS by the Independent Expert Consultant. Though this confidentiality is often a matter of courtesy between organizations, and DCCADV did appropriately view it as a courtesy to DCRCC that the MOU not be provided to others,[34] it was a private arrangement made regarding the public policy agenda of the providers requesting illumination of who was actually representing them and under what terms that representation was taking place.
- A policy meeting was held at DCCADV in February 2015, that included the members of the DC SANE Program and others on the SART, but there was no explanation given of why this was taking place or what the terms of their contribution were relative to representation with policy makers.
- When the Independent Expert Consultant inquired about who was representing the other service providers and the survivors they served in policy matters, DCRCC indicated on two occasions that they were representing DCRCC only, and that any other organizations would be represented by DCCADV because theirs was a broader coalition, and that this representational structure would continue for the foreseeable future, however informally. DCCADV's leadership confirmed this description in an interview as well.
- DCCADV also, quite rightly, is engaged in work around sexual violence as described in their 2016 request and award for funding from OVS as sexual violence is an all too integral part of domestic violence. However, these activities are not communicated or coordinated with the remaining service providers leading to the potential again for the confusion encountered when interviewing survivors, service providers and college campus advocates.
- Two survivors of the 26 interviewed noticed palpable distrust expressed by DCRCC towards NVRDC, though it should be noted that this issue was raised by the survivors themselves without any prompting. One indicated that she requested a referral, but her request was met with an awkward level of resistance. Both indicated that this was why they were no longer seeking or receiving services at DCRCC.
- As recently as December 2015, DCRCC prohibited its staff from collaborating with NVRDC to help a mutual client who had been referred by the Office of Victim Services, in spite of releases of information.

[33] Some of these organizations also serve other victims of crime and trauma, but have specific and primary programming to serve survivors of sexual assault.
[34] Telephone interview with DCCADV Executive Director, Karma Cottman, October 2, 2015.

- Two college campuses indicated a completely incorrect understanding of the DC SANE Program and indicated that they received their information from DCRCC and DCCADV.

The weight this lack of a functional coalition places on the SART is enormous. Many of the recommendations listed above could be carried out by a coalition, but currently cannot be because an enormous part of the puzzle is missing. DCRCC necessarily works with more marginalized populations who may have no desire to contact a medical professional or report to police, and the DC SANE Program's clients, where they do not overlap, may not see a need to interact with DCRCC directly except to obtain counseling services or basic information on the hotline, but the two should be working in tandem regardless. The SART could theoretically be the coalition itself but for the fact that they have government agency members who are prohibited from commenting on policy initiatives or even coordination efforts that require a legislative remedy, and because SARTs are typically and rightly very focused on the medical forensic and criminal justice response to sexual assault thus precluding much of DCRCC's service population. That focus may also validate DCRCC's expressed contention and concern that the inclusion of more system-oriented actors such as legal services providers might dilute the organization's core mission and agenda.

The lack of a functional and transparent coalition is overburdening the SART, creating conflicting outreach messaging, as well as tension that is noticeable to the individual survivor as well as anyone engaging with the parties in a group setting. Although the state coalition designation and funding streams are federal, OVS has previously also funded coalition activity at the local level. Based on the ongoing issues described above, the Office of Victim Services has indicated that they will not fund any coalition activity that does not explicitly include all service providers whose core mission includes that of providing sexual assault services. All of these factors speak to the need for a different configuration for the District's state coalition to the entire system of care and all survivors, to speak publicly on survivors' and service providers' behalf both with policy makers and the general public.

**Recommendations**

1. Establish a functional sexual assault coalition for the District that includes all organizations whose primary mission explicitly includes serving sexual assault survivors and therefore the survivors those organizations serve.

2. This coalition, however ultimately configured, should be entirely separate from any direct service provision for sexual assault survivors to facilitate transparency and avoid any apparent conflict of interest in funding and legislative advocacy efforts as well as overall philosophical orientation.

3. Any sexual assault coalition that is created or altered should contain a strong survivor

advisory board or council, and contain survivor representation at all levels from the board of directors to staff and volunteers.

4. Clarify the role of the DC Coalition Against Domestic Violence (DCCADV) within sexual assault work in the District such that projects are not in conflict with one another and so that outreach and education messaging can be appropriately coordinated.

## VI. **Conclusion**

This report covered many disparate topics, from the specific case review process to the broad issue of coalition representation for SAVRAA's system of care to gaps in services. Ultimately the SART is well on its way to being highly organized and effective, even by national standards, and the case review process is functioning beyond its mere legal requirements to identify patterns and find solutions to systemic problems. However, as discussed in the section about the system of care, there are gaps in services such as issue of mobility and overall capacity of the DC SANE Program to meet geographically scattered and non-hospital based requests for services as well as the current capacity of DCRCC's much needed hotline. In order for survivors to receive clear and correct information about where to go to receive the services they seek and to have knowledge of all of the available choices, transparency and coordination across the entire system of care is imperative. Ultimately, the SART is burdened by coalition activities and conflicts that should be undertaken by a more functional and inclusive coalition entity separate from direct service provision. Once the community addresses this critical core issue of coalition formation, the SART can focus on its legally mandated more formal system response while the badly needed rape crisis center model and philosophy embodied by DCRCC can continue to thrive as well for the benefit of all survivors in the District.