



Updated versions of the following documents are available:

Recommendations for the collection of forensic specimens from complainants and suspects

- There have been a few changes highlighted in the August version.

Recommendations for the collection of forensic specimens from complainants and suspects – the evidence

- No new papers were added from the June 2026 meeting.

Forensic Science Subcommittee (FSSC) Newsletter

Forensic Strategy and Labelling Guidance

FME Form – Complainant and Suspect

Recommendations for Collecting Hair Samples for Toxicology

Recommendations for Collecting Nail Clippings for Toxicology

General Updates

10ml Blood Volume for Toxicology

Following the introduction of larger bottles in kits, the recommended blood volume for toxicology has been increased to **10 ml**. Each bottle can safely hold 5 ml without risk of overfilling or glass breakage when frozen.

For older narrow-style vials, the recommended blood volume remains 7.5ml transferred into a 10ml tube/2x5ml tubes (no more than $\frac{3}{4}$ full).

Questions to the FSSC

1. We have a question regarding the recommended 3 cm radius from the anal orifice.

We have found that with a variation of anatomy, in children or in females that this would include the perineum or even to the vaginal introitus in some cases. Could the guidance be changed to allow for anatomical variation and age and size of patients and perhaps state 1 - 3cm around the anal orifice depending on anatomy to include the area around the anal margin?

The committee agreed that this was primarily a training issue. However, it approved updated wording in the Recommendations to clarify that a moistened swab should be rolled over the perianal skin, including the perianal skin folds.

2. I have just examined a female who had their cervix removed during a hysterectomy. In situations like this, when a female does not have a cervix, do we:
a) only take high vaginal swabs
b) swab the “void area” and document accordingly.
I have come across this a couple of times now and I have labelled the swabs as “void area at top of vaginal cavity” however, I consulted the current FFLM guidelines which stated “if endocervix is visible and it is possible to pass a swab”.
I understand I am not swabbing a cervix as there isn't one which then takes me back to my question, what do we swab if a female does not have a cervix?

The committee agreed the correct approach was to take a high vaginal swab, as this would naturally include the vaginal vault (the area present after removal of the cervix). A separate sample from the vault would not be required.





3. In my role, I regularly support victims of rape and serious sexual offences. A significant proportion of cases involve suspects who are current or former intimate partners. In these circumstances, it is common for victims to disclose consensual sexual activity with the suspect in the days preceding the assault. This presents both investigative and safeguarding challenges, particularly when considering the potential evidential value of forensic submissions.

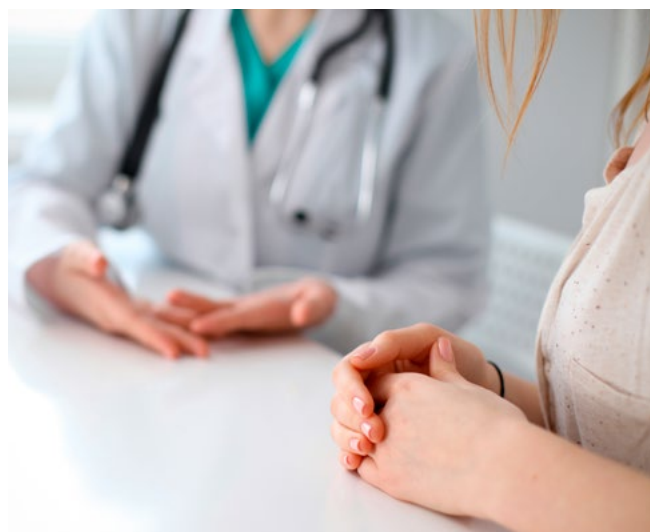
Where consensual intercourse has taken place shortly prior to a rape, there is often a perception among victims and investigators that attending a Sexual Assault Referral Centre (SARC) for forensic examination may offer limited benefit, due to the likelihood that any semen recovered could be attributed to earlier consensual activity. Clear understanding of forensic capabilities in this area is therefore crucial to ensure victims are appropriately advised, supported, and not discouraged from accessing services unnecessarily or based on incorrect assumptions.

I would be grateful for guidance on whether current forensic science is able to:

- Reliably estimate the age of semen deposits recovered from the body or clothing.
- Differentiate between semen deposited during consensual intercourse and semen deposited during a subsequent assault, where there is a known temporal gap.
- Provide any probabilistic or time-range assessments that may assist investigators and the courts in these scenarios.

The committee emphasised that SARCs provide holistic care beyond forensic sampling. It is important to emphasize that SARC forensic examination, in addition to sampling, includes an injury assessment - victims are not always aware when they have sustained an injury and verbal enquiry would not be sufficient to exclude. Victims would usually benefit from SARC attendance as the assessment is primarily health related including individualised advice regarding emergency contraception, time-critical blood borne virus prevention advice and onward referrals for ongoing support. The SARC process in these cases would also include significant time spent to explore relevant safeguarding. It is essential that the decision whether or not a client should attend SARC is not made purely from an investigative viewpoint and the wider holistic nature of the medical is understood.

Although there are currently no reliable scientific methods to accurately ascertain the age of semen or differentiate between deposits from consensual versus non consensual intercourse, forensic scientists may be able to make some comments on time since intercourse on a case by case basis by considering factors such as expected yield.



4. I've just noticed a change to the *Recommendations for the collection of forensic specimens from complainants and suspects* in relation to the taking of urine. It states that a sample should be taken if the incident is a suspected drug-facilitated crime within the preceding 14 days.

Can I ask if there is any further information to support this change please that I could refer to in order to inform our sampling policy? Previously the guidance has been 5 days for urine.

The archived versions of the *Recommendations for the collection of forensic specimens from complainants and suspects* is accessible to both members and non-members. This includes all the copies of the document since January 2017. The recommendation to obtain urine for drug-facilitated crime is contained within the 2017 document and remains valid today. The evidence document recommends urine sampling within **14 days** for suspected drug facilitated crimes. Supporting evidence is found in the following paper:

Negrusz A., Moore C., Stockham TL., & Levy NA. *Elimination of 7-Aminoflunitrazepam and Flunitrazepam in urine after a Single Dose of Rohypnol®* Journal of Forensic Sciences 2000: 45(5): 1031-40



5. The FFLM recommendations for labelling only refer to police cases. It is generally understood that no patient personal data should be included on samples or TEBS for self-referral samples however the FSR Code V2 states that samples should be labelled with date of birth.

Please would the FSSC provide guidance on the labelling of self-referral samples and TEBS.

In line with the Forensic Science Regulator Guidance: Forensic Medical Examination of Sexual Offence Complaints FSR-GUI-0020 (version 2); for self referral cases, labels should include **SARC ID** and **date of birth**, as previously noted in the January 2026 newsletter.

6. Is it possible for someone in the FFLM to contact me in relation to when a training video for the taking of early evidence samples for rape offences will be launched.

Short training videos providing clear, practical demonstrations of key non-intimate forensic sampling techniques are now available on the [FFLM website](#).

Each video focuses on a specific procedure, showing the correct equipment and collection method.

These videos are designed to support front-line police officers and forensic clinicians and reflect current FFLM guidance.

We would like to thank Police Scotland and Mountain Healthcare for sharing these videos and allowing us to make them accessible to a wider audience.

7. There does not appear to be specific guidance relating to no memory cases. My organisation has made the decision to offer full oral, vaginal/penile and anal samples in these situations. For example, where a patient reports having “blacked out” and an assault is believed to have occurred, but they awoke to anal or vaginal penetration, oral, anal and vaginal or penile samples should be routinely offered, given that it is not possible to determine what occurred while the patient was unconscious. My query is therefore around whether there should be wider guidance for clinicians as I am aware not all organisations offer all samples.

The committee agreed this was primarily a training issue. Clinicians should explain possible outcomes, respect patient choice, and apply professional judgement. No changes to Recommendations are required.

8. I have a query about obtaining the urine samples. I understand that DNA urine should be taken in a forensic bathroom, however if I am taking toxicology urine only, does this need to be done in the forensic bathroom? If urine samples have been completed prior to the patient attending the SARC, this will be done either at their own home address, the police station or in a hospital, all of which are non-forensic.

Urine collected solely for toxicology does not need to be taken in a forensic bathroom.

Where urine is collected solely for toxicology there is no need for the tissue wipe to be obtained.

If a tissue wipe is taken for DNA purposes e.g., as part of an Early Evidence Kit (EEK), it should be collected in a forensic bathroom. However, where EEK samples are taken before arrival at a SARC (such as at home, in a police station, or in a hospital), the location should be clearly documented in the officer's statement. If in a SARC setting, urine and wipes are taken outside the forensic bathroom, this should also be recorded.





9. We have been having ongoing discussions within our service regarding the swabbing of intimate injuries as a separate forensic sample.

Could you please advise whether intimate injuries should be swabbed as a separate swab, or whether it is satisfactory for these to be captured within the standard forensic swab set (for example, vaginal swabs as part of the routine set)?

Separate swabs for intimate injuries are not required; routine swabbing already covers these areas. Separate injury swabs apply only to non intimate injuries.

10. I am seeking clarification regarding the recommended procedure for obtaining urine samples for DNA purposes within a SARC setting. At our service, collecting urine for DNA analysis is an infrequently used technique, and I want to ensure we are following best practice.

In the current FFLM guidelines, the toxicology urine sample is indicated as being collected in a container with sodium fluoride, whereas the urine sample listed under DNA sampling does not specify the use of sodium fluoride. My interpretation is therefore that a urine sample taken for DNA should be collected in a different SceneSafe kit-specifically, one that does not contain sodium fluoride.

Could you please confirm whether this is correct, and whether there is a specific SceneSafe DNA urine kit that should be used when urine is required for DNA purposes?

Urine kits routinely contain sodium fluoride. DNA urine analysis is rare, and sodium fluoride has not been shown to affect results. Further feedback is awaited before any changes will be made to the Recommendations.

11. I have some queries relating to the most recent sampling recommendations.

Re Control swabs - I am assuming that the FFLM only advise taking a control swab if skin swabs are taken. The guidance does mention that a suitable control site is the opposite side to the site of interest that makes complete sense however if both sides are sites of interest should a separate nonrelated site be sampled/swabbed?

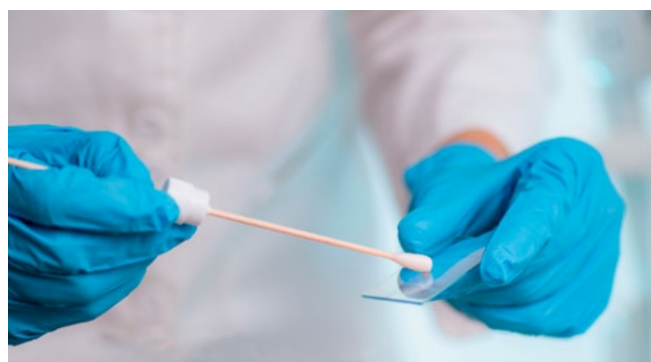
Can vulval swabs continue to be labelled as vulvo-perineal/vulva & perineum as that is what the sampling recommends that we sample. If so, would it be possible for the sampling guidance to actually say vulval & perineum rather than just Vulval swabs

Peri-anal swabs as part of the vaginal module – the FFLM has very kindly provided guidance on the order of sampling in the document *Recommendations on the order of ano-genital sampling when obtaining forensic specimens from complainants and suspects of sexual offences*. Could this 2024 guidance please be referred to or incorporated into future sampling recommendations?

Control swabs should be taken case by case, based on relevance to the allegation. They should be contextual and relevant to the allegation, rather than automatically taken from the “opposite side” of an injury e.g. a control swab opposite a ‘hickey’ may be appropriate, whereas in non fatal strangulation, both sides of the neck may be contact sites, making a different body area more suitable—or a control unnecessary altogether.

The group agreed that the control swab section of the sampling guidance should be revised to make clear that decisions depend entirely on the circumstances of the case.

Labelling queries will be addressed in the forthcoming *Forensic Sampling* guidance.





- 12. We have a few different organisations advising different things regarding storage of samples. This is mainly around wet/dry items and whether to use a plastic or paper bag then whether to store dry or freeze.**

Do England, Wales and Northern Ireland do it any differently to Scotland?



The committee discussed differing organisational practices around the storage of wet and dry clothing exhibits, particularly in relation to self referral cases. SARCs and police forces operate with different facilities and constraints, especially regarding drying rooms and freezer capacity. The committee clarified that dry clothing should be stored in brown paper bags, while soaking wet items should be frozen, as SARCs cannot dry large wet exhibits.

Underwear damp from blood or vaginal discharge, including from absorbent menstrual underwear, can be frozen if too wet for paper storage. SARCs should not attempt to dry items, and if an item is too wet to be placed in a paper bag without damaging it, it should be placed in a plastic evidence bag and frozen. Where police are involved, transport and drying procedures fall under local SOCO protocols. It was also noted that some of the confusion might stem from differences in Scottish practice.

It was noted that sanitary pads were often most useful when left in situ on underwear. It was agreed that, for clarity and consistency, sanitary pads should be left in situ on the underwear and frozen. The importance of documenting whether the underwear and sanitary wear were worn at the time of the assault or changed subsequently was also highlighted.

Regarding timing, the committee agreed that sanitary wear could be useful for up to seven days, mirroring the vaginal sampling window. Ideally, the item worn closest to the time of the assault should be recovered, but if the patient presented later, at least one item of sanitary wear should be taken if available.

With tampons, the committee agreed that sampling should be performed before removal where possible, to avoid altering distribution. The exact sequence would depend on clinical visibility and access. If specialist instruments were required to remove a tampon, and were not DNA grade, it should be documented. A control swab of the non-DNA grade item taken prior to its use may be of benefit.

- 13. Page 2 > Mouth swabs. It states some kits only contain one swab and no control swab. Please could we discuss and check which kits (if any) might only have one swab.**



Only one kit type contains a single swab. Standard kits include multiple swabs, and clinicians should take two mouth swabs. Control swabs are not required for mouth sampling. The reference to a control swab will be removed, as no control swab is required for mouth sampling.



14. I would be I would be grateful if the following could be discussed at the next meeting:

a. Penile swabs in cases of alleged oral rape or forced fellatio.

The FFLM Recommendations state penile swabs should be collected for “recovery of body fluids/DNA/other material (even if condom purported to have been used) if intercourse within 3 days (72 hours.)”

This guidance does not seem clear as to whether “intercourse” includes oral intercourse, or just vaginal/anal intercourse. Other parts of the FFLM recommendations specify vaginal or anal intercourse.

The consensus of my colleagues is that penile swabs should be taken for up to 48 hours after oral contact, as for other skin swabs.

b. For mons pubis swabs, the time frame for collection is not stated, but “as per vulval swabs” suggests they should be taken up to 7 days. Is this correct?

The July 2025 FSSC newsletter included discussion on whether they should be treated as for genital swabs (up to 7 days) rather than as skin swabs (up to 48 hours).

Penile swabs in oral rape cases should be obtained for up to 72 hours.



Mons pubis swabs should follow the seven day window used for external genital sampling. The Recommendations have been updated accordingly.

15. We have received some feedback from a Forensic Service Providers (FSP) via a police force that we have never come across before. I appreciate there may be differences in FSP protocols and procedures but wondered if there was any scientific rationale for the statement below:

“Unfortunately, the SARC report shows that the victim opened their bowels prior to the medical. Therefore, any semen or male DNA that may have been present will have been lost through this action. As a result, I am unable to progress this request.”

Background from our side:

- It was an anal assault
- Anal samples were taken within timeframe as per FFLM guidelines
- All sampling undertaken was in the correct order using the correct technique
- Patient had opened bowels once prior to SARC attendance

Any advice you can give us would be greatly appreciated.

The committee discussed and confirmed that FSPs would not refuse to process anal samples even if the client had opened their bowels prior to the examination. While the likelihood of recovering semen or male DNA would be very low and additional items would be requested where possible, laboratories would still proceed with analysis rather than declining the sample. In allegations of anal rape, SARC services should consider the need to prioritise such clients at the point of case triage due to evidential yield loss when bowels are opened.





16. I sit on the FFLM FSSC as the Northern Ireland representative. Just wondering if we could potentially discuss the following topics at the next FSSC meeting.

- a. Sanitary wear - At FSNI, we find the recovery of sanitary wear and nappies can be variable between incident types and clinicians. In a couple of cases, intimate swabs were recovered, however, the sanitary wear item was discarded, as the clinician thought that was too long after the alleged incident. Could we give more guidance on timescales for recovery?
- b. Biological male sampling - We never see male 'mons pubis' samples or the male equivalent being recovered. I am wondering should we specifically promote the recovery of a male pubic bone area sample either under the skin swabs guidance section or alongside the mons pubis sample. In certain allegations, there would be a good chance of skin-to-skin contact at this area, even if condom used, and we occasionally get very good results from female mons pubis samples submitted for analysis.

Sanitary wear should be recovered if the client presents within the timeframe for intimate samples.



Mons pubis swabs should also be taken in **biological males**, including those without pubic hair. It was agreed that the Recommendations should make this clear.

17. Please could SceneSafe add two more TEBs into the nail swabbing (scraping) kits. There are two TEBs currently for right- and left-hand swabs but no TEBs for the paper sheets for under the hands that should be exhibited separately - right and left hand.



The committee discussed whether two paper sheets were necessary, given that they would not be exhibited unless there was visible debris. While some clinicians use the sheets simply as a surface for the hands to rest on, the committee agreed that only one paper sheet was required for this purpose. One paper sheet will be removed from the kit, and an additional evidence bag will be included for occasions where the sheet needs to be exhibited. The paper sheet should only be exhibited if visible debris is present.

18. If a patient alleges anal rape, our standard practice is to complete vaginal samples as well. However, if the case (for example) is not called in until approximately 75 hours post assault, the patient would be outside the recommended timeframe for anal samples. In this scenario, should we still offer an appointment for vaginal sampling only, given that the vaginal timeframe remains open?

Vaginal sampling is generally **not required** when the allegation is exclusively anal and outside the sampling window.



19. Can the following be considered:

- Under rectal swabs it states: "If it is not possible to pass a proctoscope, try to obtain two 'blind' anal canal/rectum swabs, and label as such." Why should it be labelled blind anal canal/rectum when it is only a blind rectal? For high vaginal it says to only label as blind high not blind low/high vaginal so should it not be the same?
- When obtaining a urine for toxicology only should we still be asking the patient to use the tissue as this is a DNA sample? Or should we just be discarding it from the pack.
- Fingernail recovery states 48 hours only. Would this be extended to 7 days if not washed as per hands? If so, can this be added.

- For mons pubis and vulval swabs, contact (touch) with outside areas (skin) and oral (mouth) to vulva are both 48 hours - would either of these be extended to 7 days if not washed or not because of the nature of drainage? If yes, can it please be added.

- What is the rationale for ejaculation onto perineum being 7 days, considering that anal penetration with penis is only 72 hours?
- Can contact (touch) outside areas (skin) and oral (mouth) to perianal both be added to Perianal - assuming both would be 48 hours as per vulval
- Skin controls - there is still varying practice and confusion. It is clear if swabbing an injury you would take a control.
 - i. Would you take a control when you are swabbing for significant contact (no injury) for instance neck swabs following NFS, or reports of grabbing/sucking breasts?
 - ii. Would you take a control when you are swabbing due to prolonged skin-to-skin contact and/or drainage for example inner thighs, groins, or buttocks. Would it not be simpler to just say all skin swabs need a control then you can't go wrong?

The committee agreed that there was no need to label these as "blind anal canal" swabs and the Recommendations would be updated accordingly.

If urine is obtained exclusively for toxicology there is no need for the tissue wipe to be exhibited.

The committee considered whether the 48-hour window for fingernail swabs should be extended when a patient has not washed their hands. Current guidance already allows hand swabs to be taken up to seven days post-incident if the hands have not been washed. The committee agreed that fingernail swabbing may be extended to seven days if hands have not been washed.

The committee discussed concerns that fingernail clippings were being taken routinely. Routine nail clipping should not occur unless visible material is present.

The committee discussed whether the timeframe should be extended from 48 hours as washing history could sometimes be unclear. The committee recognised the need for caution and noted that scientific evidence for extended timeframes was limited. It was agreed that the guidance may need refinement to allow clinicians to use professional judgement without being overly prescriptive. Further consideration will take place before any changes are made to the Recommendations.

Due to the rugous mucosa in this area, there is potential for evidence from the vulval area to remain within the folds of the rugae for a longer period of time.

Clarity will be added to the Recommendations document.

As referenced in an earlier question, the decision to take a control swab should rely on the clinician's professional judgement and be both contextual and relevant to the allegation.



20. I am trying to establish if there are any papers regarding drainage of semen from the vagina into the anus/rectum or semen being 'drawn' into the rectum from the peri-anal area.

We take it as read that semen can be introduced onto the anal region from vaginal drainage, but I have been asked if there is any supporting literature. I can only find very old papers i.e. 1970s.

The issue stems from defence counsel providing it had been agreed in a previous trial (unsure if this was in a joint minute or if an expert medical/scientific gave evidence) that semen could drain into the anus.

The queries arising are:

- Can semen on the external skin e.g. perianal area passively drain into the anus? Is the opinion the same if the complainer was deceased (no traumatic genital injuries)?
- Could semen move into the anus from the perianal region by body movement of the complainer's anus?

There is no robust evidence quantifying passive movement of semen into the anal canal. Interpretation must consider anatomy, physiology, case circumstances, and potential undisclosed activity. Clear terminology distinguishing anatomical areas is essential.