

April 2016

**A National Protocol for
Sexual Abuse Medical
Forensic Examinations
*Pediatric***

A National Protocol for Sexual Abuse Medical Forensic Examinations Pediatric

**U.S. Department of Justice
Office on Violence Against Women**

April 2016

NCJ #

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Note that the protocol borrowed from and built upon many excellent state, federal, national, tribal, and international resources, as well as research related to community response to child sexual abuse and pediatric sexual abuse medical forensic examinations. In particular, this protocol benefited from guidance offered in *The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs* (Day & Pierce-Weeks, 2013), *Updated Guidelines for the Medical Assessment and Care of Children Who May Have Been Sexually Abused* (Adams et al., 2015), and *Medical Response to Child Sexual Abuse: A Resource for Professionals Working with Children and Families* (Kaplan et al., 2011). It also adapted recommendations, where applicable, from the U.S. Department of Justice's [National Protocol for Sexual Assault Medical Forensic Examinations—Adults/Adolescents](#) (2013).

Forward

Sexual violence is a significant health, social, and legal problem in the United States. The U.S. Department of Justice, Office on Violence Against Women (OVW) strives to support communities across the country in their efforts to implement an effective response to victims of sexual violence. The medical forensic examination is an integral component of this response. It is designed to address victims' health care needs and promote their safety and healing. In addition, forensic evidence collected during the examination—information gathered during the medical history, documentation of exam findings, and forensic samples, if potentially available—can help facilitate case investigation and prosecution of perpetrators of sexual violence. Success in meeting these objectives depends not only on the skills and knowledge of the health care providers conducting the examination, but also the coordinated efforts of all disciplines involved in the response to victims.

With successful medical forensic care as a goal, OVW released the *National Protocol for Sexual Assault Medical Forensic Examinations—Adults/Adolescents* in 2004 and a second edition in 2013.¹ It was evident during protocol development that the medical forensic care of adult and adolescent victims should be addressed separately from younger child victims, as considerable variations in approaches exist with these populations. OVW is pleased to now offer the *National Protocol for Sexual Abuse Medical Forensic Examinations—Pediatric*, which focuses on prepubescent children (see “Use of Terms” on page 8 for an explanation of terms used in this protocol).

¹The 2004 adult/adolescent protocol was developed under the direction of the U.S. Attorney General pursuant to the Violence Against Women Act (VAWA) of 2000. The statutory requirement can be found in Section 1405 of the VAWA of 2000, Public Law 106-386. The 2nd edition of this protocol is available at www.ncjrs.gov/pdffiles1/ovw/241903.pdf. The VAWA requirement also mandated the development of a national recommended training standard for health care professionals performing these examinations, as well as training for health care students. The *National Training Standards for Sexual Assault Medical Forensic Examiners* was released in 2006 and is available at www.ncjrs.gov/pdffiles1/ovw/213827.pdf.

Introduction

The *National Protocol for Sexual Abuse Medical Forensic Examinations—Pediatric* is a guide for: (1) health care providers who conduct sexual abuse medical forensic examinations of prepubescent children; and (2) other professionals and agencies/facilities involved in an initial community response to child sexual abuse, in coordinating with health care providers to facilitate medical forensic care. The main goals of a pediatric sexual abuse medical forensic examination, as described in this protocol,² are to:

- address the health care needs of prepubescent children who disclose sexual abuse or for whom sexual abuse is suspected;
- promote their healing; and
- gather forensic evidence for potential use within the criminal justice and/or child protection systems.³

It is also essential during the exam process to address concerns regarding children's safety, as well as to offer emotional support, crisis intervention, education, and advocacy to children and their caregivers as needed. Coordination across disciplines and agencies/facilities in a community, as well as across jurisdictions in some instances (e.g., in concurrent federal and tribal cases), is crucial to simultaneously address the above health, legal, safety, and support goals.

About this Document

Protocol Development

The OVW funded the International Association of Forensic Nurses (IAFN) to coordinate the development of the *National Protocol for Sexual Abuse Medical Forensic Examinations—Pediatric*. Leveraging the expertise of professionals involved in a community response to child sexual abuse at the local, state, federal, tribal, and national levels, including providers and organizations from health care and other relevant disciplines, was critical to protocol planning (as described below). The IAFN and the OVW also partnered with other U.S. Department of Justice (DOJ) agencies and federal agencies outside of the DOJ. The goal was to build upon their existing initiatives in responding to child sexual abuse and utilize the relationships they had established with organizations and experts around the country who serve this victim population.

Starting in the fall of 2014, the IAFN began gathering information and resources on protocols and practices related to pediatric sexual abuse medical forensic examinations. Over the course of protocol development, it solicited input on issues, gaps, and promising

² This protocol focuses on examinations for victims, not suspects. However, note that in the case of prepubescent children who display problem sexualized behaviors, examinations should be done by health care providers as these children may also be victims of sexual abuse. See Cavanagh Johnson (2009) for one resource on helping children with problem sexual behavior.

³ Note that the U.S. justice response to child sexual abuse encompasses two systems—criminal justice, which deals with crimes, and child protection, which deals with civil legal issues related to child abuse and neglect (adapted from Finkelhor, Cross, & Cantor, 2005). This protocol speaks to how these systems must coordinate their initial interventions when disclosures or suspicions of child sexual abuse are reported, as well as work collaboratively with agencies outside the justice system to facilitate medical forensic care for children and psychosocial support for children and their families to promote healing.

practices from an advisory committee, as well as numerous organizations, associations, and individuals.

- The advisory committee, formed in December 2014, included representation from child abuse pediatricians, pediatric sexual assault nurse examiners (SANEs), children's hospitals, hospital emergency departments, children's advocacy centers, community sexual assault victim advocacy programs, law enforcement agencies, prosecutors, and various groups that speak on behalf of specific populations. This committee assisted the IAFN and the OVW in: identifying and gathering supporting documents and data that informed decision making related to protocol scope, framing, and content; identifying issues and gaps in guidance for responders involved in the pediatric exam process; identifying potential elements of the protocol; and considering how to design the protocol to include needs of children with specific circumstances and from specific communities.
- Two work group meetings held in March 2015 generated a wealth of information and insight. These meetings called upon practitioners involved in health care, children's advocacy, victim advocacy, criminal justice, child protection, and forensic sciences fields to assist in crafting the national protocol. Numerous medical and nonmedical professionals involved in the work group meetings were able to address medical forensic care and coordinated response issues for different populations of child victims.
- Several phone conference discussions with victim advocates and other service providers took place after work group meetings to gain additional victim perspectives on the initial community response to disclosures and suspicions of child sexual abuse and to more fully understand barriers facing child victims from specific populations.

A preliminary draft of the protocol was developed in July 2015 and was distributed to a wide array of individuals and organizations for their review. Reviewers were selected based on a number of factors: their expertise on the topic of pediatric sexual abuse medical forensic care or some aspect of the community response to prepubescent child victims; their representation of particular populations (e.g., victims, community, or institutional setting); or their representation of entities that would be asked to play a role in the distribution and/or implementation of the protocol. DOJ partner agencies were also involved in the review process. Comments received from reviewers were incorporated into the document as appropriate. For a listing of individuals involved, see [Appendix 10. Participants in Protocol Development](#).

Protocol Organization

Protocol recommendations are organized into two broad sections:

1. [Section A. Foundation for Response During the Exam Process](#) focuses on guiding communities in laying a foundation of approaches and practices that support successful response during the exam process to disclosures or suspicions of sexual abuse in prepubescent children, and
2. [Section B. Exam Process](#) focuses on the various components of the sexual abuse medical forensic exam process.

Readers may be tempted to proceed directly to *Section B* for specific exam process guidance, however, *Section A* is important to review as it speaks to framing and infrastructure issues that communities should consider when creating a sexual abuse medical forensic examination protocol for prepubescent children. Sections A and B are comprised of chapters that discuss elements essential to those sections and offer related recommendations and considerations. Each chapter builds on previous chapters. Although an effort was made to avoid repetition of information, data may be repeated for clarity or emphasis.



The web version of the protocol, available at www.Kidsta.org, allows users to (1) easily access and navigate the protocol components, (2) view key recommendations as well as link to relevant chapters for recommendation details, and (3) connect to many of the references cited in the protocol. Note that protocol appendices are limited as related technical assistance and training resources are available through Kidsta.org.

Protocol Approach to the Examination

Key points to know regarding this protocol’s approach to the medical forensic examination include:

- Although the protocol’s focus is on the exam process, it also speaks to the initial community response to prepubescent child sexual abuse, as it is a gateway for victims to access medical forensic care. The protocol also acknowledges the necessity of a comprehensive, coordinated community response to fully address the needs of children specific to their individual circumstances. Planning at the conclusion of the examination can help connect children and their families to resources and prepare them for next steps in the community response.
- The protocol promotes multidisciplinary response teams and partnerships with children’s advocacy centers, where available, as tools to foster coordination and communication in these cases across disciplines and agencies/facilities, both in a community and across jurisdictions as needed.
- Although some prepubescent children disclose their experiences of sexual abuse, many do not or cannot. This protocol stresses that a suspicion of child sexual abuse should be all that is needed to trigger community interventions—including, but not limited to, medical forensic care, child protection, criminal investigation, victim services, and mental health care.
- Communities must be cognizant of and responsive to “contact” children—other children beyond presenting victims who may have had contact with, and possibly been abused by, the perpetrator (e.g., the siblings of a child sexually abused by a family member). This protocol encourages a multidisciplinary, collaborative approach, jurisdictional and multijurisdictional as applicable, to identify and sensitively address the needs of contact children.
- This protocol affirms that a medical forensic examination should be accessible to all prepubescent sexual abuse victims, regardless of the child’s background, circumstance, or geographic location.⁴ Due to the adverse health consequences

⁴ Existing guidelines related to the clinical management of suspected child sexual abuse generally recommend that all child victims undergo a medical forensic examination (Adams et al., 2015; Finkel, 2011; De Jong, 2011; Walsh et al., 2007).

associated with child sexual abuse as summarized later in this chapter, it is imperative that children who disclose sexual abuse or are suspected of being sexually abused receive timely health assessment, treatment, and interventions, regardless of the probability of evidence on their bodies or clothing.

- The protocol speaks to the fact that, due in part to the timing of disclosures, individual cases can vary in the urgency of medical forensic care necessary—meaning that the need for medical forensic care may be acute or nonacute. Generally, an acute examination should be conducted within the time frame prescribed by the jurisdiction, if a possibility exists that evidence may be present on the child’s body or clothing OR if factors beyond that time frame indicate a need for acute medical forensic care (one example is the child’s or the caregiver’s perception of urgency of the need for care). In most jurisdictions, a child is referred for a nonacute examination if the abuse occurred beyond the jurisdictional time frame for an acute examination AND no indication exists for acute medical forensic care. The protocol directs health care providers—rather than law enforcement or child protective service representatives—to determine the urgency of care appropriate for a child. Exam findings should always be documented, regardless of whether forensic samples are collected or whether the care provided is acute or nonacute.
- As prepubescent children typically present for health care accompanied by a caregiver, this protocol speaks to responders’ interactions with caregivers during the exam process. It stresses the need not only to aid caregivers and other family members in supporting the victimized child in the healing process, but also in dealing with their own reactions to the sexual abuse. In addition, it discusses safety measures if it is disclosed or suspected that a person accompanying the child during the exam process is the perpetrator, in collusion with the perpetrator, or otherwise abusive of the child.

USE OF TERMS

Note that the protocol uses a variety of terms and acronyms. The terms are described in the text and footnotes of the protocol, and the acronyms are spelled out the first time they are used, yet room for confusion may remain. For clarification, select terms are included in the glossary and a list of acronyms is provided.

- **CAREGIVER**⁵ refers to a person exercising a day-to-day caregiver role for a prepubescent child, such as a parent, guardian, foster parent, older sibling, relative, or family friend. Additional persons may play a temporary caregiver role for the child, such as a child care provider or babysitter. Note that a caregiver may or may not have legal responsibility over the child. Parents generally have the responsibility to make legal decisions that may be necessary for their children’s welfare, with jurisdictional laws defining exceptions. However, if prepubescent children do not have a parent who is qualified according to jurisdictional laws to make legal decisions on their behalf, they may need a separate individual to attend to their legal rights. In such instances, a guardian may be chosen voluntarily by the family

⁵ This bullet is adapted in part from the International Rescue Committee [IRC] (2012), Washington Coalition of Sexual Assault Programs [WCSAP] (2009), and Day and Pierce-Weeks (2013). The information related to parental/guardian responsibilities was drawn from FindLaw (2015) at <http://family.findlaw.com/guardianship/guardianship-of-minors.html>.

or appointed by the court to make legal decisions for them. For this reason, when discussing consent issues, the terms parent and guardian may be used rather than caregiver.

- **CHILD SEXUAL ABUSE:** Child sexual abuse, as used in this protocol, is intended to encompass any sexual act a prepubescent child may experience, with the exception of developmentally appropriate sexual behaviors that may occur among children, as described in [B3. Entry into the Health Care System](#). Specifically, child sexual abuse refers to the involvement of a child in sexual activity that she/he does not fully comprehend and is unable to give informed consent, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society (World Health Organization [WHO], 1999). It can occur between a child and a person or persons of any age or relationship to the child. The general intent of the sexual abuse is to gratify or satisfy the needs of the other person(s) (WHO, 1999). (See the [Introduction](#) for a discussion on the nature of child sexual abuse acts.) **Note that the term CHILD SEXUAL ABUSE often has a different meaning across jurisdictions and clinical settings**—for example:
 - Jurisdictions vary in statutorily defined child sexual abuse acts as well as language used to describe these acts. See www.childwelfare.gov/topics/systemwide/laws-policies/state/ for differences across states and territories. American Indian and Alaska Native tribes often have tribal codes defining child sexual abuse—see www.tribal-institute.org/lists/codes.htm for links to select resources. See www.justice.gov/criminal-ceos/citizens-guide-us-federal-law-child-sexual-abuse for U.S. federal laws related to child sexual abuse. Note the U.S. federal statute, 18 U.S.C. § 2246, broadens the intent of sexual abuse to include “to abuse, humiliate, harass, degrade, or arouse or gratify the sexual desire of any person.” Criminal justice and child protection systems utilize their jurisdiction’s statutory definitions. Factors such as the age of child victims and/or perpetrators (if they are minors), the relationship between victims and perpetrators, and the specific nature of the acts can influence what a jurisdiction considers illegal. Regardless of whether a specific sexual abuse act is considered illegal in a jurisdiction and requires justice intervention, however, it is imperative that the child receive medical intervention due to the adverse health implications associated with child sexual abuse (as discussed in the *Introduction*).
 - Clinically, the age and developmental level of child victims can impact whether they are cared for by health care providers trained in pediatric versus adult/adolescent medical forensic care.
- The **EXAM PROCESS** refers to the child’s entry into the health care system, the medical forensic examination in its entirety, and planning at the exam’s conclusion to facilitate post-exam health care and referrals to address child, family, and case needs.
- **PEDIATRIC** (adapted from Stanton & Behrman, 2011): Generally concerned with all aspects of the wellbeing of children. The pediatric population addressed in this protocol is solely prepubescent children as described below. Pediatric health care

must be concerned with particular organ systems and biological processes, developmental issues,⁶ and environmental and social influences that affect the health and wellbeing of children and families.

- **PREPUBESCENT:** A child's stage of pubertal development is determined by assessing secondary sexual characteristics rather than chronological age. Although the onset and timeline of the pubertal process is unique to each child, the stages are identifiable and predictable (Fritz, 2011; Jenny, 2011; Kaplowitz, 1999).⁷ **TANNER STAGES** detail the physical signs of breast, pubic hair, and male genitalia development for the five sexual maturation stages (Child Growth Foundation, n.d.; Marshall & Tanner, 1969).⁸ (See [Appendix 1. Tanner Stages of Sexual Maturation](#)) The sexual characteristic development of prepubescent children is reflected as Tanner stage 1 or stage 2. During the medical forensic examination, children require interventions that are tailored to their developmental stage. In addition, these interventions must be based on population-specific knowledge of development and differences between normal variants and healed injuries from prior abuse.
- Pubertal development is a natural differentiation between adolescents and prepubescent children. As indicated above, this protocol focuses on Tanner stage 1 and 2 children. **ADOLESCENTS**, as defined in this document, are children who are Tanner stage 3 and above who have potential reproductive capability. A Tanner stage 3 or 4 biological female, even if premenarchal, potentially has reproductive capacity.
- Adolescent victims as defined above are NOT addressed in this protocol, but in the adult/adolescent protocol available at www.ncjrs.gov/pdffiles1/ovw/241903.pdf. However, note:
 - ***Treatment of Tanner stage 3 and 4 children requires calculated clinical decisions that take into account children's developmental level in addition to sexual maturation stage.*** Despite their potential reproductive capacity—an issue that is addressed in the adult/adolescent protocol—Tanner stage 3 and 4 children are still children. As such, they should receive specialized medical forensic care that speaks to their developmental needs. There may be additional reasons in individual cases to involve a pediatric examiner when examining an adolescent (e.g., to recognize findings of healed anogenital trauma in an adolescent for whom abuse is the only form of sexual contact that has occurred).
 - ***Female children who have not reached the onset of menses should be examined by health care providers specifically trained in pediatric sexual abuse.***

⁶ Child development refers to how children become able to do more complex things as they get older, with a focus on gross and fine motor, language, cognitive, and social skills (University of Michigan Health System, 2015). In addition to physical growth, children typically experience distinct periods of development as they age. For information on developmental milestones, see the Center for Disease Control and Prevention (CDC) (2015c) at www.cdc.gov/ncbddd/childdevelopment/facts.html.

⁷ The onset of puberty should not be correlated to a chronological age; however, concerns about precocious or delayed sexual development should be referred to the appropriate pediatric specialist.

⁸ Note that the scale was developed with reference to a single ethnic group and a relatively small sample of only 200 children (Blackmore, Burnet, & Dahl, 2010). Care should be taken to assess children for pubertal development based on a knowledge of local ethnic variations in breast development, pubic hair growth, distribution, or growth patterns and common characteristics.

- ***Female children who are premenarchal must not have a speculum examination, unless there is associated trauma requiring surgical involvement.***
 - ***Extreme care should be taken when deciding to do a speculum examination on a young postmenarchal adolescent,*** in order to prevent further injury, pain, or trauma.
- **PREPUBESCENT CHILDREN WHO DISCLOSE SEXUAL ABUSE OR FOR WHOM SEXUAL ABUSE IS SUSPECTED⁹** may also be referred to as **CHILD SEXUAL ABUSE VICTIMS**. Note that because the protocol addresses a multidisciplinary response to child sexual abuse, “victim” is not used in a strictly criminal justice or child protection context. Rather, its use simply acknowledges that children who disclose sexual abuse or for whom sexual abuse is suspected should have access to certain services and interventions designed to address their health care needs and help them be safe, heal, and seek justice. In a health care context, these children may be referred to as **PATIENTS**.



Note that when caregiver involvement in exam process is discussed in the protocol, it is generally within the context of a caregiver who is not suspected of being the perpetrator of the sexual abuse (a nonoffending caregiver). That said, it is often unknown by initial responders whether sexual abuse of a prepubescent child actually occurred and/or, if so, who is the perpetrator. Equally important to note is that it is not the role of health care providers or other non-investigative entities to make such determinations. However, if it is suspected that the caregiver or other person accompanying a child during the exam process is the perpetrator, in collusion with the perpetrator, or otherwise abusive of the child, it is critical that the child is protected from that individual. In addition to urgent outreach to law enforcement and child protective services to convey specific safety concerns, health care providers should follow their facility policy on response to this type of threatening situation. Note that the main safety concern in such situations is usually imminent danger of child abuse; there also may be a risk of danger posed to others at the health care facility. It is important that health care facilities and providers have the ability in such situations to create a safety plan for/with the child, including but not limited to the child’s admission to the facility when necessary (if the facility has inpatient capacity).

Protocol Recommendations for Standardized, High-Quality Examinations

This protocol offers recommendations to facilitate standardized, high-quality sexual abuse medical forensic examinations of prepubescent children,⁹ as well as coordination across disciplines, involved entities, and jurisdictions as applicable, to address child, family, and case needs during the exam process. Note:

- Recommendations are provided for baseline practices as well as “gold standard” practices where they have been identified. The intention is to inspire jurisdictions to “reach for gold” while ensuring a solid base. To the extent possible, recommendations are evidence-informed—meaning based on available evidence from research, but also on an understanding of related issues and responder experiences. To that end, where little or no research support practices, protocol

⁹ Standardization of medical processes is intended to reduce variability, improve care, reduce mortality and morbidity, and decrease costs (Adams et al., 2015).

developers looked to experts for consensus. However, consensus simply does not exist on every practice. Communities often have unique and/or different ways of responding to child sexual abuse. The protocol recommends following jurisdictional and/or health care facility policies in many instances, recognizing that multiple valid ways may exist to handle a particular issue.

- This document can aid communities in developing or revising protocols for providing sexual abuse medical forensic care for the prepubescent child. It supplements but does not supersede protocols that have been created at the local, state, territorial, tribal, and federal levels, or by national and international entities. To the extent appropriate, this protocol builds upon the [*National Protocol for Sexual Assault Medical Forensic Examinations—Adults/Adolescents*](#).
- Although the protocol strives to be inclusive of related issues and needs of different types of communities, institutional settings that house or care for children, and diverse populations of child victims, the recommended practices may need to be tailored for local communities and different populations and settings.
- This protocol is meant to improve the prepubescent child sexual abuse medical forensic exam process, and the criminal justice and child protection systems' response to prepubescent child victims. It does not address other civil justice remedies that may be available to these children (e.g., restraining orders or temporary custody arrangements) and does not create a right or benefit, substantive or procedural, for any party.
- The protocol is not intended as a comprehensive primer on the issue of child sexual abuse nor as training curricula for health care providers or responders from other disciplines. However, it does introduce readers to the topic and offers a wealth of information—for communities, agencies, organizations, and facilities involved in the response to child sexual abuse, and for institutions that house or care for children—to consider as they develop related policies and staff training.¹⁰
- Finally, many of the laws that may impact medical forensic care—such as mandatory reporting, medical records privacy, consent to health care, and privileged communications—vary significantly from jurisdiction to jurisdiction. Although these laws are discussed in general terms throughout this document, health care providers should consult an attorney who is familiar with the laws of their health care facility and jurisdiction.

Protocol Focus on Children

Prepubescent children experience sexual abuse across multiple settings within the home, community, and broader society (Day & Pierce-Weeks, 2013; East, Central, and Southern African Health Community, 2011; Population Council, 2008). The nature of the sexual abuse may be affected by a variety of factors, including but not limited to those listed below.¹¹

¹⁰ It can also be a useful reference for entities that are required to comply with legislation involving immediate response to child sexual abuse victims. For example, for juvenile detention center administrators striving to comply with the Prison Rape Elimination Act (PREA), the protocol can help them customize a standardized response to sexual abuse of prepubescent children housed in their facility (noting it is rare for young children to be in juvenile detention). The *Introduction* and *Chapters A1* through *A3*, in particular, offer these administrators insights on victim care and coordinated response issues specific to this population.

¹¹ Also the CDC (2015a) at www.cdc.gov/violenceprevention/childmaltreatment/riskprotectivefactors.html offers information on factors that contribute to the risk of child abuse and neglect, as well as protective factors that buffer children from that risk.

Examples of Factors that Can Influence the Nature of Sexual Abuse (not inclusive)

ACTS¹²

(Note: The general intent of sexual abuse acts is to “abuse, humiliate, harass, degrade, or arouse or gratify the sexual desire”¹³ of the perpetrator or any involved person. **These acts do not encompass activities that occur in the course of appropriate child care or medical care, or developmentally appropriate sexual behaviors of children, as described in B3. Entry into the Health Care System.** Acts listed below are **not legal definitions** and are intended as examples.)

- Penetration, however slight, by a person into the genital, anal, or oral opening of a child, including using objects
- Sexual contact between the genital and anal opening of a child and mouth or tongue of another person
- Intentional touching of a child’s genitals, breasts, groin, inner thighs, or buttocks, or the clothing covering them
- Requiring, directing, coercing, encouraging, or permitting a child to engage in sexual acts, or negligently failing to prevent a child from engaging in these acts (e.g., with adults, children, or animals, and/or with objects)
- Requiring, directing, coercing, encouraging, or permitting a child to view one or more sexual acts or materials, or negligently failing to prevent a child from viewing such acts or materials
- Exhibitionism—intentional exposure of genitals in the presence of a child, if such exposure is for purposes of sexual arousal or gratification, humiliation, degradation, and/or other similar purposes
- Commercial sexual exploitation—causing or enticing a child to engage in sexual activity for someone else’s economic or sexual advantage, gratification, or profit (e.g., requiring, directing, coercing, encouraging, or permitting a child to solicit or engage in commercial sexual acts or negligently failing to prevent such activity)¹⁴
- Making recorded images of a child engaged in sexual activity or in sexually suggestive poses or scenarios (e.g., to buy, trade, or sell sexual acts involving a child)
- Sadoomasochistic acts, which involve inflicting/receiving pain for purposes of sexual stimulation of the person or child
- Child sexual abuse as a part of a separate crime (e.g., domestic violence, abduction, hate or war crime, trafficking, ritual abuse, or drug exposure¹⁵)

FREQUENCY AND SCOPE OF VICTIMIZATION

- Single or multiple types of sexual victimization during one incident or over time
- Polyvictimization (multiple victimizations of different kinds)¹⁶

NUMBER AND CHARACTERISTICS OF PERPETRATORS

- Single or multiple perpetrators¹⁷
- Relationship of perpetrator to child (e.g., intra-familial, caregiver, person of authority, acquaintance, familial/non-familial youth perpetrator, or stranger) or societal/cultural practices, such as genital mutilation¹⁸ and child marriage¹⁹
- Perpetrator of the same or different sex, sexual orientation, or gender identity as the victim²⁰

¹² The list was drawn in part from the Ohio Chapter of the American Academy of Pediatrics (AAP) Committee on Child Abuse and Neglect (2009).

¹³ Drawn from 18 U.S.C. § 2246. See Offices of the U.S. Attorneys. (n.d.).

¹⁴ See the National Children’s Advocacy Center’s Child Abuse Library Online (CALiO) at <http://calio.org/resources/trafficking-and-commercial-sexual-exploitation-of-minors> for information and links to resources on commercial sexual exploitation of children.

¹⁵ See CALiO at <http://calio.org/resources/drug-endangered-children-resources> for resources on drug-endangered children.

¹⁶ This definition emphasizes different kinds of victimization, rather than just multiple episodes of the same kind of victimization (Finkelhor, 2011). See CALiO at <http://calio.org/resources/poly-victimization> for more resources on polyvictimization.

¹⁷ Note there may be instances where individuals are coerced to sexually abuse a child (e.g., in a domestic violence scenario).

¹⁸ Genital mutilation involves partial or total removal of the external genitalia or other injury to the genital organs, whether for cultural or other nontherapeutic reasons. See WHO (2014) and WHO and the Joint United Nations Program on HIV/AIDS (2007).

¹⁹ See WHO (2013) for information on child marriage.

²⁰ Be aware of differences among terms: SEX refers to the sex designation that a person was assigned at birth, generally determined by genitalia and/or reproductive anatomy. Sex may also be inferred by someone’s secondary sex characteristics or chromosomes. GENDER refers to the attitudes, feelings, and behaviors that a given culture associates with a person’s biological sex. Individuals may



Note that being sexually abused by someone of the same or opposite sex, sexual orientation, or gender identity may create questions or confusion for children (National Child Traumatic Stress Network, 2014).²¹

Sexual abuse of children is different from sexual victimization of adults. An impetus for this protocol was the fact that child sexual abuse differs from sexual assault of adults and adolescents; the difference compels a response to child sexual abuse that is tailored for children (Christian, Lavelle, & De Jong, 2000; Day & Pierce-Weeks, 2013; Girardet, 2011; Palusci et al., 2006; WHO, 2003; Young et al., 2006). Children are not little adults.

Sexual abuse against prepubescent children is distinct, particularly due to their dependence on their caregivers and the ability of perpetrators to manipulate and silence them (especially when the perpetrators are family members or other adults trusted by, or with power over, children).²² Very young children and children with disabilities who have increased reliance on caregivers are particularly at risk (CDC, 2015a).²³ Sexual abuse may be a single encounter, but often it is ongoing over many weeks, months, or even years due to perpetrators' unfettered access to and control over their victims. Episodic sexual abuse may become more invasive over time as perpetrators gradually sexualize their relationship with their victims (WHO, 2003). Sexual abuse is often hidden by perpetrators, unwitnessed by others, and may leave no obvious physical signs on child victims (Allnock, 2010; WHO, 2003).

Getting help is complex. There are many barriers to the reporting of sexual abuse for children (NSVRC, 2012b). (See the examples below.) Prepubescent children, by nature of their development, may be incapable of or have difficulty with identifying sexual abuse, communicating with others about it, and knowing how and having the capacity to access

or may not adhere to societal expectations associated with their presumed gender, which often only includes two genders (male and female). GENDER IDENTITY refers to an individual's internal sense of being male, female, or another gender (not necessarily visible to others). INTERSEX refers to a variety of conditions in which a person is born with reproductive anatomy that does not fit the typical definitions of female or male, or has chromosomal structures other than just XX or XY. TRANSGENDER is often used as an umbrella term to encompass a wide range of people whose gender identity or expression may not match the sex they were assigned at birth. SEXUAL ORIENTATION refers to whether someone is primarily attracted to people of the same gender (lesbian or gay) or the opposite gender (heterosexual), or attracted to more than one gender (bisexual). This information was drawn from the National Sexual Violence Resource Center [NSVRC] and Pennsylvania Coalition Against Rape (2012) at www.nsvrc.org/sites/default/files/Publications_NSVRC_Guides_Talking-Gender-Sexuality.pdf, National Child Traumatic Stress Network (2014) at www.nctsn.org/sites/default/files/assets/pdfs/lgbtq_tipsheet_for_professionals.pdf, and personal communications with M. Munson, November 2015. Also see FORGE (2012) at <http://forge-forward.org/wp-content/docs/FAQ-05-2012-trans101.pdf>. A related note: Although this document sometimes uses he/him/his and she/her/hers pronouns, a growing number of people are using gender neutral or alternative pronouns such as ze, xe, and the singular they. Similarly, many individuals may use a name and pronoun that is different than their identification or insurance documents. The protocol recommends that responders ask children what name and pronoun they prefer. For more information on this topic, see FORGE (2015) at <http://forge-forward.org/wp-content/docs/FAQ-Pronouns.pdf>.

²¹ It is important that responders are aware and can explain to children and caregivers (adapted from Male Survivor, n.d.; 1in6.org, n.d.): Sexual abuse is about taking advantage of a child's vulnerability; it is not caused by the sex, sexual orientation, or gender identity of the perpetrator. Sexual abuse cannot determine a victim's sexual orientation and gender identity. Even if the child liked the attention she/he received or was sexually aroused during the sexual abuse, these reactions do not indicate the child's sexual orientation or gender identity. This issue can also be explored post-exam, particularly in victim advocacy and mental health settings.

²² The National Children's Advocacy Center (2015) at <http://calio.org/images/grooming-bib2.pdf> offers a bibliography of articles on perpetrator manipulation of child victims.

²³ See Smith and Harrell (2013) for a discussion on sexual abuse of children with disabilities. Children with disabilities are three times more likely than children without disabilities to be victims of sexual abuse (Lund & Vaughn-Jensen, 2012; Smith & Harrell, 2013). The likelihood is even higher for children with certain types of disabilities, such as intellectual or mental health disabilities (Lund & Vaughn-Jensen, 2012; Smith & Harrell, 2013).

help. These difficulties can be exacerbated for children with disabilities (Smith & Harrell, 2013). Prepubescent children may also have much lower tolerance than adolescents or adults for activities associated with seeking assistance from unfamiliar people.

Examples of Reasons Why Children Do Not Disclose Sexual Abuse²⁴

- A child may lack awareness that they have experienced sexual abuse;
- A child's linguistic or developmental limitations may prevent disclosure;
- A disability may hinder a child in disclosing sexual abuse or reaching out for help;
- A child may be manipulated by the perpetrator to maintain silence (e.g., told she/he will get in trouble if she/he tells);
- A child may fear, as well as be told by the perpetrator, that a disclosure will lead to negative consequences (e.g., further abuse or violence, family discord, unfair treatment by responders, removal from her/his family, deportation if she/he is a recent immigrant, public exposure as a sexual abuse victim, public perception that she/he is lesbian or gay if abused by a perpetrator of the same sex or that she/he is transgender if the perpetrator is transgender, and/or blame, shaming, and shunning of a child and her/his family by the community);
- A child may worry a disclosure of sexual abuse will be discounted by adults;
- A child may blame her/himself for causing the abuse;
- A child may be embarrassed (e.g., because she/he trusted the perpetrator or liked receiving attention from him/her);
- A child may want to avoid punishment if the abuse occurred in the course of an activity which was illegal (e.g., drinking alcohol) or prohibited by her/his caregivers (e.g., running away from home); and/or
- A child may wish to protect the perpetrator (e.g., she/he loves him/her and does not want him/her imprisoned).

Barriers to reporting exist for adults as well, as when a child discloses sexual abuse to them or they suspect that child sexual abuse may have occurred. For example, adults may not know what to do or who to call for help or may feel they have to prove the abuse happened before they report it (NSVRC, 2012b). They may worry that it is none of their business or that they will make things worse by reporting (NSVRC, 2012b). They may worry about consequences they may experience if they make a report on behalf of a child, such as loss of friendships, a job, or social status (NSVRC, 2012b). Victims' family members may also be hesitant to report due to the stigma associated with sexual victimization and fear of legal action against perpetrators who might be family members or friends (Almeida et al., 2008).

When children do disclose sexual abuse, the disclosure itself is often part of a process rather than one event (Allnock, 2010; Flam & Haugstvedt, 2013; Schaeffer, Leventhal, & Asnes, 2011). Sexual abuse is not typically disclosed to or suspected by others immediately following the abuse (McElvaney, 2015). A disclosure may be initiated, whether accidentally or purposefully, following a change in the child's behavior or a physical complaint (for example, pain when washing the genital area or a bloodstain in diapers or underwear) (WHO, 2003). (See [B3. Entry into the Health Care System](#) for more on related signs and symptoms.)

²⁴ This list was adapted primarily from IRC (2012) and NSVRC (2012b). Also see Schaeffer, Leventhal, and Asnes (2011).

Children may first “test the waters” to see how adults react to hints about sexual abuse—if they react with anger, blame, or other negative responses, the child may stop talking or later deny the abuse (IRC, 2012). Children may also only partially disclose, telling just enough about the abuse to initiate a response that will end further abuse. This manner of delayed and drawn-out disclosure can have implications for agencies and professionals involved in the initial response to child sexual abuse, as well as for examination and investigative approaches.²⁵ For example, child sexual abuse medical forensic examinations usually require interpretation of physical findings that may be healed injuries, rather than injuries seen following a recent sexual abuse (Arkansas Commission on Child Abuse, Rape, and Domestic Violence, 2014). The examiner must be able to distinguish normal genital variations and changes as children grow from evidence of healed injuries of sexual abuse (Arkansas Commission on Child Abuse, Rape, and Domestic Violence, 2014).

Prepubescent children who experience sexual abuse can suffer from a wide range of health problems across their lifespan. In addition to immediate health issues, such as sexually transmitted diseases (STDs),²⁶ physical injuries, and psychological trauma, child sexual abuse victims are at greater risk for a plethora of adverse psychological and somatic problems into adulthood in contrast to those who were not sexually abused (Jenny et al., 2013; Springer et al., 2003). Health problems can include but are not limited to those below.

| <i>Examples of Health Problems Associated with Child Sexual Abuse²⁷ (not inclusive)</i> |
|---|
| <ul style="list-style-type: none"> • Suicide attempts • Depression • Anxiety • Low self-esteem • Symptoms associated with post-traumatic stress disorder²⁸ • Conduct disorders/delinquency |

²⁵ Campbell et al. (2013) found that adolescent victims with voluntary disclosure patterns were more likely to remain engaged with the legal system throughout the investigation process than those with involuntary disclosure patterns. Different dynamics contribute to whether, when, and how prepubescent children disclose sexual abuse compared to adolescents. However, this study has application in that it emphasizes considering which disclosure patterns and help-seeking activities of child victims and their caregivers may correlate with their engagement in the medical and legal systems.

²⁶ Although the term sexually transmitted disease (STD) is used in this protocol, STDs are also commonly and correctly referred to as sexually transmitted infections (STIs). (See [Glossary and Acronyms](#).)

²⁷ This list was adapted in part from Day and Pierce-Weeks (2013); Jenny, Crawford-Jakubiak, and the Committee on Child Abuse and Neglect (2013); Springer et al. (2003); and OVW (2014). Also see the CDC (2014a).

²⁸ The following overview was drawn from the National Institute of Mental Health (n.d.): PTSD is an anxiety disorder that develops for some people after seeing or experiencing a dangerous event. PTSD symptoms can be grouped into: (1) re-experiencing symptoms, such as flashbacks (reliving the trauma over and over); bad dreams; and frightening thoughts; (2) avoidance symptoms, such as staying away from places, events, or objects that are reminders of the experience; feeling emotionally numb; feeling strong guilt, depression, or worry; losing interest in activities that were enjoyable in the past; and having trouble remembering the dangerous event; and (3) hyperarousal symptoms, including being easily startled, feeling tense or “on edge,” and having difficulty sleeping and/or having angry outbursts. For very young children, PTSD symptoms may include bedwetting, forgetting how or being unable to talk, acting out the scary event during play, and/or being unusually clingy with caregivers or other adults. Although some of these symptoms naturally persist after a traumatic event, when symptoms last more than a few weeks and become ongoing, they may suggest PTSD. The National Center for PTSD (2015) noted that children who experience prolonged, repeated sexual victimization and other trauma may have additional symptoms indicative of more severe psychological harm (sometimes referred to as complex PTSD)—they may have problems with emotional regulation, dissociation, self-perception, and perception of the perpetrator and relationships with others, and experience a profound sense of hopelessness and despair. The Welfare Information Gateway (2015) at www.childwelfare.gov/pubs/issue-briefs/brain-development/ offers a brief on the effects of child maltreatment on brain development.

Examples of Health Problems Associated with Child Sexual Abuse²⁷ (not inclusive)

- Unsafe sexual behaviors
- Substance use, addiction, and abuse
- Eating disorders
- Obesity
- Chronic pain
- STDs
- Overall poor health
- Sexual and intimate partner violence victimization
- Sexual dysfunction²⁹

Every child is different in how they are affected by sexual abuse. A variety of factors can impact the severity of their reactions. Factors fall broadly into the following categories (WCSAP, 2009):

- The child's previous experiences and history of trauma (with more trauma and adverse life experiences, such as chronic abuse and polyvictimization, likely increasing the risk of serious problems from the sexual abuse);
- The nature of the sexual abuse and the child's reactions during the abuse (the potential for negative impact may be greater in certain situations—for instance, when the child believed she/he was in extreme danger or the abuse was her/his fault, when the abuse occurred over time and the child lived with ongoing fear and worry about being abused, and when the child was abused by someone who was important to her/him); and
- What happens after the sexual abuse, especially how caregivers respond (e.g., in a way that is validating and supportive of the child versus not believing the child, minimizing what happened, or making the child feel guilty for not disclosing sooner or for disrupting the family) and the child's perception of what occurred.

With appropriate support and resources, children can heal from sexual abuse. From a health perspective, the medical forensic exam process provides a proactive vehicle for communities to:

1. assess sexually abused children's health status and identify health concerns of children and their caregivers;

²⁹ The following are examples of supporting literature: suicide attempts (Devries et al., 2014; Chen et al., 2010; Pérez-Fuentes et al., 2013); depression (Bebbington et al., 2011; Coles et al., 2015; Danielson et al., 2010), anxiety (Chen et al., 2010; Simon et al., 2009); low self-esteem (Coles et al., 2015); PTSD symptoms (Barrera, Calderón, & Bell, 2013; Chen et al., 2010; Danielson et al., 2010); conduct disorders/delinquency (Danielson et al., 2010; Maniglio, 2015); unsafe sexual behaviors (Jones et al., 2013; Mosack et al., 2010); substance use, addiction, and abuse (Balsam et al., 2011; Danielson et al., 2010; Khoury et al., 2010; Najdowski & Ullman, 2009; Topitzes et al., 2010); eating disorders (Chen et al., 2010; Doshi & Grossman, 2012; Sanci et al., 2008); obesity (Midei, 2011; Rohde et al., 2008); chronic pain (Coles et al., 2015); STDs (Jewkes, Sen, & Garcia-Moreno, 2002), including human immunodeficiency virus (HIV) (Jones et al., 2010; Mosack et al., 2010); overall poor health (Coles et al., 2015); sexual and intimate partner violence victimization (Balsam, et al., 2011; Black et al., 2011; Lalor & McElvaney, 2010; Messman-Moore et al., 2010); and sexual dysfunction (Straples, Rellini, & Roberts, 2012; Swaby & Morgan, 2009). In addition, Jones et al. (2013) found that child sexual abuse victims may internalize the trauma (e.g., by withdrawing, becoming anxious or depressed, and complaining of bodily health problems) or externalize the trauma (e.g., by having attention-deficit problems, engaging in aggressive behaviors, and breaking rules). Victims who exhibited externalized behaviors were at increased risk of engaging in sexual intercourse before the age of 15, having multiple partners, and not using protection during sex.

2. provide emotional support for children and their caregivers as well as education so they are aware of their options and available resources for treatment and healing;
3. coordinate treatment for physical, psychological, and behavioral issues; and
4. develop a plan to promote healing that minimizes and mitigates the negative health outcomes for children over time.

Justice system agencies can also help facilitating healing for children in these cases by addressing their safety needs and connecting them and their families with related justice system services.

Mental health treatment can play an integral role in reducing children's trauma symptoms.³⁰ Ongoing support from victim advocacy programs can promote children's healing, while assisting children and their caregivers with planning for physical and emotional safety. A range of additional services specific to child and family needs can contribute to children's wellbeing. All involved in the community response to child sexual abuse can build upon children's resiliencies—their ability to maintain or recover wellbeing despite adversity—to help them cope with their reactions (adapted from IRC, 2012).

Family issues are complicated. Caregivers and other family members often play a primary supporting role for prepubescent children during reporting, initial community response, the exam process, and beyond (whereas adult and adolescent victims may also or instead turn to friends and intimate partners for support after sexual victimization). Caregivers in particular need to be educated on how to provide support and protection to prepubescent children while facilitating their healing over time. In addition to verbal education on these matters, it can be helpful to provide caregivers with related written materials during and at the conclusion of the exam process. They also may benefit from ongoing help to cope with the impact of the child's victimization on their own lives (e.g., they may react by feeling self-blame and guilt for not preventing the abuse or believing a child's disclosure, or, if the perpetrator is their family's main source of income, they may be stressed by the financial implications of loss of that income). Some caregivers may have their own trauma histories that may or may not have been previously addressed. They may experience PTSD from their own victimization, which can impact their ability to facilitate their child's healing. They may require support to be able to move towards healing themselves and to assist their children.

If the caregiver or another family member accompanying the child during the exam process is the perpetrator or is in collusion with the perpetrator, or is otherwise abusive to the child, an issue of paramount importance is protecting the child during the examination and after. It is also critical to identify and protect any potential contact children. It can be complicated to help children move towards healing when perpetrators are caregivers or family members, especially if other family members are torn about whom to believe or are in denial that someone they care about would engage in such an act (WSCAP, 2009).

³⁰ See CrimeSolutions.gov (n.d.) at www.crimesolutions.gov/PracticeDetails.aspx?ID=45 for a discussion of therapeutic approaches for sexually abused children and their families, based on review of several meta-analysis studies. Also see the National Crime Victims Research and Treatment Center's *Child Physical and Sexual Abuse: Guidelines for Treatment* (Saunders, Berliner, & Hanson, 2003) at <https://mainweb-v.musc.edu/vawprevention/general/saunders.pdf>. In addition, the Child Welfare Information Gateway at www.childwelfare.gov/topics/responding/trauma/treatment/ offers links to resources on the treatment programs to meet the needs of children, youth, and families affected by trauma.



Throughout the protocol, examples of resources for responders, victims, and families are referenced. In addition, www.Kidsta.org offers information and links to resources to further responders' knowledge about the prevalence of child sexual abuse in general and for specific populations, the dynamics and impact of child sexual abuse, disclosure and reporting issues, healing from child sexual abuse, and support needs of caregivers and families. It also offers links to resources for victims, caregivers, and families.

A. Foundation for Response During the Exam Process

Overview

Section A of the protocol focuses on guiding communities in laying a foundation of approaches and practices that support successful responses during the exam process to disclosures or suspicions of sexual abuse in prepubescent children. It includes the following chapters:

A1. Principles of Care *(for all responders)*

A2. Adapting Care for Each Child *(for all responders)*

A3. Coordinated Team Approach *(for all responders)*

A4. Health Care Infrastructure

A4a. Pediatric Examiners

A4b. Facilities

A4c. Equipment and Supplies

A5. Infrastructure for Justice System Response During the Exam Process

A5a. Reporting

A5b. Confidentiality and Release of Information

A5c. Evidentiary Kits and Forms

A5d. Timing of Evidence Collection

A5e. Evidence Integrity

A5f. Payment Issues



See www.Kidsta.org for community assessment tools related to the response to child sexual abuse and the exam process.

A1. Principles of Care

While these recommendations are primarily for health care providers involved in caring for prepubescent child sexual abuse victims, they should be considered by all professionals who have a role in the initial response to child sexual abuse. Implementation of these principles requires collaboration across involved disciplines and entities.

Provide interventions that are child-focused, victim-centered, and trauma-informed. These terms are explained below as they are used in the protocol:

- **CHILD-FOCUSED:** An approach to care that is developmentally, linguistically, and culturally appropriate for prepubescent children; designed with their needs, abilities, and best interests in mind; and intended to reduce potentially traumatic effects of the exam process.
- **VICTIM-CENTERED:** An approach to care that is grounded in an awareness of and commitment to addressing the needs of victims of sexual abuse during the exam process. It is informed by the victim's circumstance (See [A2. Adapting Care for Each Child](#)). A victim-centered approach recognizes that victims deserve timely, compassionate, respectful, and appropriate care to promote their healing, as well as information to support their decision making. This approach encourages choice for victims whenever possible, as fitting their developmental level and applicable laws. Medical personnel may refer to victim-centered care as patient-centered care.
- **TRAUMA-INFORMED:** An approach to care that seeks to support the healing and growth of children who have experienced sexual abuse, while avoiding their retraumatization (National Sexual Assault Coalition Resource Sharing Project [RSP] & NSVRC, 2013).³¹ A trauma-informed approach considers and evaluates all interventions in light of a basic understanding of the role that violence plays in the lives of victims (Harris & Fallot, 2001), as well as integrates an understanding of the child's history and the context of their experience (RSP & NSVRC, 2013).³² It recognizes the effects that trauma can have on children's behavior, coping strategies, relationships, and ability to interact with health care providers, law enforcement, and other professionals.

In addition to interventions directed at victims, a child-focused, victim-centered, trauma-informed approach to prepubescent child sexual abuse also seeks to assist caregivers in developing strategies and skills to protect, reassure, and support child victims, as well as

³¹ Trauma begins when the experience overwhelms normal coping mechanisms; in response to the traumatic event, the child may have a range of physical and psychological reactions (RSP & NSVRC, 2013). Retraumatization can occur when environmental cues related to the trauma (e.g., sound or smell) trigger a fight, flight, or freeze response (Proffitt, 2010).

³² See RSP and NSVRC (2013) at www.nsvrc.org/sites/default/files/publications_nsvrc_guides_building-cultures-of-care.pdf for more on trauma-informed care. This resource offers an ecological model of trauma that illustrates how a child's reaction to sexual abuse is influenced by circumstances surrounding the abuse and the child's life experiences. The attributes of the community to which the child belongs also can influence how she/he is affected by the abuse. Implementing trauma-informed care involves striving to understand victims within their familial, social, and community context and experience (Proffitt, 2010; RSP & NSVRC, 2013). Core principles of trauma-informed care include (Proffitt, 2010; RSP & NSVRC, 2013): physical and emotional safety of victims; trust (with providers striving to maximize their trustworthiness to victims, make clear tasks, seek consent, maintain appropriate boundaries, etc.), choice (supporting victims' choices and control during the healing process); collaboration between victims and those providing care; empowerment (identifying the child's strengths and prioritizing building skills that promote healing and growth); and cultural competency (ensuring cultural applicability of care and options, as well as sensitivity to the role of culture in the child's experience and decision making).

cope with their own distress.³³ Community interventions that build upon children’s strengths, along with a protective, reassuring, and supportive response by caregivers, can help lessen the abuse’s negative impact on children (WCSAP, 2009, 2015a).



In each case, responders need to assess the child’s developmental level and communication skills as these factors can impact the nature of their interactions. (See [A2. Adapting Care for Each Child](#))

Especially with younger children, caregivers play a primary role in providing and receiving information during the exam process. In the protocol, note the need for this assessment whenever the phrases “child and caregiver” is used in the context of communicating information to them or decision making.

Uphold guiding principles of care. Below are seven principles and key actions that responders can take to support child-focused, victim-centered, trauma-informed care for prepubescent children who disclose sexual abuse or are suspected of being sexually abused (adapted in part from Day & Pierce-Weeks, 2013; United Nations High Commissioner for Refugees, 1995).

Guiding Principles of Care for Prepubescent Children

Principle 1: Provide children with timely access to examinations, trained examiners, and quality care.

Principle 2: Secure the physical and emotional safety of children.

Principle 3: Recognize each child has unique capacities and strengths to heal.

Principle 4: Offer comfort, encouragement, and support.

Principle 5: Provide information about the exam process and links to resources to further address needs.

Principle 6: Involve children in decision making, to the extent possible.

Principle 7: Ensure appropriate confidentiality.

³³ Examples of related resources: Yamamoto (2015) at www.nsvrc.org/sites/default/files/publications_nsvrc_guides_the-advocates-guide-working-with-parents-of-children-who-have-been-sexually-assaulted.pdf offers an advocate guide for working with caregivers of child victims. It includes parent tip sheets. The National Child Traumatic Stress Network (2009) at www.nctsn.org/sites/default/files/assets/pdfs/caring_for_kids.pdf offers a guide on what caregivers of sexually abused children need to know. WCSAP offers a parent survivor brochure at www.wcsap.org/parent-survivors. Caregiver resources are also offered at www.nctsn.org/resources/audiences/parents-caregivers (National Child Traumatic Stress Network) and www.stopitnow.org/ohc-content/resources-for-parents-of-survivors (Stop it NOW!).

Guiding Principles of Care — Prepubescent Children

Principle 1: Provide children with timely access to examinations, trained examiners, and quality care.

- Offer every child who discloses sexual abuse or is suspected of being sexually abused a medical forensic examination. However, children should never be forced to undergo the examination.
- Offer all children high-quality medical forensic care, regardless of factors such as ethnicity, race, language, religion, sex, sexual orientation, gender identity, ability/disability, or financial situation.³⁴ A child's unique needs and circumstances should influence nuances of care (See [A2. Adapting Care for Each Child](#)).
- Ensure that examinations are conducted by medical providers who are trained to conduct the pediatric sexual abuse medical forensic examination (See [A4a. Pediatric Examiners](#)).
- Consider child sexual abuse a priority at health care facilities. Promptly evaluate children to treat serious injuries and determine the urgency of medical forensic care needed. Seek assistance to address immediate safety concerns and provide emotional support. An appropriately timed medical forensic examination should follow. Understand that a disclosure or suspicion of sexual abuse, even if delayed, may be an emergency for the child and family (See [B3. Entry into the Health Care System](#)).
- Focus on care of the whole child—she/he is more than a victim of sexual abuse.
- Maintain the priority of the health of children over the collection of forensic evidence.

Principle 2: Secure the physical and emotional safety of children.

- Evaluate the consequences of actions during the exam process with children and caregivers. The least harmful course of action for the child is always preferred.
- Be cognizant of safety risks facing children during the exam process and have mechanisms in place to address imminent risk of danger. For example, if the accompanying caregiver is suspected of perpetrating the sexual abuse, convey this urgent concern to law enforcement and child protective services, and follow health care facility policy on responding to this situation. Do not conduct a forensic examination of the suspected perpetrator at the same time and location as the child examination (although it might be feasible for another examiner to conduct the suspect examination in another facility location). Avoid actions that might overwhelm or frighten the child, such as placing her/him in a noisy room with many unfamiliar people and no personal support person.
- Encourage communication, information sharing as allowed by applicable laws, and collaboration among responders to identify and address safety concerns in a timely and appropriate manner. Connect children and caregivers to resources for post-exam safety planning assistance (e.g., child protective services and victim advocacy services).

Principle 3: Recognize each child has unique capacities and strengths to heal.

- Identify and build upon the strengths of the child and the family as a part of the healing process.
- Use a person-first approach to care that places the focus on the child first—her/his experiences, safety

³⁴ Federal law prohibits recipients of federal financial assistance from discriminating based upon a person's membership in a protected class. Protections vary by statute, but generally speaking, recipients must comply with the prohibition against race, color, and national origin discrimination contained in Title VI of the Civil Rights Act (Title VI) of 1964, as amended, 42 U.S.C. § 2000d; the prohibition against disability discrimination contained in Section 504 of the Rehabilitation Act (Section 504) of 1973, as amended, 29 U.S.C. § 794; the prohibition against age discrimination contained in the Age Discrimination Act (Age Act) of 1975, as amended, 42 U.S.C. § 6102; and the prohibition against sex discrimination in education programs contained in Title IX of the Education Amendments (Title IX) of 1972, as amended, 20 U.S.C. § 1681. Certain funding statutes also contain prohibitions on discrimination, and recipients of funds made available under those statutes must comply with requirements of those statutes. Recipients of funds made available under the Omnibus Crime Control and Safe Streets Act (Safe Streets Act) of 1968, as amended, 42 U.S.C. § 3789d(c); the Juvenile Justice and Delinquency Prevention Act (JJDP Act) of 1974, as amended, 42 U.S.C. § 5672(b); and the Victims of Crime Act (VOCA) of 1984, as amended, 42 U.S.C. § 10604(e) are prohibited from discriminating on the basis of race, color, national origin, religion or sex. Recipients of funds under the VAWA of 1994, as amended, 42 U.S.C. § 13925(b)(13), are prohibited from discriminating on the basis of race, color, national origin, religion, sex, disability, sexual orientation, or gender identity.

Guiding Principles of Care — Prepubescent Children

and wellbeing, needs, and reactions. When working with children with disabilities, utilize the same person-first approach to ensure that the focus is not placed on the child's disability status.

- Encourage factors that promote children's resiliency. Resiliency is the ability to thrive and grow during and following an adverse experience (NSVRC, 2013; Steele & Malchiodi, 2011). Resiliency results from individual characteristics and coping mechanisms (innate and acquired) and protective factors in a child's ecology, which the child uses to defend her/himself against violations of her/his rights and cope with and recover from adversity (IRC, 2012). On the family level, examples of protective factors include involvement on the part of caregivers, family cohesion, adequate housing, and stable and adequate family income (IRC, 2012). Examples of protective factors at the community level include involvement in community life, peer acceptance, supportive mentors, and access to quality schools and health care (IRC, 2012).

Principle 4: Offer comfort, encouragement, and support.

- Seek training on how to respond in a child-focused, victim-centered, trauma-informed way to disclosures of sexual abuse from children.³⁵ The impact of adult reactions to such disclosures on children's psychological health can be profound—negative reactions can traumatize children; whereas calm and supportive reactions can foster feelings of safety and acceptance (IRC, 2012). Understand that a lack of a disclosure or a recantation on a child's part does not necessarily mean the sexual abuse did not occur. Also, educate caregivers about this fact.
- Seek training on how to guide caregivers to be supportive and reassuring to their children in the aftermath of sexual abuse. For instance, caregivers may benefit from discussions with responders about what is helpful to say and do to comfort the child and what they should avoid saying, what to tell their other children about the abuse, and how to handle it when other children are angry when the abused child is "getting all the attention." Responders can also model appropriate behavior for caregivers to use with child victims. Modeling may be particularly effective when it is delivered by pediatric health care providers, as caregivers may consider the providers to be experts in the health of children.
- Offer children crisis intervention, support, and victim advocacy as early as possible. Also, offer these services to caregivers to help them cope with their reactions to the abuse, reduce their stress, and aid them in supporting the child.
- Afford children as much privacy at the health care facility as possible. For example, if possible, do not leave children and caregivers in the facility's main waiting area prior to care. Throughout the examination, limit exposure of the child's body to the area being examined.
- Consider the child's comfort throughout the exam process. For example, reduce wait time as much as possible. Offer developmentally appropriate toys, stuffed animals and dolls, books (in languages/formats they can understand), and electronic devices to occupy them while waiting for the examination. Consider how to enhance comfort via the physical environment (e.g., comfortable furniture, low lighting at least prior to the examination, and calming pictures on the walls that children can focus on during the examination). Consider additional measures that can be taken by responders to increase comfort. For instance, for a child who is thirsty during an acute examination, make collection of oral samples a priority so the child is able to drink as soon as possible. If nonacute medical forensic care is needed, schedule it at a time that works best with the child's routine (e.g., not at her/his bedtime). Before discharge, provide the opportunity for the child to wash, brush his/her teeth, have a snack, and change clothes. Offer replacement clothing if clothing was taken as forensic evidence.

³⁵ See NSVRC (2014) for Bringing Hope: Responding to Disclosures of Child Sexual Abuse (online course).

Guiding Principles of Care — Prepubescent Children

- Provide accommodations and other modifications in care so that the exam process is welcoming to and inclusive of the needs of children and caregivers (e.g., providing language interpreters as necessary, describing the exam room and what is happening for someone who is blind, accommodating requests for responders of a specific gender or culture, if possible, etc.). (See [A2. Adapting Care for Each Child](#))
- Recognize that the exam process may take longer with some children. Avoid rushing to finish. Rushing may not only distress children, it can lead to gaps in the collection of information, forensic specimens, and documentation.
- Recognize in some instances that a caregiver may be more upset than the child during the exam process and need support to stay calm around the child. Victim advocates can be helpful in providing such support.³⁶

Principle 5: Provide information about the exam process and links to resources to further address needs.

- Offer verbal information to children and caregivers during the exam process, tailored to developmental level and linguistic capacity. Before or at discharge, provide a packet of written information summarizing what was said or referred to during the exam process. Topics to cover minimally include:
 - What will happen during the examination (overall and for each procedure);
 - Exam finding results, including that it is "normal to be normal" and follow-up care instructions/appointments;
 - Sexual abuse dynamics, related laws, the range of victim reactions and concerns of children and caregivers, and the process of healing from sexual abuse;
 - Safety planning;
 - Costs families will be expected to cover for the examination and other related medical care, what the jurisdiction will cover, and their options for financial assistance in covering these expenses;
 - Resources available in the community to address post-exam needs related to the sexual abuse, such as victim services, mental health counseling, and crime victims' compensation programs;
 - Criminal justice and child protection investigative processes, as applicable; and
 - Contact information for involved responders.
- Recognize that most children and caregivers have little knowledge about the exam process and sexual abuse. Provide them a balance of information and appropriately time its delivery—the goal is to help them be more prepared rather than overwhelmed.
- Encourage questions from children and caregivers about the information provided. If they have questions post-exam, be clear to whom they should direct questions regarding specific topics.
- Tailor referrals to the needs of children and caregivers (e.g., seek mental health providers who can speak the same language as the child, have expertise in child sexual abuse issues, and experience addressing other issues of the child that may impact counseling effectiveness, such as those related to race, ethnicity, religious affiliation, sexual orientation, gender identity, disability, and/or living in an institutional setting). Avoid generic referrals when specialization is more fitting. Respect child and caregiver decisions to prioritize or decline referred services. For example, a mother may decline counseling for herself because she is more concerned about getting financial aid to cover medical costs and deflect wages lost while attending medical appointments with her child.

³⁶ Rheingold et al. (2013) found that child and caregiver understanding of the examination and caregiver response to the disclosure of sexual abuse were associated with caregiver and child anxiety. In addition to providing information about the examination to reduce their distress and providing advocate support during the exam process, caregivers who experience high levels of anxiety can be referred to advocacy programs for individual and group support services, as well as for mental health counseling.

Guiding Principles of Care — Prepubescent Children

- Help children and families in accessing resources. For example, rather than just providing referrals, connect them with service providers, and help schedule appointments and coordinate transportation to/from services.
- Be aware of the best ways to connect victims with services in your community. In some communities, one referral to victim advocacy services or a child advocacy center is sometimes all a health care provider needs to do to ensure children and caregivers are assisted in coordinating all other necessary services.

Principle 6: Involve children in decision making, to the extent possible. (See [B1. Consent to Care](#))

- Inform children what their options are throughout the exam process. Encourage related questions.
- Give children control during the examination whenever possible (e.g., seek their permission to proceed with exam steps, let them choose which color of gown to wear and whether to have a support person in the exam room, and ask for their input on where to position that person in the room). However, recognize their capacity to make decisions depends in part on their developmental level and applicable laws.³⁷
- Honor children’s right to decline all or part of the medical forensic examination (with the exception of emergent/urgent medical care and treatment), even if the parent/guardian consents.
- Recognize children may need time and support to overcome hesitation to allow exam procedures. Some may benefit from more explanation (e.g., an older child may feel more comfortable agreeing to the examination if he/she is provided with a description of equipment that will be used and can see it in advance). It is also helpful to explain in advance to children and caregivers if they will be left alone for periods of time (e.g., while waiting for a specialist consultation) and the anticipated time frame so as to avoid increasing anxiety.
- Talk directly to children (as is developmentally appropriate) rather than talking about them to caregivers.
- Interact with children in a transparent and respectful manner. For example, if a child’s wishes (e.g., for an examiner of a specific gender) are not able to be followed, explain the reasons why.

Principle 7: Ensure appropriate confidentiality. (See [A5b. Confidentiality and Release of Information](#))

- Inform children and caregivers of mandatory reporting requirements. Provide examples of what needs to be reported, why, and reporter responsibilities. (See [A5a. Reporting](#))
- Ensure children’s medical records are securely stored and carefully controlled by the health care facility, as per applicable laws and policies. Release records only according to applicable jurisdictional laws and facility policies.
- Recognize children and caregivers may have confidentiality concerns (e.g., that others will find out that the child contracted a STD from the sexual abuse). Explain that they will receive medical results from the examination, but typically will not have access to the investigative report until after the case is closed. Explain what will be shared with the investigative team, what communications the team will likely have with them, and measures that will be taken to protect the child’s personal information outside of the team. Be open to discussing how they can talk to their families about sensitive topics or what to do to cope if certain information becomes public.

³⁷ All states and the District of Columbia allow minors 12 and above to consent to certain health care services without permission of parents/guardians—see www.gutmacher.org/statecenter/spibs/spib_OMCL.pdf (Guttmacher Institute, 2015) for examples. Some may also allow minors to seek or receive these services without parental/guardian notification. However, in most jurisdictions, prepubescent children do not have these rights. Responders should become familiar with the applicable related laws of their jurisdiction.

In addition to the specific references to other protocol chapters, the above principles of care are woven throughout all the chapters of this protocol.



See www.Kidsta.org for resources to help communities incorporate the above principles of care into their response to prepubescent child sexual abuse. Also, see resource examples referenced in the protocol.

Provide prepubescent child victims and their families with timely access to victim advocacy services during the exam process. This access is important to upholding the above principles of care in individual cases. Victim advocates typically function to aid victims and their families in getting help to cope with the impact of sexual victimization in their lives and to promote healing. They may also encourage coordination and collaboration among responders so that interventions are child-focused, trauma-informed, and victim-centered. Victim advocates who serve prepubescent child sexual abuse victims and their caregivers should receive specialized training for working with these populations.

In many jurisdictions, advocates who serve child sexual abuse victims and their families (via community-based sexual assault victim advocacy programs, children’s advocacy centers, criminal justice system victim-witness offices at the local, state, territorial, tribal, and federal levels,³⁸ military family advocacy programs, tribal social services, and others) may be available to assist children and/or caregivers during the exam process. Some, community-based sexual assault victim advocacy programs in particular, offer children and/or caregivers accompaniment during the examination, providing crisis intervention, emotional support, help in voicing their concerns, short-term safety planning, information, and/or referrals. Outside of the exam process, victim advocacy programs may offer assistance with longer-term safety planning, counseling/referrals to counselors, support groups for nonoffending caregivers, assistance with applications for victim compensation programs, and accompaniment during related medical appointments and legal proceedings. In communities where community-based sexual assault victim advocacy programs exist but are not involved in the exam process in prepubescent child sexual abuse cases, responding entities are urged to partner with them to engage advocates in this process (See [A3. Coordinated Team Approach](#)).

In jurisdictions where victim advocacy programs are not available to provide children and/or caregivers services in these cases, exam facility staff (e.g., child life specialists,³⁹ social workers, chaplains, and/or behavioral health staff) may be enlisted to provide them with support during the exam process. Like advocates, facility staff that provide such support should receive specialized training to prepare them to address the support needs of child sexual abuse victims and their caregivers.

³⁸ Note that criminal justice system-based advocates/victim service providers, such as those in law enforcement or prosecution offices, generally cannot offer confidential services, while community-based advocates/victim service providers generally provide confidential services (to the extent permissible by jurisdictional law and their program policies).

³⁹ Child life specialists are professionals trained in child development who help children cope with the stress and uncertainty of illness, injury, disability, and hospitalization. They most commonly work in hospital pediatric programs. (This explanation was drawn from Child Life Council (n.d.).)



See www.Kidsta.org for links to resources for victim advocacy programs for working with child sexual abuse victims and their caregivers. Also check out resources from sexual assault coalitions (go to www.justice.gov/ovw/local-resources for links to state, territorial, and tribal coalitions) and the Office of Juvenile Justice and Delinquency Prevention's (OJJDP) regional children's advocacy centers (go to www.ojjdp.gov/Programs/ProgSummary.asp?pi=30 for links to the Northeast, Southern, Midwest and Western regional children's advocacy centers).

A2. Adapting Care for Each Child

These recommendations are for all responders to adapt care to address each child's needs.

Adapt care to each child's needs and circumstance. Gathering information about a child victim's circumstance allows responders to provide customized interventions that meet the child's needs, as well as investigative needs. Understanding the child's circumstance includes looking at obvious facts (e.g., the child's developmental level, the nature of the sexual abuse experienced, and child's reactions to it) and beyond those factors (see the table below). The goals are for responders to acknowledge and appreciate the whole child and be sensitive and inclusive in their interactions with each child.

| <i>Examples of Differences in Circumstances for Child Victims</i> | |
|--|--|
| <p>Characteristics/Background</p> <ul style="list-style-type: none"> • Age and developmental levels • Family: caregivers, siblings, and others living with the child in the home • Residence, including homelessness and institutionalized settings • Preferred communication method • Language needs for limited English proficient children, those who are Deaf and hard of hearing, and those with disabilities that affect communication (also consider language needs of accompanying caregiver) • Sex • Gender identity or expression • Sexual orientation • Physical health history and current status • Mental health history and current status • Disability status and type of disability • Ethnic and cultural beliefs and practices • Religious and spiritual beliefs and practices • Economic status • Immigration and refugee status of child and family, including recent and undocumented • Military status of family • If there is a history of victimization • If there has been exposure to violence in the home • If there has been exposure to substance use in the home • Experience with the juvenile justice, criminal justice, and/or child protection systems • Tribal affiliation of child and family | <p>Sexual Abuse Experienced</p> <ul style="list-style-type: none"> • Type(s) of acts, frequency • Number of perpetrators • Relationship with perpetrator(s) • Where the abuse occurred • If it involved drugs and/or alcohol • If photographic images of the abuse were taken/distributed • If there was exposure to pornography • Whether physical injuries were sustained from the abuse and the severity of injuries • Concerns regarding STDs, including HIV • Child's reactions to the sexual abuse • Concerns about safety and continued violence • Level of caregiver/family support available to facilitate child safety and healing • Strengths child and family bring to healing process <p>Community/Societal Issues</p> <ul style="list-style-type: none"> • Community/cultural attitudes about child sexual abuse, its victims, and perpetrators • Frequency of sexual abuse and other violence in the community and historical responsiveness of the justice system, health care systems, and service agencies to it • Accessibility of relevant community resources/services for children from different populations and settings |

Do not press children or caregivers for this information during the exam process beyond what is essential for providing medical forensic care (See [B5. Medical History](#)). It is inappropriate to ask about some information, such as immigration status or sexual orientation. *It is more important to be guided by what children and caregivers self-identify, as well as what is observed* (avoiding subjective interpretation of behavior observed).



Child victims have varying levels of tolerance for interacting with multiple unfamiliar adult responders. Some children may become irritable (especially younger children who are used to a routine schedule), frightened, or overwhelmed. Building rapport with children from the first interaction is critical to increasing their comfort level. (See below for communication strategies).

Assess these fundamental communication issues early in the exam process in each case:

- ***Evaluate children’s development level so that appropriate language is used.*** Developmental level and language skills and preferences must be factored into responders’ decisions regarding how to build rapport with children, as well as the scope of information that is communicated to and sought from them (See [B5. Medical History](#)). Literacy of prepubescent children also must be considered when offering material (e.g., pictures may be more appropriate than words for younger patients).
- ***Identify if there is a need for language assistance or other accommodations to allow a child and/or caregivers to clearly and fully communicate with responders during the exam process.*** To facilitate provision of language assistance and communication-related accommodations, health care facilities and other responding agencies should have policies in place to (1) work with children and caregivers to identify if a need exists for such services and, if so, to determine specific needs; and (2) arrange for those services (e.g., specifying who and how to contact, what should happen once a request for services is made, and who can approve the cost of securing these services). Agencies and facilities should develop service agreements with those providing language access and accommodation services in order to provide prompt access when needed. At a minimum, agreements should specify: protocols for requesting services; response time to such requests; who will provide services (certified and qualified individuals); how to determine if a particular service provider is a good fit for a case; and personnel training needed prior to service provision..

NOTE: See below for more discussion on arranging language services and other communication accommodations. Pages 35-36 provide “Tips for Arranging Language Services” and page 37 provides “Tips for Arranging Other Communication Accommodations.”

Tips for Arranging Language Services

- Recognize that health care facilities and providers generally are subject to federal civil rights laws for language access services to ensure meaningful access for limited English proficient (LEP) individuals and effective communication services for persons who are Deaf or hard of hearing, including the use of qualified bilingual staff, interpreters, and translators (The Joint Commission on Accreditation of Healthcare Organizations [The Joint Commission], 2010).⁴⁰ These laws are incorporated into the Joint Commission's standards.⁴¹
- During the examination, use appropriate bilingual/multilingual examiners or provide monolingual examiners with support from certified interpretation services and translated materials for children and caregivers who are not proficient in English, are LEP, or who may prefer to communicate in a non-English language. Sign language services may be needed for children and caregivers who are Deaf or hard of hearing—American Sign Language (ASL), Signed English, or, for patients who are Deaf or hard of hearing and are LEP, sign language services in their language of origin.⁴²
- Let children and caregivers specify individual preferences of style and language of oral and written communications. Ask: "What is your preferred way to communicate?" "What is the best way for us to communicate with you?" Adapt questions as needed to be developmentally appropriate for a child. Language identification cards and posters are sometimes used to help responders determine a person's preferred language. The goal is clear and full communications; limited communication is insufficient.
- Use certified and qualified interpreters and translators.⁴³ Certification usually indicates that a person has met the minimal requirements of an accrediting body (usually a state or national organization) for providing interpretation and/or translation services in a specific language. There are also more specialized certifications, such as for medical or legal interpretation and translation services. In addition to being certified, interpreters and translators must be qualified for the assignment of working with prepubescent children and caregivers in sexual abuse cases. They should be educated on: the basics of communication with children and adults, child sexual abuse, and the medical forensic examination; confidentiality requirements; words and phrases used during the exam process; and language that will allow them to sensitively and respectfully talk about sexual abuse and related health care and legal issues with children and adults. They should understand that, although it is unlikely, they may need to testify in a case. Qualification for a particular assignment may be further influenced by interpreter/translator skill set and experiences (e.g., in working with individuals with disabilities that affect speech), child or caregiver needs (e.g., some children may not be comfortable with interpreters or translators of the opposite sex), and prior connection to those involved in the case (this issue is discussed below). Also, country of origin, acculturation level, and dialect of children and caregivers must be taken into account when selecting interpreters and translators. For example, a Spanish-speaking Cuban interpreter may encounter language and trust obstacles when communicating with a child and caregiver from rural Mexico (Zarate, 2003).

⁴⁰ For applicable laws, see www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf (Appendix D of The Joint Commission document).

⁴¹ See Joint Commission's *Standards and Elements of Performance for Patient-Centered Communication* (2010) at http://medicine.osu.edu/orgs/ahec/Documents/Post_PatientCenteredCareStandardsEPs_20100609.pdf. Applicable standards include: human resources (HR.01.02.01), provision of care, treatment, and services (PC.02.01.21), record of care, treatment, and services (RC.02.01.01), and rights and responsibilities of the individual (RI.01.01.01, RI.01.01.03). A federal resource for providing language services across a variety of settings is www.lep.gov. Kidsta.org offers links to resources available through that website, which have particular application for health care settings. The federal government suggests that recipients of federal financial assistance develop a language assistance plan: a process for identifying LEP individuals who need language assistance; information about language assistance measures; training for staff; notice to LEP persons; and monitoring and updating the plan. See *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, 67 Fed. Reg. 41455 (June 18, 2002).

⁴² See Smith and Hope (2015) for a discussion of issues facing victims from the Deaf community to accessing services. Although it is not written specifically about child victims, it can be applied to this population.

⁴³ To clarify, interpreters convert information from one spoken language into another (or in the case of sign language interpreters, between spoken and sign language), while translators convert written materials from one language to another (Miller, 2012).

Tips for Arranging Language Services

- To increase access to certified, qualified interpreters and translators, health care facilities and other agencies responding to child sexual abuse are encouraged to create multilingual staffing opportunities as well as develop working relationships with external language services. Multilingual staff's interpretation abilities should be assessed by the facility/agency rather than relying solely on a person's self-identification as multilingual.
- In each case, use interpreters and translators who are neutral third parties and do not have a prior relationship with the child, the family, or the perpetrator, if known. Do not use the child's caregivers, family members, or friends as interpreters or translators. Their use could result in unreliable communication as well as jeopardize the admissibility of statements in court. It may be difficult for them to adopt a neutral stance or to avoid interjecting their own thoughts in the conversation.
- Recognize that in rural and remote areas especially, there may be limited access to certified and qualified interpreters and translators. In addition, when they are available, it is possible they may have prior connections to the child, family, and/or perpetrator, if known. Pediatric examiners and multidisciplinary response teams in these regions should brainstorm strategies to secure access to a pool of certified and qualified interpreters and translators in the languages predominant and emerging in the area, with interpreters and translators in the pool having limited connections to the local community.
- Be aware that for specific languages, especially those not frequently used in a community, it may be difficult to identify face-to-face interpreters and translators who are certified and qualified AND who do not have prior connections to the child, family, or perpetrator, if known. Although less preferable than face-to-face services, phone and video remote interpretation services may be an option in some instances. Examiners and other involved responders need to assess if remote interpretation services are appropriate and would be effective in an individual case, taking into consideration issues such as logistics of service provision, confidentiality, comfort level of the child and caregiver with such services, interpreter competency in providing remote services, etc. Note that remote interpretation may be inappropriate to use with certain populations—for example, individuals who are Deaf and hard of hearing.
- Make sure space is available for those assisting with language needs during the exam process. Consider the best location for these service providers in relation to the child, both to respect the child's privacy and modesty and to allow optimal communication. The location used should also be well lit.
- If forms and materials are not available in a language or format that is accessible to a child or caregiver in a case (accessible information is preferred), engage a translator to assist in sight translation. If the child or caregiver is blind or has low vision, forms and materials may need to be read aloud. If the child or caregiver has intellectual disabilities,⁴⁴ information from forms and materials may need to be translated into plain language⁴⁵ and/or pictures to convey meaning. As with interpretation, accurate translation of information is crucial given its emotional, medical, and legal implications.
- Make interpreters and translators aware that these assignments have the potential to be traumatic for them, particularly if they have a history of sexual victimization. Outlets should be available to them to promote self-care and address vicarious trauma they may experience in the course of service provision. In addition to helping prepare a pool of interpreters and translators for their role in the exam process, responding agencies/facilities and multidisciplinary response teams could invite them to participate in related programming they may offer.

⁴⁴ Intellectual disabilities is a term used when there are limits to a person's ability to learn at an expected level and function in daily life (CDC, n.d.). Levels of intellectual disability vary greatly in children. For more information, see www.cdc.gov/ncbddd/actearly/pdf/parents_pdfs/IntellectualDisability.pdf.

⁴⁵ Plain language is communication a person can understand the first time they read or hear it—language that is plain to one set of readers may not be plain to others (plainlanguage.gov, n.d.). For tips on developing messages and materials appropriate for targeted audiences, see the CDC (2014b) at www.cdc.gov/healthliteracy/developmaterials/testing-messages-materials.html.

Tips for Arranging Other Communication Accommodations

- Do not assume children with disabilities affecting communication will need specialized assistance. Explain exam procedures to children and caregivers and ask what specific help might be necessary, if any, to accommodate their communication needs. The goal is for children to be able to fully participate in and benefit from the examination—responders should be clear that they strive for this goal with every child, regardless of their ability/disability, and it is standard practice, rather than an inconvenience, to arrange accommodations needed.
- Recognize that there is a range of assistive and augmentative communication tools, devices, and services that may benefit persons with sensory disabilities (speech, vision, and hearing), including but not limited to video phones, word boards, speech synthesizers, anatomically detailed dolls, materials in alternative formats (large font, Braille, audio file, plain language, etc.), and interpreter and translation services. Become familiar with the basics of communicating with individuals using these tools, devices, and services. Note that individuals may have their own assistive devices, but words needed to communicate may have to be programmed. Avoid assumptions about which technology is appropriate for an individual based on her/his disability (e.g., do not assume that just because a person is Deaf or hard of hearing, she/he will understand sign language or can read lips, or that if a person is blind, she/he can read Braille). Work with each child and caregiver to determine what tools or services are appropriate.⁴⁶
- In general, children who use assistive or augmentative tools and devices depend on them (these tools and devices may be viewed by children as extensions of themselves). If these tools or devices are considered as forensic evidence in a case, they can be swabbed and photographed with the same intent and process used to collect and photo-document forensic evidence from the body, but they should not be taken away from the child.⁴⁷
- Recognize that for all children, including those with disabilities, the option to have a support person present during the exam process might increase their willingness to engage with responders. For example, a child with an anxiety disorder who is fearful and worried may be comforted by the presence of a caregiver, a victim advocate, or a child life specialist, which in turn may reduce the child's hesitancy to interact with the examiner (For more on considerations related to support persons in the exam room, see [B5. Medical History](#) and [B7. Examination](#)).

Although it is impossible to know all cultural and linguistic issues that may impact the care of any individual child, **take general measures to promote culturally and linguistically appropriate care during the exam process** (Weaver, 2013). A few key actions are offered below (adapted from Weaver, 2013):

- Recognize that everyone has biases that can negatively impact their ability to provide high-quality care for all children. Work to overcome personal biases.
- Consider how historical oppression (racism, sexism, ableism, audism,⁴⁸ classism, homophobia, religious persecution, etc.) can impact care provided and identify approaches to create conditions that are more just for all children served.⁴⁹

⁴⁶ For more information on assistive and augmentative communication, see www.asha.org/public/speech/disorders/AAC/ (American Speech-Language-Hearing Association, n.d.). For further information, see the Assistive Technology Industry Association at www.atia.org/i4a/pages/index.cfm?pageid=3859.

⁴⁷ If there are concerns about potential damage to an assistive device in the course of forensic evidence collection, consult with appropriate local/regional disability organizations.

⁴⁸ The notion that a person is superior based on the ability to hear or to behave in the manner of one who hears (Humphries, 1977).

⁴⁹ WCSAP offers a webinar and material (Guy Ortiz, 2008) exploring the concept of cultural competency and service provision strategies to help providers work with survivors of color. It is designed for victim advocacy, but has applicability across disciplines. See www.wcsap.org/culturally-relevant-advocacy-victimssurvivors-color.

- Understand that each person is multicultural, bringing a blend of cultural and linguistic considerations. View multicultural identity of children and family members in these cases as a potential strength they can draw upon to cope with adversity in their lives, care for one another, and heal, rather than seeing another's cultural beliefs and practices as only presenting challenges to the response process.
- Provide the type of care preferred by each child.
- Recognize that evidence-informed care is only as good as the diversity of populations sampled for research and that it needs to be balanced with child-focused, victim-centered, and trauma-informed principles of care.⁵⁰



Generally speaking, **CULTURE** is a body of learned beliefs, traditions, and guides for behaving and interpreting behavior that is shared among members of a particular group (Blue, n.d.). ***In this protocol, a cultural group refers not only to ethnic or racial groups, but also other groups with distinct cultures.*** Examples include faith communities; Deaf and hard-of-hearing communities; lesbian, gay, bisexual and transgender individuals; immigrants; refugees; the homeless; military personnel and their dependents; and individuals in detention settings, foster care systems, boarding schools, and other residential settings. One culture may be closely connected to another (e.g., an ethnic group may be rooted in religious and/or spiritual beliefs of a particular faith community). Individuals often belong to multiple cultural groups. Note that cultural beliefs may or may not affect a child's experience of sexual abuse, the related reactions of the child and caregiver, and preferred approaches to emotional support, healing, and justice (adapted from DeBoard-Lucas et al., 2013). If culture is influential in this regard, responders can offer to help children and caregivers to access cultural resources during the exam process and beyond.

Consider general communication strategies that can help build rapport with children across populations and facilitate culturally and linguistically appropriate care (see below). Building rapport with the child is essential not only to the effectiveness of the exam process, but also in reinforcing for children that there are adults who are safe and can be trusted. Ultimately, the message that responders should seek to convey is that all children deserve respect and are capable of healing from the abuse.

⁵⁰ Definitions of cultural and linguistic competence have evolved over time (Weaver, 2013). Clinical cultural competence is "the ability of health care professionals to communicate with and effectively provide high quality care to patients from diverse socio-cultural backgrounds" (Betancourt & Green, 2010). Linguistic competence is "the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse groups including persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are Deaf or hard of hearing. Linguistic competency requires organizational and provider capacity to respond effectively to the health and mental health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity" (Goode & Jones, 2009). A more general explanation of cultural competency is ensuring cultural applicability of services and options; and sensitivity to the role of culture in a person's experience and decision making (adapted from Proffitt, 2010; NSVRC & RSP, 2013). See the National Center for Cultural Competence at <http://nccc.georgetown.edu/information/organizations.html> for further information on frameworks, guiding values, and principles for organizations to achieve cultural and linguistic competence. To help ensure cultural competency in the exam process, involved entities are encouraged to consider and evaluate (adapted from NSVRC & RSP, 2013): In routine services, how is the cultural competence of services provided assessed? Are involved agency and team structures, locations, designs, and/or décor representative of the communities that they serve? Are services available in the preferred languages of children and caregivers? Do responders receive training and supervision on cultural competency? Do responders collaborate with partnering organizations that have expertise in working with different cultures? Is there diversity in the staff of the responding entities?

General Communication Strategies⁵¹

- Introduce yourself to the child and your role in exam process.
- Ask children their preferred name (“What would you like me to call you?”) and greet them as such. If pronouns are used, use ones the child prefers—use the child’s choice of language (it is important for responders to be aware that transgender and gender non-conforming people exist and to allow children to define their own gender⁵²).
- Begin by discussing things other than the reason for their visit (e.g., schools, pets, siblings, and likes/dislikes).
- Have a calm demeanor. Avoid the appearance of being rushed.
- Speak at the child’s eye level or below.
- Maintain eye contact with the child if culturally appropriate.
- Speak directly to the child, even when a caregiver or interpreter is present or the child is nonverbal.
- Be clear, concise, and exact in explanations. Ask concrete rather than vague questions.
- Be empathetic and nonjudgmental. Believe the child.
- Avoid verbal language that might convey you are blaming the child for the abuse (e.g., “girls your age need to wear more than underwear around male relatives”).
- Avoid body language that might indicate you are judging the child (e.g., cringing when the child reveals she/he engaged in survival sex, is transgender, or was used in sadomasochistic acts).
- Avoid making assumptions about nonverbal behavior of children.
- Avoid making assumptions about the way the child feels about the perpetrator and acts of sexual abuse (and do not talk disparagingly to the child about the perpetrator).
- Seek to learn about and reflect the child’s language (e.g., for body parts⁵³).
- Do not touch the child without permission.
- Allow the child to participate in and make choices during the exam process, to the extent possible (e.g., ask the child “What color blanket would you like?” “How are you doing now?” “Are you ready to do the next thing?”).
- Affirm the child throughout the process, while offering information and opportunities for questions (e.g., “You did a great job with that part of the visit. Here is what is coming up next. Do you have questions about what is happening?”).
- Explain what information gathered during the exam process will be shared with others (e.g., caregivers and the investigative team) and when it will be shared, and be open to discussing any related concerns (See [A5b. Confidentiality and Release of Information](#)).
- Do not pressure the child to respond to questions or agree to exam procedures.

Children’s communication skills, attention, and tolerance for interacting with responders may quickly deteriorate if they are feeling traumatized, tired, apprehensive, anxious, irritable, hungry, thirsty, distracted, uncomfortable, or negatively judged, or if they perceive their concerns are being minimized. For each child, consider what measures might aid in

⁵¹ This listing was adapted in part from Day and Pierce-Weeks (2013), IRC (2012), and Weaver (2013).

⁵² This awareness enables responders to: (1) not assume someone is male or female; and (2) engage in discussions that includes what name, pronoun, gender identity, and language that people use to describe themselves. It is also important for responders to understand that sexual abuse may be intertwined with the victims’ gender identity—e.g., people may experience violence due to their perceived gender identity. (M. Munson, personal communications, 2015).

⁵³ If responders do not understand children’s vocabulary, it is possible they might misinterpret their account of what happened. For example, in one case, a young girl was taught by her caregivers to call her vagina her “purse.” When she tried to tell a trusted adult she had been sexually abused, she said, “He touched my purse.” Not being aware of the meaning of the child’s words, the adult initially told her there was nothing wrong with someone touching her purse. Some child sexual abuse victims have considerable shame about or dissociation from their bodies. If it is too difficult to talk about their bodies, consider alternative means of communication (e.g., anatomically detailed dolls the child can use to point to body parts or paper and pen so the child can write or draw).

sustaining optimal communication with responders throughout the exam process. Acknowledge any apprehension the child has about the exam process or seeking help in general, and discuss what would help her/him be more comfortable.

On an ongoing basis, seek to learn about different populations and community settings. Responders should strive to optimize the exam process for each group. They should not assume that children and caregivers hold certain beliefs or have certain needs and concerns merely because they belong to a specific population or live in a specific setting. (See below to learn about four broad strategies and key actions that can optimize the exam process for specific populations and settings.)

**Broad Strategies to Optimize the Exam Process for
Specific Populations and Settings**

Strategy 1: Reach out to and partner with those who serve specific populations.

Strategy 2: Learn about issues facing specific populations of prepubescent children in the community.

Strategy 3: Plan across responding entities to meet the needs of specific populations of child victims and remove barriers they face in accessing timely, high-quality examinations.

Strategy 4: Evaluate the inclusivity and accessibility of forms and informational materials.

Broad Strategies to Optimize the Exam Process for Specific Populations and Settings

1. Reach out to and partner with those who serve specific populations. Organizations, professionals, and community leaders that serve or represent specific populations may be willing to:

- provide responders with training and consultation on working with children from populations they serve or represent,
- give input on the development of response protocols and appropriate services,
- offer culturally specific support to children and caregivers during the exam process, and
- be a referral source for children and families (See [A3. Coordinated Team Approach](#)).

Engaging these entities and individuals to improve response to specific populations is not a one-time event in response to individual case needs, but an ongoing, planned effort.

2. Learn about issues facing specific populations of prepubescent children in the community. For example:

- The prevalence, risk factors, and dynamics of sexual victimization for specific populations of children;
- Issues, needs, resources, and gaps in services for specific populations of child sexual abuse victims;
- Geographic factors that impact access to services in the community (e.g., access to and provision of timely care and protection is often challenging in rural and remote regions where community members may be physically isolated from local services by considerable distance and/or difficult terrain);
- A specific population's cultural beliefs about sexual abuse and the impact of those beliefs on seeking help to address health, safety, and legal needs of child victims;
- Oppression, stigma, and other barriers that increase resistance within a specific population or community setting to discussing sexual victimization, disclosing it to authorities, or otherwise seeking help;
- The historical context in which victimization occurs and impacts a specific population;⁵⁴
- A population's practices for healing and seeking justice, and their application to sexual abuse;
- Aspects of a specific culture that protect children from child sexual abuse and/or can be strengths in helping children in the aftermath of sexual abuse;⁵⁵
- Coping mechanisms commonly seen in sexual abuse survivors from specific populations;
- Commonly seen medical issues for specific populations and if/how they can impact medical forensic care;⁵⁶
- The impact of tribal sovereignty on response to child sexual abuse in American Indian and Alaska Native communities (tribes, as sovereign nations, may have their own laws and regulations; many tribes also have their own health care systems, law enforcement agencies, child protective services/social services, prosecution offices, courts, advocacy programs, and other services to address child sexual abuse);
- Jurisdictional issues and challenges related to state-tribal relations;⁵⁷
- Laws and regulations related to the response to sexual abuse in specific institutional settings;⁵⁸
- Procedures and services to address child sexual abuse on military installations; and
- Similarities and differences in language and in beliefs and practices related to safety, addressing health concerns, healing, and justice across subgroups of a broad cultural group (e.g., American Indian and Alaska Native, Hispanic, Asian, Muslim, Christian, and Jewish).

⁵⁴ For example, see the Minnesota American Indian Women's Resource Center (2009) for a history on victimization and oppression of Native women and girls and its impact on current day commercial sexual exploitation of this population in Minnesota.

⁵⁵ For example, in cultures where elders have leadership and mentoring responsibilities, they may play an integral role in promoting safety and wellbeing of children as well as be instrumental in facilitating family healing from sexual abuse.

⁵⁶ For example, children may have disabilities that cause physical immobility and affects their ability to get on and off an exam table, among other activities. Prepubescent children may be receiving hormone treatment for pubertal suppression and anticipated subsequent gender transition (see Hewitt et al., 2012; Shumer & Spack, 2013; Spack et al., 2012).

⁵⁷ For example, a state school system on reservation lands, which has access to tribal children, may not follow tribal law on mandatory reporting of child abuse.

⁵⁸ For example, PREA standards for detention facilities set requirements for sexual abuse prevention, detection, response, and monitoring.

Broad Strategies to Optimize the Exam Process for Specific Populations and Settings

3. Plan across responding entities to meet the needs of specific populations of child victims and remove barriers they face in accessing timely, high-quality examinations. For instance, identify/create:

- Practices to promote access for child victims from specific populations to streamlined, prompt, and culturally and linguistically appropriate medical forensic care, and to encourage reporting of child sexual abuse;
- Procedures to facilitate outreach to community-based organizations that serve specific populations and invite their participation on the multidisciplinary response team, in the development of response protocols, in team training opportunities, and as resources for children and caregivers as appropriate/applicable in a case;
- Coordinated response policies that address concurrent jurisdiction in a case (e.g., tribal, state, or federal) or cases that involve institutional settings with their own policies related to sexual abuse response;
- Policies that facilitate assessment of need for language services in a case, determine specific services necessary, and subsequently ensure services are arranged;
- Sources of certified interpretation and translation available to responding agencies/facilities, agreements regarding service provision among responding entities and interpreter and translation services, and instruction for responders on utilization of interpreters and translators during the exam process;
- Resources to accommodate children with disabilities during the exam process, including instructing responders on communicating with individuals using assistive tools and devices as well as interpreters and translators, and guiding responders on modifying exam procedures to accommodate an individual child's needs;
- Measures that create an inclusive and welcoming exam process for all children;
- Policies to address the child's need for modesty and privacy when providers assisting with communications are present in the exam room;
- Resources for mental health counseling for specific populations of child sexual abuse victims; and
- Policies and resources to address the needs facing recently immigrated child sexual abuse victims, including those who are refugees from areas of conflict.⁵⁹

4. Evaluate the inclusivity and accessibility of forms and informational materials.

- To the extent possible, forms and informational materials should be developed to be inclusive and welcoming to all populations;⁶⁰
- Translated materials should be available at minimum in languages commonly encountered in the jurisdiction—also be aware of resources for translation into additional languages, especially those emerging in the community (e.g., due to a recent influx of refugees from a particular country); and
- Written materials should be available in alternative formats such as large font, Braille, plain language, and audio file.

⁵⁹ The National Immigrant Women's Advocacy Project at www.niwap.org is a source for related information and resources. Also see Dettlaff and Johnson (2011), Dirks-Bihun (2014), and Lin and O'Brien (2013).

⁶⁰ The field of universal design provides a framework to create printed materials that are accessible to the widest possible audience of users. See www.universaldesign.com/what-is-ud/. For example, intake form questions that ask about sex and gender should allow a response to be written in or include transgender and intersex options. Questions should appropriately distinguish between sexual orientation (the gender(s) to which one is attracted), gender identity (the internal sense of being female, male, or gender non-conforming), and biological sex. Any questions regarding religious affiliation should be inclusive of the diversity of faith communities in the area, and provide options for no affiliation and for writing in an answer.



This chapter offered general recommendations for adapting the exam process for each child. Additional considerations are noted throughout the protocol, both broadly and in reference to specific populations and community settings. See www.Kidsta.org for additional resources on working with child sexual abuse victims from specific populations and in specific community settings, as well as on issues of cultural and linguistically appropriate care.

A3. Coordinated Team Approach

These recommendations are for communities to facilitate a coordinated team approach to response to prepubescent child sexual abuse during the exam process.

Promote multidisciplinary coordination during the exam process, within a community and/or across jurisdictions as applicable in a case. The medical forensic examination in its entirety addresses the health needs of child sexual abuse victims AND is a potential evidentiary source for investigative agencies. The medical history, exam findings (written and photo-documentation), and forensic samples if collected during the examination can supplement other evidence and information gathered by investigators. Coordination across responding entities can help ensure that medical forensic care is a component of the initial response to child victims, along with protection, access to other community resources, and support to minimize trauma. Coordination and communication among initial responders can also enhance documentation and evidence collected during medical forensic care as well as information gathered during forensic interviews,⁶¹ which can aid law enforcement and child protective services in investigating these cases and keeping children safe, and support prosecutors in holding perpetrators accountable for their behavior.

Use multidisciplinary response teams to foster coordination and communication among responding agencies/facilities in a community in prepubescent child sexual abuse cases. Teams should include multijurisdictional representation if cases typically involve responding entities from more than one jurisdiction. A team structure provides a mechanism to link key entities involved in the response during the exam process and allow them to consistently coordinate interventions whenever there is a report of child sexual abuse. It also helps them communicate about and stay abreast of what is happening in individual cases. The team structure can be a quality assurance tool, promoting regular meetings of responders, case reviews, responder education, activities to prevent vicarious trauma of responders, and evaluation of team effectiveness. Jurisdictions vary in the extent and formality of team coordination, as well as in specific team purposes (e.g., to provide coordination around victim care and protection, investigative activities, and/or comprehensive response). In many jurisdictions, multidisciplinary teams and team coordination protocols are statutorily mandated in child abuse and neglect cases.⁶² Often, children's advocacy centers assist in the coordination of these teams (see below). A spirit of cooperation, information sharing, and case coordination are a few benefits of these multidisciplinary response teams (Knapp, 2014). Such benefits can lead to better case outcomes and greater child and family satisfaction with interventions than seen with

⁶¹ See [B5. Medical History](#) for a discussion of the difference between the medical history and forensic interviewing.

⁶² See www.ndaajustice.org/pdf/MDT%20draft%20for%20MAB_%2001052015-last.pdf for a National District Attorneys Association's 2015 review of state, federal, and territorial legislation sanctioning use of multidisciplinary response teams for child abuse and neglect investigations. In addition to prosecution-based multidisciplinary teams, multidisciplinary child protection teams are legislated in many jurisdictions. Child protection teams focus on the protection of children who are victims of abuse or neglect from additional maltreatment. Child protection often involves civil action, while prosecution is a criminal justice issue (Center for Child Abuse and Neglect, 2000). Applicable criminal and civil justice actions should be considered in each case, and actions taken should be coordinated to the extent appropriate.

community response to child abuse that is not coordinated across disciplines or jurisdictions if applicable in a case.⁶³

Identify core responding sectors and their roles during the exam process, in cases of prepubescent child sexual abuse. Note that if a CHILDREN’S ADVOCACY CENTER exists in a community, it may coordinate a multidisciplinary, multijurisdictional response.



For the list below, be aware: it does not include comprehensive interventions beyond the exam process; it is limited to key broad roles of core responders in individual cases; and responders’ roles/tasks may differ based on jurisdictional and agency/facility policies and case circumstances. See the various protocol chapters for further discussion on response components and the infrastructure needed to support an effective response.

| Sector | Key Broad Roles: Exam Process <i>(Roles may vary in specific cases and based on jurisdictional and agency/facility policies)</i> |
|--------------------|--|
| ALL | <ul style="list-style-type: none"> • Tailor response to the developmental level of each child as well as the cultural and linguistic needs of the child and caregiver. • Arrange for language assistance and other accommodations as needed in a case. • Offer crisis intervention and support for the child and caregiver as early as possible. • Offer the child and caregiver information to facilitate informed decision making throughout. • Coordinate/communicate with other involved responders. • Inquire about safety at each contact with the child and caregiver: provide immediate assistance as needed and connect them to resources for safety planning assistance. • Adhere to jurisdictional laws on victim’s rights. |
| HEALTH CARE | <p><i>Initial response: child’s entry into health care system</i></p> <ul style="list-style-type: none"> • Assess the child for acute medical needs, stabilize, and treat. • Determine the urgency of care needed and arrange for acute/nonacute medical forensic care. • Mandatorily report the abuse as per jurisdictional law and facility policy. • If the child has urgent safety needs at the health care facility, immediately involve law enforcement/child protective services and follow facility procedures. <p><i>Conduct acute/nonacute examinations:</i></p> <ul style="list-style-type: none"> • Obtain/document the medical history. • Perform the physical and anogenital examination and document findings. • Collect, dry, package, label, seal, and securely handle forensic specimens. • Evaluate and treat injuries. • Evaluate for STDs, including HIV, and provide care. • Collect samples for toxicology analysis. • Plan for discharge and follow-up care (medical, safety, mental health, victim services, investigation, etc.). |

⁶³ For a bibliography of articles on multidisciplinary teams and collaboration in community response to child abuse, see www.nationalcac.org/professionals/images/stories/pdfs/mdt%20bib2.pdf. Of related interest are studies by Campbell et al. (2011), Campbell et al. (2012), Campbell et al. (2013), and Greeson and Campbell (2013, 2015) that explore the effectiveness of sexual assault response teams (SARTs). While this body of research mainly focuses on adult and adolescent victims, it has some applicability for coordinated team response in prepubescent child sexual abuse cases.

| Sector | Key Broad Roles: Exam Process <i>(Roles may vary in specific cases and based on jurisdictional and agency/facility policies)</i> |
|---|---|
| VICTIM ADVOCACY (see definition in Glossary) | <p><i>Initial contact with the child and caregiver:</i></p> <ul style="list-style-type: none"> • Offer crisis intervention, support, information, and safety planning to the child and family. • Explain victim rights to the child and family, review community response procedures and options, answer their questions, and provide referrals. • Support the child and caregiver in voicing their concerns. • Advocate for the child’s self-identified needs to be addressed with a coordinated, developmentally, culturally, and linguistically appropriate response. • Accompany the child/caregiver during the examination. • Mandatorily report the abuse as per jurisdictional law (if identified as a mandatory reporter). • Explain longer-term advocacy services available to aid in addressing child and family needs related to the abuse (e.g., ongoing support, safety planning, counseling/referrals, culturally specific services, legal and medical systems advocacy, and service coordination). |
| LAW ENFORCEMENT <i>(local, state, territorial, tribal, military, federal)</i> | <p><i>Timely response to reports:</i></p> <ul style="list-style-type: none"> • Respond to 911 calls and referrals from child protective services. • Determine basic facts of the reported incident, if the child is in imminent danger, need for immediate medical attention, and case jurisdiction (avoid delaying response to the child if delays exist in determining jurisdiction). • Work with child protective services as needed to provide child protection. • Facilitate access to an initial medical assessment and medical forensic examination (arranging transportation as needed). • Coordinate crime scene processing. • When contacted by the exam site to pick up forensic evidence, retrieve evidence and deliver to designated labs/law enforcement storage facility. • Conduct/arrange the preliminary interview of the child/forensic interview, preferably by someone trained to interview child sexual assault victims, either before or after the medical forensic examination, in conjunction with child protective services as applicable to the case. |
| CHILD PROTECTIVE SERVICES <i>(county, state, territorial, tribal, military)</i> | <p><i>Timely response to reports:</i></p> <ul style="list-style-type: none"> • Assess the child’s immediate safety. • Make referrals to the appropriate law enforcement agency and coordinate multi-agency response based on circumstances of report and initial assessment of child safety. • Facilitate access to an initial medical assessment and medical forensic examination (arrange transportation as needed). • Conduct/arrange the preliminary interview, preferably by someone trained to interview child sexual assault victims, of the child/forensic interview either before or after the medical forensic examination, in conjunction with law enforcement as applicable to the case. |

NOTE: The core responders below typically have more of an advisory rather than a direct role during the exam process.

| Sector | Key Broad Roles: Exam Process |
|--|---|
| PROSECUTION <i>(county, state, territorial, tribal, military, federal)</i> | Be available to consult with first responders to answer questions that arise and to request additional information as necessary to aid in case prosecution. |
| FORENSIC SCIENCE <i>(state, territorial, federal, private)</i> | Be available to consult with criminal investigators and pediatric examiners to answer questions to assist in identification, collection, and processing of forensic evidence. |



See www.Kidsta.org for details on the range and roles of professionals involved in the exam process, as well as in a more comprehensive response.

Clarity of core responders' roles during the exam process can help increase their collaboration in individual cases and reduce conflicts surrounding issues such as reporting, victim protection, health care, safety planning, victim services, and investigation.

Encourage the development and use of children's advocacy centers to facilitate coordination of multidisciplinary response teams. Children's advocacy centers have been established in many jurisdictions to facilitate team coordination in child abuse and neglect cases, with the goals of child safety, trauma-informed care, justice, and healing. These centers are child-friendly facilities in which the team—typically comprised of law enforcement, child protective services, prosecutors, medical professionals, mental health providers, and victim advocates—coordinates the investigation, prosecution, child protection, and treatment of child abuse. In addition to brokering coordination among responders in individual cases, many children's advocacy centers offer a location to provide services under one roof, such as forensic interviews, medical forensic examinations, victim advocacy, and mental health treatment. Children's advocacy centers can be developed to serve a community or a region (e.g., in a rural or sparsely populated area), and involve representatives from a single jurisdiction or multiple jurisdictions.⁶⁴

Multidisciplinary response teams are encouraged to include community-based sexual assault victim advocacy programs on their teams, as well as seek their input when developing team response protocols. Involvement of these programs in coordinated response team efforts helps ensure that children and families have a continuous source of victim-centered, trauma-informed support during and beyond their interactions with the health care system and criminal justice and child protection systems. Most community-based sexual assault victim advocacy programs have crisis intervention and support services available 24 hours a day, every day of the year. They can also address children's support needs as they mature into adolescents and adults. These programs are often experienced in systems advocacy around sexual victimization issues, which could be an asset to team sustainability. If a community-based sexual assault victim

⁶⁴ See www.ndaajustice.org/pdf/Update%20Vol24_No2.pdf for a resource on children's advocacy centers in Indian County.

advocacy program serves child victims, advocates should be trained in working with children and their caregivers. If it does not serve children, it may still offer support services for caregivers.

As mentioned earlier, if a community-based sexual assault victim advocacy program exists in a community but is not yet involved in the exam process in these cases, teams are urged to partner with these programs to engage advocates in this process and build their capacity to do this work.

Promote partnerships between children’s advocacy centers and community-based sexual assault programs,⁶⁵ as well as with other entities that have a victim advocacy role during the exam process and beyond. Together, they can coordinate resources and determine the spectrum of victim services they can provide to children, caregivers, and families to strengthen the community response in individual cases.



See www.Kidsta.org for additional resources on multidisciplinary teams to respond to child sexual abuse cases, children’s advocacy centers, and community-based sexual assault victim advocacy programs.⁶⁶ Staff at Kidsta.org are also available to answer specific questions related to establishing these entities.

Develop a diverse team representative of the community that can address the varied needs of children and caregivers in specific cases and support all aspects of response during the exam process. The use of a tiered team structure can be helpful to identify the range of responders who might potentially be involved in the exam process and indicate at what point they may be activated. For example, the first tier should encompass core responding sectors in a community that typically might be drawn into a sexual abuse case during the exam process—including but not limited to health care, victim advocacy, law enforcement, child protective services, prosecution, and forensic sciences (note that, during the exam process, prosecution and forensic sciences usually have advisory rather than direct roles).⁶⁷ If a children’s advocacy center exists in a community, it may play a central role in coordinating a multidisciplinary response. Subsequent tiers can include other professionals and entities whose participation might be requested by core responders during the exam process to address child, family, or case needs. Examples include but are not limited to mental health providers,⁶⁸ specialized investigative teams dealing with sex trafficking or drug endangerment, legal assistance services, such as civil attorneys and victim rights attorneys, financial assistance programs, and providers serving

⁶⁵ *Cruising into Collaboration: Developing Strong Relationships between Rape Crisis and Children’s Advocacy Centers* at www.nsvrc.org/sites/default/files/nsac-2014-handouts-cruising-into-collaboration-developing-strong-relationships-between-sa-programs-child-advocacy-centers.pdf provides an example of one community’s partnerships in this area.

⁶⁶ Note a few key resources: The National Children’s Alliance (NCA) at www.nationalchildrensalliance.org/ offers information on and a directory of children’s advocacy centers, as well as accreditation to centers that adhere to its member standards. Technical assistance and training providers for multidisciplinary investigative teams in child abuse and neglect cases and children’s advocacy centers include: Northeast Regional Children’s Advocacy Center at www.nrcac.org; Southern Regional Children’s Advocacy Center at www.nationalcac.org; Midwest Regional Children’s Advocacy Center at www.mrcac.org; and Western Regional Children’s Advocacy Center at www.westernregionalcac.org. See www.justice.gov/ovw/local-resources for links to state, territorial, and tribal sexual assault coalitions.

⁶⁷ Note, however, that some communities, especially those with children’s advocacy centers, may consider prosecutors to be direct rather than advisory core responders during the exam process.

⁶⁸ Note, however, that some communities, especially those with children’s advocacy centers, may consider mental health providers as part of the core responder team.

specific populations (e.g., local programs for persons who are Deaf and hard of hearing, or for individuals from specific cultural, racial, or ethnic communities).

An additional group to consider is the personal support persons whose presence children and/or caregivers may request during the exam process, beyond family members or friends (e.g., a religious/spiritual support person, a school guidance counselor or favorite teacher, or a culturally specific support person such as a mentor from a local ethnic community center). While personal support persons are unique to a case and typically not response team members, teams should recognize their utility in helping children and caregivers who request them to positively cope with the exam process. (See [B5. Medical History](#) and [B7. Examination](#) for more explanation on personal support persons and the need to educate them on the scope and limitations of their role)

Communities and teams of all types can create tiered team structures tailored to their teams' purposes and requirements (e.g., jurisdictional legislation may mandate that, minimally, certain agencies participate), available resources, and the needs of children and families.

Include a trained pediatric examiner as a core team responder.⁶⁹ The examiner may be a physician, advanced practice provider (e.g., advanced practice nurse or physician's assistant), or registered nurse. The team should be aware of qualifications for pediatric examiners from various disciplines in their jurisdiction and seek qualified personnel. The team can reach out to health care providers in the community who serve children, as well as organizations such as the American Academy of Pediatrics (AAP), the NCA, and the IAFN to search for candidates.⁷⁰ (See [A4a. Pediatric Examiners](#))

Ensure that all team members are aware that they may be called to be involved in a coordinated response in these cases, including and beyond the exam process as determined by a community, and be willing to respond. To foster collaboration, core responders and/or team coordinators such as staff from children's advocacy centers are encouraged to reach out and engage other potential team members. They should work with potential team members to overcome any hesitation they may have regarding their involvement.

Outline responding entities' team roles and responsibilities in written agreements, such as an interagency memorandum of understanding (MOU) or memorandum of agreement (MOA). Such agreements may address the exam process only or speak to a more comprehensive response, highlighting the terms of the response protocol. These agreements should help clarify for all responders: their roles on the team; team confidentiality issues and requirements (see [A5b. Confidentiality and Release of Information](#)); how to contact and interact with each other as needed in a case; and the need to respect one another's contributions to the team, even if their roles might sometimes conflict. Agreements should be signed by leadership of each entity involved

⁶⁹ See Canaff (2004) for key reasons that pediatric examiners are critical team members.

⁷⁰ For example, the IAFN website offers a mechanism to search for SANE programs by location at www.forensicnurses.org/search/custom.asp?id=2100.

and be revised and renewed on a periodic basis. (See [Appendix 4. Customizing a Community Protocol](#))



Many potential challenges exist to creating functional multidisciplinary and multijurisdictional response protocols and teams, including ones stemming from scarce resources, lack of expertise, and conflicts among entities. Contact staff at Kidsta.org for input on overcoming specific challenges, offer ideas for engaging responding entities, and provide examples of written agreements among team members.

Employ team features that strengthen the team’s capacity to protect prepubescent child victims, address their health care needs, and gather forensic evidence during the exam process. Note that many of the features described below also support a comprehensive response and promote team quality assurance. Team features that apply to direct response should be incorporated into the response protocol.

Recommended Features of Multidisciplinary Response Teams

- **Ensures mechanisms are in place to activate core responders.** Policies and procedures for activating core responders should take into account that children “enter the response system” at different points. (See [B2. Initial Response](#) and [B3. Entry into the Health Care System](#)) Educate first responders about their roles in triggering team action. Note that if there is a children’s advocacy center, it may play a central role in activating the team response.
- **Ensures policies and procedures are in place for core responders to identify if there is a need for additional providers and entities to be involved during the exam process, and then request their involvement.** To the extent possible, these “additional” responders should be informed of such policies and procedures in advance and be willing to carry out assigned roles.
- **Publicizes team response procedures to community professionals who have frequent contact with prepubescent children and their families** (e.g., health care providers serving children, hospital emergency department staff, staff from youth organizations, school personnel, contractors and volunteers, child care providers, personnel serving children with disabilities and those who are Deaf, faith community leaders, mental health and social service providers, and staff from youth residential programs and emergency shelters). Also publicize team services broadly to the public, encouraging reporting of child sexual abuse.⁷¹
- **Maintains a protocol for information sharing** that speaks to the extent of information sharing possible among various team members in individual cases, according to applicable laws and agency/facility policies. As mentioned above, a written agreement among team members should address team confidentiality issues and requirements.
- **Works to implement best practices in secure storage, retention, and release of case information across all relevant entities.** Team and agency/facility consultation with their legal counsel and technology security representatives, as well as with the prosecution office, can be a useful tool. (See [A5b. Confidentiality and Release of Information](#), [B4. Written Documentation](#), and [B6. Photo-Documentation](#))
- **Operates on a 24/7 basis** to respond to reports of sexual abuse, assess and address safety issues, medically assess children to determine urgency of care needed, conduct acute examinations, make referrals for nonacute examinations, and provide support to children and families. To address acute

⁷¹ Note that [B2. Initial Response](#) speaks to initial response to reports or suspicions of child sexual abuse, prior to the children’s entry into the health care system. [B3. Entry into the Health Care System](#) includes procedures targeting initial responding primary care providers and emergency department clinicians.

Recommended Features of Multidisciplinary Response Teams

and nonacute exam needs, a need for flexibility exists in program coverage; no one discipline should define service hours and options for the team. **If a children's advocacy center's medical clinic performs both nonacute and acute examinations, but is open only at certain times** (e.g., 9 a.m. to 5 p.m. during weekdays), **the community still needs 24/7 coverage for acute cases.**

- ***Requires a health care provider to medically screen each child to determine the urgency of care needed and what type of medical forensic examination is appropriate.*** (See [B3. Entry into the Health Care System](#)) Law enforcement agencies, child protection services, and other first responders should have procedures to connect the child on a 24/7 basis to a health care provider for this purpose. (See [B2. Initial Response](#))
- ***Documents the team's response in each case.*** Not only does documentation lend itself to team accountability, it serves as a tool for case review and assessment of next steps in a case. Statutorily mandated multidisciplinary response teams are often required to retain such documentation. When documenting response, maintain the privacy of the child's personal information to the extent possible, as per applicable laws (See [A5b. Confidentiality and Release of Information](#)).
- ***Meets regularly*** (regularly is locally defined) for two distinct purposes, in acute and nonacute cases. The first reason is for case review—discussion and information sharing among the team on active cases, including the investigation, case status and service provision, potential challenges, and next steps. Core responders should participate in case review meetings. Pediatric examiners should be included even though they also participate in medical peer review. (See [A4a. Pediatric Examiners](#)) Additional responders who were involved in specific cases might also be invited to participate; their participation may depend on whether it is appropriate for them to have access to child-specific information shared at case review meetings. Secondly, the team can utilize meetings of members to maintain and enhance the quality of the team. This task involves addressing system issues, such as revising procedures in response to agency/facility and statutory changes and scientific or technological advances. It also involves facilitating the team's continuing education. All team members could be invited to meetings addressing systemic issues.
- ***Facilitates team communications related to specific cases.*** Much can happen in a case in the short-term after a report is made. Mechanisms should be in place to assemble involved team members sooner than a scheduled case review meeting, if needed, to debrief, troubleshoot, and discuss next steps.
- ***Plans in advance to respond in varying circumstances.*** (See [A2. Adapting Care for Each Child](#)) For example, it would be useful for agencies/facilities that comprise the team to have incremental goals for building multiple language service capacity to be inclusive of all child populations. It might be helpful to create a coordinated system for relaying information in individual cases about the need for language services and accommodations, so that needed services and accommodations can be arranged prior to the child and caregiver seeing the next responder. Organizations that serve specific populations in the community can be sought out as potential resources to aid children and families requesting culturally-specific support. The team can establish procedures for coordinating with other specialized investigative teams as needed in a case, such as child endangerment and sex trafficking task forces. The team should have a standard approach to initially assess safety for children in various situations. It should consider how to coordinate a response when child sexual abuse is reported in institutional settings or has occurred on a military installation, as well as multijurisdictional coordination needs. The team should stress to its members the expectation that relevant responders in a case should be prepared and available to testify in court if subpoenaed.
- ***Seeks feedback from team responders and other community professionals involved in a case*** (e.g., who referred children to the team or interacted with children after the exam process). Use this feedback, gathered post-examination, to improve team coordination and interventions in the future.

Recommended Features of Multidisciplinary Response Teams

Input could be sought via participation in team meetings or other forums, with care taken to maintain confidentiality of victims' personally identifying information within the team. Also, obtain post-examination feedback from children and caregivers about exam process experiences.

- **Addresses vicarious trauma⁷² among team members via discipline-specific support and team infrastructure and policies.** The support that team members and involved agencies/facilities can offer to one another can be instrumental in reducing the impact of vicarious trauma. Formal and informal venues can be used to facilitate discussions among responders about self-care and working together to prevent and cope with secondary trauma. Critical incident stress debriefings might be useful in individual cases.⁷³
- **Encourages education for team members.** Consider discipline-specific training that advances responder skills and emphasizes a team approach, multidisciplinary training, cross-training between disciplines, and informal educational opportunities. Multidisciplinary trainings and cross-trainings can build knowledge of the nature and dynamics of sexual abuse; describe the team response process, explaining roles and challenges facing each discipline; review mandatory reporting obligations and report writing; emphasize a child-focused, victim-centered, trauma-informed approach; promote culturally and linguistically appropriate care; stress the need for a prompt examination and ongoing safety planning; provide expert witness training; describe related policies, protocols, agreements, and forms; build understanding of needs and challenges in response to child sexual abuse in specific populations; and provide a forum for staff from different agencies/facilities to build relationships, identify common goals, and ask questions.
- **Strategizes how to offer training for team members in rural, remote, poor, and other communities that lack the needed resources and/or expertise.** Jurisdictions may want to consider forming specialized training teams that can offer multidisciplinary training consistent with cutting-edge practices in child sexual abuse cases. These teams can work with local responders to ensure that the training sessions they offer address unique community needs and challenges (e.g., safety challenges and resources unique to a tribal community). They can also determine the best method to train responders—in some instances, use of online, live webinars and video conferences, online interactive training modules, and other distance learning tools might be useful.
- **Plans team activities, communications, and materials so that they are accessible to all its members.** For example, team meetings and trainings should be held at accessible locations. Members who are Deaf or hard of hearing may require sign language interpretation.



See www.Kidsta.org for resources related to building community capacity to implement the above features of multidisciplinary teams to respond to prepubescent child sexual abuse cases. Staff from Kidsta.org are also available for consultation on community-specific issues.

Consider unique coordination issues when child sexual abuse occurs in institutional settings, tribal lands, or military installations. The following section is meant simply to

⁷² Vicarious trauma means the cumulative effect of witnessing the suffering of others over time—the term refers to the negative changes to an individual's physical, psychological, and spiritual health (RSP & NSVRC, 2013). The NSVRC and IAFN (2014) at www.nsvrc.org/sites/default/files/nsvrc-publications_sane-mobile-app_resources-vicarious-trauma.pdf offer a related clinician discussion and resources. NSVRC and RSP (2013) offer another resource for ideas for building trauma-informed programs that support the self-care of those doing this work at www.nsvrc.org/sites/default/files/publications_nsvrc_guides_building-cultures-of-care.pdf.

⁷³ Critical incident stress debriefing is a proactive intervention involving a group discussion about a distressing critical incident. Based on core principles of crisis intervention, it is designed to mitigate the impact of a critical incident and to assist the persons in recovery from the stress associated with the event. Ideally it is conducted between 24 and 72 hours after the incident. (The explanation was drawn from Critical Incident Stress Management International (2015) at www.criticalincidentstress.com/what_is_cism..)

further teams' thinking about customizing coordinated response for these settings and communities. It is not meant to be an inclusive listing of all coordination or responder training issues relevant to these settings and communities.

Institutional Settings

- Multidisciplinary response teams should collaborate with institutions in their community that either house prepubescent children or place them in homes (e.g., residential programs, shelters, detention facilities, boarding schools, and foster care), with the goal of ensuring that children in these systems receive adequate and coordinated interventions in the event that they are sexually abused.
- Although these institutions may have their own protocols and services to respond to child sexual abuse (including requirements of oversight agencies or as prescribed by legislation⁷⁴) and mechanisms to investigate sexual abuse as a violation of institutional policies, the community justice system is ultimately responsible for criminal justice and child protection remedies for children in these settings. Community resources may be needed to care for victims in these settings.
- Agreement between the team and an institution can help extend the team's protocols and resources to children in the institution and build upon institutional capacities to address needs of child victims in a timely and appropriate manner. In addition to team training on response protocols specific to an institutional setting, protocols between an institution and community responders should be incorporated into institutional policy and relevant staff training.
- The team can plan with an institution regarding how children, caregivers, staff, and others within the institution should make a report and seek help for sexually abused children; how to facilitate communication between the institution and the team when there is a report; who must be notified regarding a report; what consent for care is needed and how to obtain it; and how to coordinate each step of response. Variations in response must be considered when suspected perpetrators are institutional personnel or foster home providers. Children need to be placed in alternative housing if their safety in an institutional setting or foster home cannot be secured.
- For acute and nonacute medical forensic care, the team must consider how children and first responders in an institution access pediatric examiners and the logistics of arranging such care when conducted at a community-based health care facility versus within the institution. Examples of logistical issues include transportation of the child to/from the exam site and child accompaniment by staff and/or caregivers during transportation and the examination.

⁷⁴ For children in all types of residential facilities (Brown, 2008): States are primarily responsible for ensuring the wellbeing of children in facilities and setting standards that certain facilities must meet to obtain and maintain an operating license. Federal agencies also set requirements for children's wellbeing that states uphold in exchange for receiving federal funds—such as those administered by the U.S. Department of Health and Human Services to support state systems of care for child welfare, mental health, and substance abuse; by U.S. DOJ for state juvenile justice systems (implementing PREA); and by the U.S. Department of Education for state education systems. If patterns of child abuse and neglect are identified and found to violate the civil rights of children in certain facilities that are operated or substantially sponsored by state and local governments, the federal Civil Rights of Institutionalized Persons Act can authorize the U.S. Attorney General to conduct investigations and bring actions against state and local governments. Federal oversight authority does not extend to private facilities that serve only children placed/funded by caregivers or other private entities.

American Indian Tribes and Alaska Native Villages

- American Indian tribes and Alaska Native villages, as sovereign nations, may have their own laws and regulations. They may also have law enforcement agencies, child protective services/social services, prosecution offices, courts, advocacy programs, health care systems, and other services to address child sexual abuse.
- When child sexual abuse takes place on tribal land, one or more governments (tribal, federal, or state) may be able to take action in response.⁷⁵ A tribal criminal justice system, if it has jurisdiction in a case, may investigate and prosecute the case concurrently with another government's investigation and prosecution.⁷⁶
- A tribe may have its own multidisciplinary response team or a team may be in place to promote multidisciplinary coordination within and across jurisdictions among entities in the response to child sexual abuse on tribal lands, the investigation and prosecution of these cases, and the care of victims.⁷⁷ Jurisdiction-specific roles and coordination tasks must be delineated to prevent confusion when intervening in individual cases and to ensure that the collective response is streamlined and effective. Coordination is crucial to enable victims to access the full range of resources these jurisdictions collectively offer. Multijurisdictional partnerships are needed to move towards a system that provides evidence-informed services for children and families.
- Protocols should standardize activation of responding entities across jurisdictions, according to agreed-upon procedures, to allow for quick determination of jurisdiction in a case and how to assist each child.
- Nontribal responders that serve child sexual abuse victims from tribal communities should be familiar with procedures for coordinating initial interventions with tribal entities, including ensuring children have timely access to the medical forensic examination. Ideally, they should also have training on working with tribal communities.
- Multijurisdictional coordination plans should address distribution and disposition⁷⁸ of forensic evidence collection kits used in prepubescent child sexual abuse cases; related health care and forensic specimen preservation; transfer of forensic evidence to the appropriate investigative agency, crime lab, or designated evidence storage facility; exam payment to the facilities and examiners; and family reimbursement for medical costs incurred (as allowable).⁷⁹

⁷⁵ Determining the appropriate jurisdiction can be very difficult and confusing. For a summary of which government entity has jurisdiction under different scenarios, see the United States. Attorneys' Criminal Resource Manual, Section 689 available at www.justice.gov/usam/criminal-resource-manual-689-jurisdictional-summary

⁷⁶ Sekaquaptewa, Bubar, and Cook (2008) offer a discussion of factors that tribes should consider when making the decision to prosecute a tribally defined child sex crime case concurrent with a federal prosecution of the same case (where an Indian is the suspected perpetrator). See Chapter 8 at www.tribal-institute.org/download/CCC_February_2009.pdf.

⁷⁷ For example, Peterman (2010) indicated that depending upon the tribe, a federal multidisciplinary team that has jurisdiction in child sexual abuse cases on a specific reservation usually includes but is not limited to representatives from the following agencies: United States Attorney's Office; FBI (victim-witness specialist and special agent); Bureau of Indian Affairs, Office of Law Enforcement Services (victim-witness specialist and special agent); the tribal police department; Indian Health Service; nurse midwife program; mental health services; tribal child welfare; tribal attorney general's office, state child protection, and tribal victim services. The multidisciplinary team model has been invaluable in Indian Country primarily because of the distance between most U.S. Attorney's offices and the reservations for which they are responsible (a 100-mile trip between sites is not unusual). See www.justice.gov/sites/default/files/usao/legacy/2010/07/26/usab5804.pdf.

⁷⁸ Disposition refers to the ongoing process of determining what to do with evidence in a case (Technical Working Group on Biological Evidence Preservation, 2013).

⁷⁹ For a resource for building tribal-state relations, see Child Welfare Information Gateway (2012c).

Military Installations (drawn from militaryonesource.mil)⁸⁰

- Child abuse reports relating to victims with parents or guardians who are military members can be made either to appropriate child protective service agency or the installation family advocacy program. When suspected abuse is reported, a team will assess the safety and welfare of the child. If child protective service team members learn the call involves a military family and a memorandum of understanding is in place, they should contact the installation family advocacy program.
- Child abuse and neglect are defined in the military as injury, maltreatment, or neglect to a child that harms or threatens the child's welfare. The family advocacy program will become involved when one of the parties is a military member or, in some cases, a DoD civilian serving at an overseas installation. The family advocacy program will also intervene when a dependent military child is alleged to be the victim of abuse and neglect while in the care of a DoD-sanctioned family child care provider or installation facility, such as a child development center, school, or youth program.
- When the family advocacy program receives a call concerning the safety and welfare of a child, it ensures that everyone who is capable of protecting the safety and wellbeing of the child—the active-duty member's commander, law enforcement, the medical treatment facility, and child protective services—is aware of the risk and protective factors that are impacting the family. These community members often work as a team to ensure that children are protected, the parents receive appropriate intervention, and the family receives the services they need to be able to form more healthy relationships.
- If child protective services determines that abuse or neglect did occur, the civilian family court system will become involved. Sometimes, the judge will appoint a guardian ad litem to represent the child's interests. This attorney will review all available information and evidence from law enforcement, the family advocacy program, and child protective services, and make recommendations to the court based on what he or she believes is in the child's best interest.
- For the medical forensic examination, child sexual abuse cases are referred to local civilian medical experts when no trained military pediatric medical forensic examiner is available to the military installation. (K. Robinson, personal communications, May 28, 2015).
- Multidisciplinary response teams from local communities that surround military installations should develop procedures in conjunction with family advocacy programs for coordinating interventions and services for children in sexual abuse cases who are military dependents based at these installations. Written agreements should be developed and signed by all involved entities to clarify roles and responsibilities. Providers near military installations should reach out to the family advocacy program on the installation to determine the best way to collaborate.



Contact staff at Kidsta.org for input on overcoming specific coordination challenges in responding to child sexual abuse in institutional settings, tribal communities, or military installations.

⁸⁰ For more information, see Military OneSource (n.d.) at www.militaryonesource.mil/health-and-wellness/family-violence?content_id=282305.

A4. Health Care Infrastructure

Introduction

This section discusses the local health care infrastructure essential to conducting the sexual abuse medical forensic examination for prepubescent children:

- Pediatric examiners;
- Health care facilities; and
- Equipment and supplies.

This infrastructure should be built on the recognition that child sexual abuse is a serious health problem, in addition to a child protection and criminal justice issue, and that the local health care system plays a crucial role in caring for prepubescent children who have been sexually abused. This infrastructure must be built on the knowledge that local response to child sexual abuse is complex and multifaceted, requiring the health care system to be part of a multidisciplinary coordinated effort. (See [A3. Coordinated Team Approach](#))

Pediatric examiners' presence in a community and their participation on the multidisciplinary response team depends to a large extent upon the capacity and/or commitment of the local health care system(s) to provide a high-quality response to child sexual abuse. Implementation of such a response includes but is not limited to: supporting specialized education of medical providers in the evaluation of child sexual abuse; hiring trained examiners; implementing comprehensive examination protocols; promoting feedback methods on examiner performance, including a system of peer review; and supporting continuing education and networking for examiners (Green, 2013; Meunier-Sham, Cross, & Zuniga, 2013; West Virginia Children Advocacy Network, 2014).

Although it may not be feasible for every health care facility in a community to offer specialized care for this population, every community should make available:

- Pediatric examiners who provide this specialized care as part of a multidisciplinary team response; and
- Health care facilities in which pediatric examiners conduct acute and nonacute examinations and where optimal access is offered to the full range of medical services that child victims may require (for acute care).

Every health care facility in a community—but particularly in pediatric primary care settings and hospital emergency departments—needs the expertise to initially assess children who present with sexual abuse to determine the urgency of medical forensic care needed, and arrange for the appropriate care. (See [B3. Entry into the Health Care System](#))

A4a. Pediatric Examiners

These recommendations are for communities and health care systems related to pediatric examiners. For recommendations related to health care providers involved in initial response prior to the medical forensic examination, see [B3. Entry into the Health Care System](#).

Every community should have ready access to trained, competent pediatric examiners who can provide medical forensic care to prepubescent children who disclose sexual abuse or are suspected of being sexually abused. (Ready access means that the community has designated pediatric examiners to respond to requests to perform examinations within prescribed time frames for acute and nonacute cases. For example, a community might require examiners to respond within 60 minutes to requests for acute care. Response times for nonacute care typically are more flexible) Communities across the country rely on a range of health care providers (e.g., physicians, advanced practice nurses and physician assistants, and registered nurses) who have been specially educated and have completed training requirements to perform this examination for a pediatric population.

*Key Roles and Responsibilities of Pediatric Examiners: Prepubescent Children*⁸¹

- Work as part of a multidisciplinary team to respond to child sexual abuse
- Communicate with children in a child-focused, victim-centered, and trauma-informed manner
- Provide ethical, compassionate, and objective health care
- Ensure children’s immediate safety issues are addressed
- Recognize the impact that sexual abuse can have on children’s health and wellbeing
- Ensure the needs of children and caregivers for support and crisis intervention are addressed
- Document the medical history
- Conduct a physical and anogenital examination and document exam findings (written and photo-documentation)
- Collect forensic samples as applicable
- Screen for and treat STDs, including HIV, as applicable
- Refer children for post-exam care and services and caregivers for supportive services
- Testify in court if needed
- Recognize the examination is an opportunity to facilitate healing by treating children holistically, taking into consideration the unique needs of each child and family unit



See www.Kidsta.org for updates on the development of national training standards for pediatric examiners.

As much as possible, pediatric examiners should be on permanent rather than temporary assignment in a community. However, as health care staffing challenges exist across the country, facilities often rely on temporary staffing. It can be difficult for temporary health care staff to understand the needs of child sexual abuse victims in their assigned community or to be familiar with related facility/jurisdictional policies and procedures. Also, if staff move to another assignment, arranging court testimony can be complicated. Facilities should have policies in place to address these issues.

⁸¹ Adapted from Day & Pierce-Weeks, 2013.

Support advanced education, supervised clinical practice, and certification for health care providers who conduct medical forensic examinations for prepubescent child sexual abuse victims. It is critical that health care providers are afforded sufficient time by their health care facilities to pursue these opportunities. It is also important to recognize that specific education, practice, and supervision needs may vary across involved disciplines and jurisdictions. For example, non-physician examiners in a specific state may require medical supervision and backup in addition to completing necessary training and clinical requirements.

Pediatric examiner certification through the IAFN is available to registered nurses and advanced practice nurses trained as sexual assault nurse examiners (SANEs). Pediatricians can seek child abuse certification through the AAP. NCA standards for accredited children's advocacy centers set minimum guidelines for health care providers who conduct child abuse medical evaluation through accredited children's advocacy centers. States and communities may also have their own criteria for pediatric examiner education and clinical practice.

To support the above initiatives, communities and health care systems can encourage the following:

- The development of educational programs for pediatric examiners of all disciplines (both discipline-specific and across disciplines where appropriate);
- Provision of education in medical schools, nursing schools, nurse practitioner programs, and physician assistant programs on the general topic of child sexual abuse, with the goal of more effective medical screening and appropriate intervention if child sexual abuse is disclosed or suspected; and
- Strategic planning on how to systematically train, secure, supervise, and retain pediatric examiners to serve poor, rural, or remote areas, tribal communities, migrant farm worker communities, military installations, and other areas needing an enhanced response to child sexual abuse.



See www.Kidsta.org for more information and resources on advanced education, supervised clinical practice, and certification for pediatric examiners.

Support the ongoing education of pediatric examiners, as well as their access to experts in the child sexual abuse field who can participate in examiner training, mentoring, proctoring, peer review of medical forensic examinations, and quality assurance. Access to experts and ongoing education has been shown to increase examiner competence and improve the quality of examinations, documentation, and interpretation of findings over time (Adams et al., 2015). In addition, examiner participation in multidisciplinary training opportunities and case review can help evaluate and improve team response and interventions. (See [A3. Coordinated Team Approach](#))

Note that for purposes of tracking down examiners who have moved, most hospitals or medical clinics by which physicians or advanced practice providers are employed or affiliated require them to apply for facility privileges. Providers requesting privileges usually

must agree to submit forwarding addresses when they leave. Also, medical licenses can be tracked to the state or territory where the provider is working.

Support pediatric examiners in establishing peer review processes. In peer review, medical experts in child sexual abuse across disciplines have the opportunity to review written and photographic documentation of a child's examination. They may discuss interpretation of medical findings—particularly those thought to be abnormal or indicative of sexual abuse—and give the provider who conducted the examination input on his/her care and documentation (Adams et al., 2015; Midwestern Children's Advocacy Center, n.d.). Attention to cultural issues may also be discussed. Peer review has been demonstrated to improve professional practice patterns (Greeley et al., 2014). It can help to improve diagnostic accuracy, assist with confirmation and verification of exam findings, and establish a consensus in the data and interpretations (Morton et al., 2010). Because often no residual visible injury is seen in child sexual abuse cases, the use of peer review can be particularly helpful in strengthening examiners' skills to not overcall a normal variant finding as consistent with sexual abuse (Adams et al., 2015; Makoroff et al., 2002).

The reasons that examiner programs conduct peer review differ from jurisdiction to jurisdiction. Some programs use it as a quality assurance process, while others use it as ongoing education for providers (Rotolo & Gorham, n.d.). ***Each program should have a peer review process that is clearly defined, including a rationale for conducting the review.***



Peer review should not be confused with obtaining an expert second opinion. Obtaining a second opinion is one aspect of the overall care of the patient. For example, an examiner may reach out to an expert to obtain another opinion or confirm findings in a given case. The consulted expert reviews the medical report and photo-documentation and subsequently should provide formal written documentation of her/his review and conclusions. The second opinion report is then included in the patient's medical record, which will be released for legal proceedings upon request. Jurisdictional protocols should be clear in what situations a second opinion may be helpful and the process for obtaining one, and clarify how a second opinion and formal report differs from a program clinical peer review.

Encourage continued research and pilot projects related to telehealth practices in child sexual abuse medical forensic examinations.⁸² Some jurisdictions, particularly those in rural and remote areas, are taking advantage of a range of advanced technology to support examiners who conduct medical forensic examinations. Use of such technology in health care (sometimes called telehealth or telemedicine) can potentially allow pediatric examiners to mitigate the barriers of geography to consult with offsite medical experts.⁸³ Pediatric examiners' most common uses of telehealth strategies are in peer reviews, seeking an expert opinion, and education. Note that many national-level organizations that

⁸² For example, two studies cite benefits of telehealth strategies specific for child sexual abuse medical forensic examinations—see MacLoed et al. (2009) and Miyamoto et al. (2014). An Office of Victims of Crime-funded pilot project, the National Telehealth Nursing Center, is using telemedicine technology to provide expert consultation to clinicians caring for adult and adolescent sexual assault patients in remote and/or underserved regions of the country.

⁸³ There are two basic telehealth approaches (drawn from WHO, 2010): Store-and-forward, or asynchronous, strategies involve the exchange of pre-recorded data between two or more persons at different times. For example, pediatric examiners may use store-and-forward applications to obtain input on a case from a medical expert for peer review purposes or a second opinion. Real time, or synchronous, strategies require involved persons to be simultaneously present for immediate exchange of information, as in the case of live peer review. In both applications, information may be transmitted in a variety of media.

provide training and technical assistance of interest to pediatric examiners use technology strategies to extend their services to the widest possible audience.

An emerging practice is telehealth as a tool to help guide clinicians in real-time patient encounters through live expert consultation. Before live remote consultation during medical forensic examinations of prepubescent child sexual abuse victims can become more widely accepted, there are a range of logistical and ethical issues and concerns to be considered, practices to be evaluated, guidelines and professional education to be developed. A few of the related issues that need to be explored are:

- The need for experts' licensure in the state in which the consultation is being provided;
- The need for liability insurance for experts;
- Practices regarding who covers costs of expert consultation;
- Experts' participation in potential criminal and civil justice proceedings;
- Impact of telehealth strategies on case prosecution;
- The possibility that the video consultation could become part of case evidence (recognizing that consultation is part of any criminal, civil, or family court proceedings);
- Procedures for protecting patient privacy and complying with applicable privacy laws;⁸⁴
- Logistics of child-focused, victim-centered, trauma-informed care using telehealth strategies; and
- Concerns about telehealth strategies being viewed as a budget-cutting tool that could lead to the elimination of local examiners (recognizing that a trained pediatric examiner on-site is the best practice).



See www.Kidsta.org for further information and resources on pediatric examiner continuing education and peer networking opportunities, peer review opportunities,⁸⁵ and related telehealth strategies.

⁸⁴ Health care facilities must ensure that electronic communication concerning patient health information conforms to applicable privacy laws (e.g., the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH)). (See [A5b. Confidentiality and Release of Information](#).)

⁸⁵ For example, the Midwest Regional Children's Advocacy Center hosts medically-focused peer review groups (see www.mrcac.org/peer-review/). Its Midwest Regional Medical Academy offers [myCasereview](http://www.mrcac.org/medical-academy/mycasereview) (anonymous case review). See www.mrcac.org/medical-academy/mycasereview.

A4b. Facilities

These recommendations are for communities to build the capacity of local health care systems to respond to sexual abuse of prepubescent children.

Recognize the obligation of health care facilities to serve prepubescent patients who have experienced sexual abuse.⁸⁶

- **Although not every health care facility in a community has the capacity to offer pediatric medical forensic examinations, every community should designate health care facilities that can provide this specialty care** (within a reasonable travel distance for children and their families, with the term reasonable locally defined). The medical forensic examination of prepubescent child sexual abuse victims should occur at a medical site where trained pediatric examiners conduct the examination. Acute and nonacute care may be offered at the same or different facilities, but both types of examinations need to be readily available to the local population. (Examinations that are readily available are offered within a prescribed time frame appropriate for the urgency of care needed and within a reasonable travel distance for children and their families) For acute care, the exam site should also have easy access to a full range of medical services that may be required by these children.
- **All health care facilities, but especially primary care settings and hospital emergency departments, should screen for child sexual abuse. If sexual abuse is disclosed or suspected, care providers should be aware of community response policies and implement community-specific interventions for initial health assessment** (note this initial assessment is NOT the medical forensic examination). Primary care and emergency department medical personnel should: (1) ensure that child victims who enter the health care system receive necessary emergency medical treatment and are assessed for urgency of medical forensic care needed; (2) make a mandatory report of the sexual abuse to legal authorities; and (3) arrange medical forensic care performed by a pediatric examiner. (See [B3. Entry into the Health Care System](#))



The Joint Commission on Accreditation of Healthcare Organizations (the Joint Commission)⁸⁷ requires that emergency and ambulatory care facilities have policies to identify and assess possible victims of sexual assault, sexual molestation, and child abuse and neglect; and require staff training on the policies. As part of the assessment process, the Joint Commission requires facilities to define their responsibilities related to collection and preservation of evidentiary materials. Pediatric examiners aid many health care facilities in carrying out the requirements.⁸⁸

⁸⁶ Historically, response to child sexual abuse has been perceived as largely a criminal justice or child protection system responsibility. However, child sexual abuse is a public health issue that has negative long-term implications for victims, families, and communities, and requires specialty care for its victims.

⁸⁷ Joint Commission standards for accreditation (www.jointcommission.org/standards_information/standards.aspx) address a health care organization's level of performance in specific areas—not just what it is capable of doing, but what it actually does. The standards set forth maximum achievable performance expectations for activities that affect quality of care.

⁸⁸ The paragraph was drawn in part from Bobak (1992) and Ledray (2001).

Facilities should be familiar with the federal Emergency Medical Treatment and Active Labor Act (EMTALA), which has provisions pertaining to the ability of hospitals to transfer patients with emergency medical conditions.⁸⁹

Explore possibilities for optimal exam site locations. Multidisciplinary response teams for child sexual abuse, in conjunction with health care facilities and pediatric examiners, should determine where acute and nonacute examinations for prepubescent children should be conducted for their community.

Key Factors to Consider when Identifying Designated Exam Facilities

- Access to trained pediatric examiners (top priority) (see [A4a. Pediatric Examiners](#))
- Examiner capacity to photo-document anogenital findings (see [B6. Photo-Documentation](#))
- Needs of children and families (e.g., exam site within a reasonable distance)
- 24/7 access for emergent needs, determination of urgency of medical forensic care, acute medical forensic care, and referrals for nonacute care (see [B3. Entry into the Health Care System](#))
- Particularly for acute care, access to the full range of medical services for children, supplies and equipment needed to complete an examination, lab services,⁹⁰ and a pharmacy for medication⁹¹
- Established measures to promote safety for patients, their families, and staff (see [A1. Principles of Care](#))
- Privacy for children and families (see [A1. Principles of Care](#))
- Appropriate space/setting (e.g., an exam room, sitting area, toilets, place to wash, lighting, and furniture)
- Compliance with local safety and health regulations (e.g., resuscitation equipment, electricity, water, sewerage, ventilation, sterilization, and waste disposal)
- A child-friendly environment that speaks to physical, developmental, psychological, and spiritual needs of prepubescent children and takes into account the child's best interests at all times (although the exam facility may not be specifically devoted to the care of children, such as in a children's hospital⁹² or a children's advocacy center, it should make the process as child-focused and friendly as possible) (see [A1. Principles of Care](#))
- Capacity to accommodate cultural and linguistic needs of patients and caregivers (access to language services, tools/devices to help facilitate communication for individuals with disabilities, related staff training, culturally-specific service providers and support persons, etc.) (see [A2. Adapting Care for Each Child](#))
- Capacity to accommodate needs of children with disabilities and those who are Deaf, as per standards set forth in the American with Disabilities Act (ADA)⁹³ (see [A2. Adapting Care for Each Child](#))

⁸⁹ 42 U.S.C. § 1395dd. For more information on EMTALA, see www.emtala.com. It may be useful for sites to exemplify many of the Magnet model outcomes outlined by the American Nurses Credentialing Center (2011). See www.nursecredentialing.org/Magnet/ProgramOverview/New-Magnet-Model.

⁹⁰ Hospital labs generally do not do the type of toxicology testing required in a sexual abuse case.

⁹¹ Free-standing health clinics that conduct the examination should have ready access to medications that may be needed in these cases, such as those for HIV non-occupational post-exposure prophylaxis, even without a clinic pharmacy.

⁹² See www.childrenshospitals.org/Issues-and-Advocacy/Population-Health/Child-Abuse for the Children's Hospital Association's (2011) *Defining the Children's Hospital Role in Child Maltreatment* (2nd ed.).

⁹³ Title II and Title III of the Americans with Disabilities Act (ADA) explains requirements for facilities in accommodating persons with disabilities (which may vary depending on the type of facility). Title II prohibits discrimination against persons with disabilities in all programs, activities, and services of public entities. Title III requires places of public accommodation to make reasonable modification in their policies, practices, and procedures to accommodate individuals with disabilities. See www.ada.gov for related ADA information and resources.

Key Factors to Consider when Identifying Designated Exam Facilities

- Visual indications that all types of children are welcome (e.g., displays of different faith symbols, cultural icons, and rainbow flag/triangle,⁹⁴ as well as images of children with from diverse backgrounds, children with different abilities/disabilities, and children accompanied by diverse caregiver figures) (see [A2. Adapting Care for Each Child](#))
- Clinical staff trained to care for and support children and caregivers until the examiner arrives (if not on site) (see [B3. Entry into the Health Care System](#))
- Policies and mechanism for mandatory reporting in these cases and to trigger multidisciplinary response as per jurisdictional policy (see [A5a. Reporting](#) and [A3. Coordinated Team Approach](#))
- Capacity to access victim advocacy and other child and family support services during the exam process (See [A1. Principles of Care](#) and [A3. Coordinated Team Approach](#))
- Capacity to connect children and caregivers to needed follow-up resources, care, and services (See [B11. Discharge Planning and Follow-Up Care](#))
- Capacity to ensure the appropriate evidentiary kits are available and forensic evidence collected is maintained under proper chain of custody until it is released to law enforcement (See [A5c. Evidentiary Kits and Forms](#) and [A5e. Evidence Integrity](#))
- Capacity and policies in place to securely store and appropriately release the medical records of children who receive medical forensic care (with mechanisms to limit access to only those permitted by law and in consultation with examiners for interpretation purposes) (See [B4. Written Documentation](#) and [B6. Photo-Documentation](#))
- Site billing department adherence to proper coding and billing practices for sexual abuse cases that follow federal law and jurisdictional policy (See [A5f. Payment Issues](#))
- Support of continuing education for pediatric examiners (See [A4a. Pediatric Examiners](#))
- Ideally, designated exam facilities are hospital and/or medical clinic settings (with medical clinics including but not limited to children’s advocacy centers’ medical services). The multidisciplinary response team should arrange to have at least one site in the community or region that provides 24/7 access for acute examinations conducted by trained pediatric examiners. Where they exist in a community, children’s advocacy centers with medical services typically offer the most appropriate site for nonacute examinations.



See www.Kidsta.org for technical assistance on addressing the above facility capacity issues.

Consider what type of system of designated exam facilities best serves community needs (e.g., local, tribal, regional, state, territorial, or other). Some issues that might affect this decision include: type of community demographics and geography; availability of health care facilities and specialized care programs; capacity to secure trained pediatric examiners and necessary space, equipment, and supplies; and willingness of involved disciplines to coordinate with particular facilities. Multidisciplinary response teams are encouraged to consider first using nearby facilities so that children and families do not have to travel considerable distances for care. Military installations may rely on military health facilities if they have access to a trained pediatric examiner. However, some communities may opt for regional rather than local facilities. For example, a small state, a tribe, or a sparsely populated region may establish one or more designated facilities to serve all of its localities.

⁹⁴ These are popular symbols of pride for lesbian, gay, bisexual, transgender, and/or intersex (LGBTI) people.

Consider a model of medical service provision for child victims of sexual abuse in which the initial assessment of urgency of care needed, the medical forensic examination, and related health care are provided to children in the same location and preferably by the same health care provider (a trained pediatric examiner). The exception would be if the child required emergency medical care—hospital emergency department personnel typically will attend to those needs first.



Children’s advocacy centers that are not 24/7 (most are not), or that do not have medical services on site, should coordinate with health care facilities designated as acute and/or nonacute exam sites (usually local or regional hospitals) to ensure 24/7 access for examinations conducted by trained pediatric examiners.

If a transfer of the child from one health care facility to a designated acute exam site is necessary, use procedures that address children’s needs, satisfy EMTALA requirements, and minimize time delays and loss of forensic evidence. Communities and health care facilities should avoid transfers whenever possible, as it can cause children and family members further stress, and destroy forensic evidence. However, if a child arrives at a health care facility within the jurisdictional time frame for acute medical forensic care or such care is otherwise indicated (see [B3. Entry into the Health Care System](#)) and the facility is not able to provide that specialty care, interagency transfer procedures must be in place to transfer the child to the nearest designated acute exam facility. The initial facility should communicate with the receiving exam site to confirm the availability of a pediatric examiner to provide care to ensure minimal or no delay in the medical forensic examination process. The child should receive a general medical screening promptly after arrival at the initial facility (e.g., within one hour)⁹⁵ and before transfer to another health care facility. Emergent medical injuries or psychological issues must be addressed before initiating a transfer.

Prior to the transfer, providers should discuss with the child and caregiver the reasons for the transfer. Health care providers can work with criminal justice representatives and advocates to ensure related transportation needs are met and other support needs of the family are addressed (e.g., child care for other children). Support and advocacy at the initial facility and exam site should be offered when available.

When making a transfer, health care facilities should prioritize the child’s comfort and take precautions to minimize the loss of forensic evidence. A copy of the child’s records, including reports of any treatment administered or testing performed, should be transported with the child to the exam facility.

⁹⁵ The general medical screening determines airway, breathing, and circulatory status. It does not include examination of genitalia or additional screening unless there is evidence of hemodynamic instability, psychiatric crisis, or acute medical complaint (such as genital bleeding). It includes only a minimal history to establish last point of contact and the identity of the suspected perpetrator, if known. An acknowledgement of risk factors for HIV and other STDs needs to be taken into account during and as part of transfer.

Develop agreements among responders to clarify facility issues. Communities should consider:

- ***Agreements among health care facilities regarding standard practices in screening for and responding to suspected prepubescent child sexual abuse.*** Such an agreement should address expectations related to: screening, mandatory reporting, addressing child safety issues, emergency medical care, initial assessment for urgency of care needed, arranging specialized care, backup planning (e.g., in the case a pediatric examiner is not available at the exam site or multiple victims require care beyond what one site can manage); and transfer procedures from one health facility to an exam site, if necessary.
- ***Agreements among health care facilities, exam sites, children’s advocacy centers, investigative agencies, and multidisciplinary response teams regarding the logistics of designated exam sites.*** Such an agreement should identify designated exam sites and whether they provide acute and/or nonacute examinations, primary exam sites and alternatives, hours of operation for each site, procedures for facilitating an examination at each site, and referrals to community resources.
- ***Agreements among health care facilities, exam sites, multidisciplinary response teams, children’s advocacy centers, and community-based sexual assault victim advocacy programs to ensure victim advocacy.*** Procedures are needed to allow activation of victim advocates trained to work with children (if available) to come to the exam site or another health care facility to which children may present and to provide crisis intervention, advocacy, and accompaniment services for children, caregivers, and/or other family members. This agreement can clarify the potential roles of victim advocates in the exam process, coordination of services, and confidentiality issues.

A4c. Equipment and Supplies

These recommendations are for health care facilities and pediatric examiners for exam equipment and supplies.

Plan to have specific equipment and supplies readily available for the medical forensic examination of prepubescent victims of sexual abuse. Below is a checklist of equipment and supplies, with minimum requirements starred (*) (adapted in part from Day & Pierce-Weeks, 2013). However, follow jurisdictional and facility policies regarding use of specific equipment and supplies. Note that not every item will be needed in every case.

Checklist of Equipment and Supplies

- Examination table/bed/stretchers (consider access issues for children with physical disabilities⁹⁶)*
- Patient gowns and bed linens/sheets
- Basic medical supplies for injury treatment (e.g., sutures, bandages, splints, and scissors)
- Resuscitation equipment
- Patient comfort supplies (See [A1. Principles of Care](#))
- Powder-free, latex-free, nonsterile examination gloves*
- Lubricant
- Culture supplies*
- Needles, syringes
- Sharps disposal container
- Method or device to sterilize equipment
- Sterile water, sterile normal saline*
- A method or device to dry specimens (e.g., swab dryer or open air cardboard drying rack)
- Forensic evidence collection kits, forms, and exam protocol* (See [A5c. Evidentiary Kits and Forms](#))
- Any testing supplies not included in the forensic evidence collection kit (and access to testing results)
- Forensic supplies* (e.g., paper bags, evidence tape for sealing bags, additional envelopes, containers, cotton-tipped swabs, and packaging for wet forensic evidence) (See [B8. Evidence Collection](#) for other supplies)
- Handheld magnifying glass or magnified visor
- Digital camera and related supplies (e.g., batteries, flash, photographic reference ruler/standard—basic and color, identification stickers, tripod/monopod, camera manual, and cleaning supplies) (See [B6. Photo-Documentation](#) and [B7. Examination](#))
- Colposcope⁹⁷
- Scales, height chart, measuring tape
- Written materials for children and caregivers (See [A1. Principles of Care](#))

⁹⁶ For example, the ideal is an exam table with a hydraulic lift for children with mobility impairments. If not available, health care personnel must know how to assist patients with physical disabilities onto standard exam tables. If it is determined that a patient can only be examined on an exam table with a hydraulic lift, procedures should be in place to transport the patient, in acute cases, to a site with such a table with as little loss of forensic evidence as possible.

⁹⁷ Use of a colposcope is an option if a community can afford/access such equipment. Note that colposcopes are the standard in many communities for magnified visualization and photo-documentation of anogenital structure detail. In communities which do not have the ability to use colposcopes, many are opting for digital cameras as the next best alternative to achieve magnification and capture still- and video images that allow for a permanent record of the anogenital examination findings.

Checklist of Equipment and Supplies

Additional equipment and supplies to consider:

- A mobile cart or portable pack for the inpatient child
- An alternate light source (ALS)⁹⁸ to aid in examining patients' bodies, hair, and clothing. ALS can be used to scan for forensic evidence, such as dried or moist secretions and fluorescent fibers, which is not visible in ambient light (see [B7. Examination](#))
- Toluidine blue dye (TBD) may be used to accentuate minor epithelial damage, either with or without magnification (see [B7. Examination](#))⁹⁹

Examiners should know how to properly use all related equipment and supplies, specific to prepubescent children. It is important that pediatric examiners, exam facilities, and forensic scientists stay abreast of the latest research on equipment and supplies used in caring for prepubescent children, and the current forensic science recommendations for forensic evidence collection. (See [B7. Examination](#) and [B8. Evidence Collection](#) for more on the use of equipment and supplies)



Note that **specula should not be used in the examination of prepubescent or premenarchal girls**, unless they are under sedation or anesthesia for significant medical concerns (e.g., bleeding or a mass or foreign body in the vagina). **An anoscope is also generally not indicated for prepubescent children**, unless they are under sedation or anesthesia for significant medical concerns (e.g., rectal bleeding or pain). In cases where sedation or anesthesia is necessary, pediatric examiners typically work in conjunction with appropriate surgical specialists. (See [B7. Examination](#))

⁹⁸ Examiners should be educated about the advantages and limitations of using ALS in sexual abuse medical forensic examinations and receive instruction on its proper use to improve sensitivity and specificity when identifying stains (Eldredge, Huggins, & Pugh, 2011). (See general instructions offered in [B7. Examination](#).) The Wood's lamp is no longer recommended, as semen samples do not fluoresce on fabric or skin at wavelengths associated with this light source (Anderst, 2011; Eldredge, Huggins, & Pugh, 2011; Santucci, 1999). ALSs with wavelengths of 400 to 600 nanometers (nm) are effective in fluorescing semen particles; use of light sources with wavelengths around 450 nm is reported to have 83 percent accuracy in differentiating semen from other stains. Note ALS use in detecting stains on skin is limited (Wawryk & Odell, 2005). Continued research is needed on: the use of ALS as a tool in identifying and collecting forensic evidence; the sensitivity and specificity of various long wavelength lights on various skin types and at various time frames after application of stains; the role of time and normal "wear and tear" on stains; and the development of a system to distinguish semen from other stains (Eldredge, Huggins, & Pugh, 2011). Note no research base currently supports the use of ALS to accurately interpret subclinical bruising. In fact, Lombardi et al. (2015) found in a study of adults that more than half the time, positive fluorescence of a bruise was actually something other than a bruise.

⁹⁹ TBD binds to nucleated squamous cells in the deeper layers of epidermis and, when properly applied, will only stain areas with acute injuries or those that have been recently abraded of the top epithelial layer (Blackburn & Stokes, 2013). TBD is not universally used in adult, adolescent, or prepubescent child sexual assault/abuse medical forensic examinations and is considered controversial as a tool for detecting injury in some jurisdictions (e.g., it may be perceived by the court as changing the appearance of the tissue). No research is available (and would be useful) on the use and limitations of TBD, specifically with prepubescent child sexual abuse victim population. (See [B7. Examination](#) for general instruction for use of TBD.)

A5. Infrastructure for Justice System Response During the Exam Process

Introduction

This section discusses elements essential to facilitate an effective initial response by the justice system to prepubescent child sexual abuse via child protective services and/or law enforcement agencies, focusing on multidisciplinary coordination during and related to the exam process.

A5a. Reporting

Mandatory reporting statutes in a jurisdiction identify individuals—certain professionals and community members, and sometimes, all citizens—who are required to report suspicions of child sexual abuse, physical abuse, and neglect to legal authorities. That report typically triggers protective and investigative responses and can be a tool to facilitate medical forensic care as well as support for children and their families.

A5b. Confidentiality and Release of Information

Statutes and policies addressing confidentiality of child-responder communications in child sexual abuse cases and related records (including those from the medical forensic examination) typically allow information sharing among specified protective and investigating agencies so that case decisions are as informed as possible.

A5c. Evidentiary Kits and Forms

Standardized evidentiary kits and forms are typically used during the medical forensic examination in a jurisdiction to (1) make forensic evidence collection practices consistent across the community; (2) create a record of the medical history and exam findings; and (3) maintain the chain of custody of forensic evidence and information that will be included in the kit.

A5d. Timing of Evidence Collection

Forensic evidence collection in a particular case depends on timing and case circumstances. In addition to jurisdictional time frames for forensic evidence collection (e.g., within a certain number of hours or days since the sexual abuse), case circumstances may indicate a need for acute medical forensic care and forensic evidence collection.

A5e. Evidentiary Integrity

Maintaining the integrity of forensic evidence increases the likelihood it will be admissible if the case goes to trial. Jurisdictions should have policies in place regarding drying, packaging, labeling, sealing, and security of forensic evidence, as well as transfer of forensic evidence from exam facilities to law enforcement agencies.

A5f. Payment Issues

Jurisdictions investigating these cases have an obligation to cover all forensic costs associated with the medical forensic examination (recognizing that what jurisdictions consider to be forensic expenses can vary). Children and their families should not be obligated to pay for forensic costs, nor should exam facilities bill them for forensic expenses. Children and caregivers/families should be advised of their specific responsibilities regarding coverage of expenses related to medical forensic examination as well as any financial assistance available to help with these expenses, such as crime victims' compensation. Jurisdictional reimbursement practices for examiners conducting the examinations and for the exam facilities should be fair and equitable.

A5a. Reporting

These recommendations are for communities and responders related to mandatory reporting of sexual abuse involving prepubescent children.

Develop community-wide public awareness initiatives on mandatory reporting.

Professionals who interact with children and families, as well as citizens in general, need education regarding mandatory reporting laws and policies in their communities related to child sexual abuse. The same type of constituent education is necessary in institutional settings and for tribal communities and military installations that have their own mandatory reporting requirements. In these settings, there is a need to explain if and how reporting and response to child sexual abuse is coordinated with agencies in the surrounding/another jurisdiction. Given that children who are abused often do not or cannot advocate for themselves, community professionals and citizens represent the front line in safeguarding their interests and connecting them with entities that can protect and help them.

Make sure that professionals and agencies/facilities involved in the community response to prepubescent child sexual abuse are aware of reporting requirements and what happens in a case once a report is made. They should know if they are a mandated reporter under jurisdictional laws, under what circumstances to report, the type of information to report, to whom they should report, the reporting procedures, and the timelines for making a report. They may need to be aware of reporting laws and procedures in more than one jurisdiction (e.g., for those who serve tribal communities, they should know applicable tribal, federal, and state laws and procedures for reporting). See below for a brief overview of child abuse and neglect reporting practices in the United States, which are inclusive of child sexual abuse.

General Information on Child Abuse and Neglect Reporting Practices

Requirement to report—

- **States, the District of Columbia, and territories**¹⁰⁰ (Child Welfare Information Gateway, 2014b): All require certain persons to report suspected child abuse and neglect to an appropriate agency or agencies, such as child protective services, a law enforcement agency, and/or a state toll-free child abuse reporting hotline.¹⁰¹ Mandatory reporters vary across jurisdictions, but typically include individuals who have frequent contact with children: e.g., social workers, school personnel; physicians, nurses, and other health-care workers; counselors, therapists, and other mental health professionals; child care providers; medical examiners or coroners; law enforcement officers; and multiple other persons and entities.¹⁰² Some jurisdictions require any person who suspects child abuse or neglect to report.¹⁰³ In all states, the District of Columbia, and territories, any person is permitted to report. Voluntary reporters of abuse are also referred to as permissive reporters.¹⁰⁴

¹⁰⁰ In this document, “territories” refer to those U.S. territories that are permanently inhabited: American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

¹⁰¹ For state toll-free reporting numbers, see Child Welfare Information Gateway at www.childwelfare.gov/organizations/?CWIGFunctionsaction=rols:main.dspROL&rolType=custom&rs_id=5.

¹⁰² See Child Welfare Information Gateway (2014a) for a discussion of how states have or have not addressed the issue of clergy as mandated reporters and clergy-penitent privilege within their reporting laws. At the time of this document’s publishing, a little more than half the states and Guam include clergy as mandated reporters of child abuse and neglect.

¹⁰³ Child Welfare Information Gateway (2014b) details who is required to report in a specific state or territory. See www.childwelfare.gov/pubPDFs/manda.pdf for a compilation. Alternatively, search for a specific state or territory statute at www.childwelfare.gov/topics/systemwide/laws-policies/state/.

General Information on Child Abuse and Neglect Reporting Practices

- **Tribal communities:** Federal laws (Public Law 101-630, codified in 25 U.S.C. § 3203 and 18 U.S.C. § 1169, and Public Law 101-647, codified in 42 U.S.C. § 13031 and 18 U.S.C. § 2258) require certain professionals in the health care, mental health, education, child care, and law enforcement fields who work with children in Indian Country,¹⁰⁵ as well as on federal lands or in federally operated (or contracted) facilities, to report suspected child abuse and neglect. Some tribes, particularly those in Public Law 280 jurisdictions, may also be required to follow state reporting laws and procedures. Tribes, as sovereigns, may enact their own codes and laws that include reporting requirements for professionals who may come into contact with children. In addition, certain professionals may have licensing standards that require the reporting of suspected child abuse or neglect. All mandatory reporters in the case of child abuse and neglect that occurs in tribal communities should be directed to report to the appropriate local law enforcement agency or child protection services/social services within the time frame required by statute.¹⁰⁶
- **Military installations:** Military service installations' family advocacy programs receive reports of child abuse and neglect for families of service members assigned to that installation.¹⁰⁷ Certain Department of Defense personnel are considered mandatory reporters, including commanders and military police, military health care staff, child and youth staff, and school personnel. Family advocacy program reports are shared with military police and appropriate civilian agencies (reports can also be made directly to them).
- **Institutional settings** (such as college campuses or correctional facilities) may have internal child abuse and neglect reporting requirements.¹⁰⁸

Penalties for not reporting: Most jurisdictions impose criminal penalties on mandatory reporters who knowingly or willfully fail to make a report of, or prevent a subordinate from reporting, suspected child abuse or neglect.¹⁰⁹

Immunity from liability: Jurisdictions generally provide immunity from liability for persons who in good faith report suspected child abuse or neglect under reporting laws.¹¹⁰

When to report: The circumstances under which a mandatory reporter must make a report vary, depending on the jurisdiction or institutional setting. In many jurisdictions, a report is required when the reporter, in her/his official capacity, reasonably suspects that a child has been abused or neglected.

¹⁰⁴ Note that other laws may impact voluntary reporting (e.g., VAWA confidentiality provisions as explained later in this chapter).

¹⁰⁵ Indian Country refers to: (a) all land within the limits of any Indian reservation under U.S. jurisdiction, notwithstanding the issuance of any patent, and, including rights-of-way running through the reservation, (b) all dependent Indian communities within the borders of the U.S., whether within the original or subsequently acquired territory thereof, and whether within or without the limits of a state, and (c) all Indian allotments, the Indian titles to which have not been extinguished, including rights-of-way running through the same (18 U.S.C. § 1151) (Child Welfare Information Gateway, 2012b).

¹⁰⁶ For more information on reporting in tribal communities, see *Working with Children in Indian Country: Mandatory Reporting Obligations and Victims' Rights in Federal Court* (Hagen, 2013) at www.nationaldec.org/goopages/pages_downloadgallery/downloadget.php?filename=27649.pdf&orig_name=children_indian_country_-_lh_12182013.pdf and *Child Protection in Indian Country: A Handbook for Indian Health Service and Bureau of Indian Affairs* (Center on Child Abuse and Neglect, n.d.) at www.icctc.org/IHS-BIA%20CPT%20Handbook/CPT.htm. The Tribal Law and Policy Institute at www.tribal-institute.org/lists/child.htm also offers related resources.

¹⁰⁷ Military OneSource at www.militaryonesource.mil/health-and-wellness/family-violence?content_id=282305 offers reporting instructions and a link to installation-specific contact information for family advocacy programs.

¹⁰⁸ For example, PREA requires juvenile detention centers to have reporting systems for sexual abuse. Typically, facilities are mandated to report suspicions of sexual abuse, and work in conjunction with child protection services, law enforcement agencies, and other reporting authorities so that reports are directed to appropriate responders in the facility and the community.

¹⁰⁹ Child Welfare Information Gateway (2014c) details specific penalties in different states and territories. See www.childwelfare.gov/pubPDFs/report.pdf. See Hagen (2013) for related information for Indian Country.

¹¹⁰ Child Welfare Information Gateway (2012a) details laws related to immunity in different states and territories. See www.childwelfare.gov/pubPDFs/immunity.pdf. See Hagen (2013) for related information for Indian Country.

General Information on Child Abuse and Neglect Reporting Practices

Reporting procedures: Reporting procedures vary across jurisdictions and institutional settings regarding timing of an oral report, need for and timing of a written report, and information to provide the receiving agency. Often, the following information is sought: contact and identifying information for the child and the suspected perpetrator, including the nature of the relationship between child and perpetrator; the reporter's contact information;¹¹¹ and the reason for the concern.

Initial response to a mandatory report: Laws and/or policies in each jurisdiction and institutional setting should specify procedures for the initial response required by agencies receiving child abuse and neglect reports. If a child protective service agency in a jurisdiction receives a report, it generally has a process to screen the case to determine whether acts meet jurisdictional statutory definitions of child abuse or neglect. Child protective service agencies generally have the responsibility of responding to cases in which child abuse or neglect is caused by one or more persons who have caregiver responsibilities. They also usually have jurisdiction-specific procedures for cross-reporting cases to law enforcement agencies for potential criminal investigation. Investigations may be conducted by the child protective service agency, a law enforcement agency, or cooperatively by both agencies. Institutional settings may have specific initial response procedures.

Sharing report information: Most jurisdictions and institutional settings with child abuse reporting systems require some or all agencies that receive mandatory reports to share report information among entities conducting the investigation or assessing child protective needs.¹¹² Typically, child protective service agency reports are shared among social services agencies, law enforcement agencies, and prosecutors' offices. Child sexual abuse multidisciplinary response teams should ensure that mechanisms are in place to facilitate information sharing in individual cases among agencies in their jurisdiction involved in investigations. Agencies/facilities and teams should consider applicable privacy laws when creating information sharing policies. (See [A5b. Confidentiality and Release of Information](#))

Stress that a SUSPICION of child sexual abuse alone IS SUFFICIENT to trigger a mandatory report. Child abuse reporting systems function to ensure children's safety if any question exists that abuse or neglect has occurred.¹¹³ Suspicion of sexual abuse may be based on a disclosure by the child or another person, or observations of a pattern of indicators associated with sexual abuse.

It is not a mandatory reporter's role to verify that abuse has occurred. A mandatory reporter should not make any assumptions about legal charges or actions that may be taken in response to a report. Mandatory reporters must not fail to report because they believe that the victim or another responder or third party has already reported or will make a report (e.g., primary care providers may inaccurately think that if they refer the child to a pediatric examiner, they do not need to report themselves).

¹¹¹ Although some jurisdictions permit anonymous reporting, it is helpful if the agency receiving the report has reporter contact data in case additional information is needed. Child Welfare Information Gateway (2014b) details policies on inclusion of reporters' identity in different states and territories. See www.childwelfare.gov/topics/systemwide/laws-policies/statutes/manda/.

¹¹² Child Welfare Information Gateway (2013b) details information sharing policies in different states and territories. See www.childwelfare.gov/topics/systemwide/laws-policies/statutes/confide/.

¹¹³ In some jurisdiction, the duty to report is triggered no matter how long ago the abuse occurred. In other states, time limitations are placed on the reporting obligation. Sometimes, but not always, statutes make time limitations explicit. If a jurisdiction does not have clear language regarding such time limitations in its statutes, it can be useful to seek legal guidance to answer this question. (Gudeman and Monasterio (2014).)



If the child or contact children are in imminent danger of abuse, an immediate oral report to law enforcement and/or child protective service agencies is critical. In the oral report, reporters must clearly convey the urgency of the need for an immediate protective response.

Understand how mandatory reporting and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) confidentiality provisions interact. The HIPAA privacy rule and its implementing regulations (45 CFR Part 160 and Subparts A and E of Part 164), established national standards for the protection of certain individually identifiable health information created or held by health plans, certain health care providers, and health clearinghouses. Health care facilities and medical personnel involved in caring for prepubescent child sexual abuse victims should be instructed that (1) *mandated child abuse and neglect reporting laws fit under exceptions to HIPAA and require the release of information as allowable by applicable laws when reporting is triggered* (Gudeman & Monasterio, 2014); and 2) they may disclose only information that is necessary to satisfy a jurisdiction's mandatory reporting requirements.

Ensure that mandatory reporting procedures are consistent with the confidentiality provisions of the Violence Against Women Act (VAWA). This provision prevents VAWA grantees that provide victim services from releasing personally identifying information about a victim served without the victim's consent.¹¹⁴ However, it includes exceptions in situations where release is mandated by law, such as mandatory reporting of child abuse. In such cases, the grantee is required to notify the victim and take steps necessary to protect the privacy and safety of the persons affected by the release. VAWA grantees who are not mandated reporters under their jurisdictional laws may only report abuse with victim consent.¹¹⁵

Ensure that responders know their agency/facility procedures and jurisdictional requirements for making a mandatory report of child sexual abuse. An organization may have internal procedures related to reporting to comply with applicable reporting laws. In addition to jurisdictional requirements of individual responders, some entities may require their staff to share child abuse suspicions with a centralized administrator, who then makes mandated reports on behalf of the entity (Gudeman & Monasterio, 2014). In most jurisdictions, however, reporting to a superior in an organization does not negate the obligation of the person with first-hand knowledge to report. Also, *waiting for a centralized administrator to report is not appropriate when a child is in imminent danger*. Responding agencies should train their staff on how to report so they do not need to seek out a superior or wait for a centralized administrator in order to make a report (even if they are required to involve their superior/centralized administrator at some point in the process).

Ensure that communities and multidisciplinary response teams facilitate coordination of response to reports of child sexual abuse among child protective services, law enforcement agencies, and any other agency officially designated to receive or respond to

¹¹⁴ Note that medical forensic examinations are generally not considered victim services.

¹¹⁵ VAWA grantees who are not mandatory reporters who have questions about actions they can take in response to child sexual abuse disclosures are encouraged to seek appropriate legal counsel, as well as related training. For example, the Oregon Law Center offers a slide presentation at www.doj.state.or.us/victims/ppt/confidentiality.ppt on survivor confidentiality for non-profit service providers, which addresses this scenario, among other issues (Dority & Selig, 2013).

reports. Specifically they should: (1) Educate mandatory reporters to report to the appropriate entity, but also streamline the initial response to encourage and facilitate timely reporting. No matter which agency receives a report, it should be acted upon in an appropriate, prompt manner. (2) Educate reporters regarding what type of response to expect from child protective services, law enforcement agencies, or other receiving agency following a report of sexual abuse; how these agencies respond differently given case circumstances; and if, when, and how they coordinate their actions in a case. (3) Ensure that agencies receiving reports facilitate immediate coordinated interventions in situations when there is concern about a child's imminent safety. To this end, the method to report should not be via an answering machine—a live intake person is recommended. (4) Publicize among responders to child sexual abuse and other mandatory reporters in the community or institutional setting appropriate contact persons in the child protective service agency and law enforcement agencies in case of reporting questions or concerns.



Mandated reporters should explain reporting requirements to children and caregivers, in a way that is appropriate to the child's developmental level, as well as the linguistic capacity of the child and caregiver. In particular, health care providers can: (1) Describe their obligations as mandatory reporters. (2) Include children in the reporting process, to the extent appropriate, to help reduce the fear, anger, and/or perceived lack of control that can accompany mandated reporting.¹¹⁶ For example, talk with them about confidentiality rights and that sexual abuse requires a breach in that confidentiality (Gudeman & Monasterio, 2014). If children are developmentally able, provide the opportunity for them to report without a caregiver present. Be aware that if children or their caregivers indicate a report has already been made, the health care provider is still obligated to report her/his suspicions, according to jurisdiction and/or facility policy. (3) Talk to children and caregivers, separately if appropriate, to explain: the need to report; what was reported; and that the report will likely trigger an investigation by law enforcement and/or child protective service agencies. (4) Be open to discussing concerns that children and caregivers may have regarding the implications of reporting (WCSAP, 2015). For example, how might it affect peer or family relationships? Could the report and subsequent investigation reveal the client's sexual orientation or gender identity? Does reporting create a potential safety risk and is a safety plan needed? A victim advocate is a resource for children and caregivers for further discussion on this topic.

Note that an exception to sharing this information is if the caregiver is suspected of perpetrating the sexual abuse, is in collusion with the perpetrator, or is otherwise abusive to the child. Health care providers can discuss with law enforcement and/or child protective service agencies, and facility legal counsel, how to navigate such a situation.

Encourage multidisciplinary response teams, as well as individual agencies/facilities that respond to child sexual abuse, to develop policies, tools, resources, and training related to reporting. For example, they can (drawn in part from Gudeman & Monasterio, 2014):

- **Develop policies to clarify staff reporting roles.** Also, identify staff from local child protective services and law enforcement agencies who can be resources for advice on complex questions related to reporting.

¹¹⁶ Gudeman and Monasterio (2014) offer considerations for involving youth when abuse reporting is triggered. Although their work speaks to older children, some of the tips are applicable.

- **Train staff.** For example, educate them on what is/is not reportable, procedures and required time frames for reporting, how the jurisdiction or institutional setting responds to reports, communicating with children and caregivers on reporting requirements, trauma-informed reporting practices, and other related issues.
- **Create tools to facilitate the reporting process.** For example, standardized reporting forms can allow consistent information about suspected abuse to be provided to receiving agencies. Algorithms and checklists can help explain reporting obligations, in what situations a report is required, which agencies should receive the report and their subsequent roles, what information is released to which agencies, and coordination among agencies that will occur in response to the report. If the jurisdiction does not require a written report in addition to an oral report, reporting agencies may wish to develop a form to document oral for reference purposes. If there is a separate reporting mechanism within the facility, be sure to include that component of the reporting process in any tools or educational information given to staff. If feasible, obtain a signature of receipt of a report from the receiving agency. Also, consider creating an acknowledgement form for caregivers to sign and return to the reporting agency for its records (that a report was sent, not for consent to report as that is not necessary). Such tools should be created in consultation with an entity's legal counsel.
- **Regularly review (e.g., annually) policies and training requirements/programs and update accordingly.**

Identify, in advance, situations where reporting practices may be more complex than usual due to jurisdictional issues. The multidisciplinary response team can collaborate to determine how to approach complexities in reporting and clarify practices that will be employed. For example: if the child sexual abuse occurred in a tribal community where more than one jurisdiction may be involved; if the child is a dependent of an active duty soldier living on a military installation and the abuse occurred both on the installation and off; or if a child was sexually abused in both the United States and another country. Teams can explore different situations to determine who receives the report and how to forward it to the correct responders (local, state, tribal, federal, military, neighboring country, etc.).



Health care and emotional support must not be delayed due to responders' confusion about which jurisdiction receives the report or because the child enters the helping system in a jurisdiction that differs from where the abuse occurred (e.g., a child from Florida makes a disclosure to a health provider while visiting family in Puerto Rico). (See [B3. Entry into the Health Care System](#)) Community-based sexual assault victim advocacy programs typically can provide services no matter where the abuse occurred. Most also will coordinate with programs in other jurisdictions to address support needs of a child and/or family, to the extent allowed by confidentiality policies.

Consider what actions by the responding agencies/facilities and the multidisciplinary response team could increase reporting of child sexual abuse in the community. For example:

- Plan to survey the community to learn more about related reporting trends;
- Seek input from community members and professionals on ways to improve upon child sexual abuse identification and response efforts, to increase the positive impact of reporting for children and families, and to reduce negative consequences;
- Identify measures the community can employ to help children and families feel safer in seeking help—e.g., provide individualized safety planning assistance and information about interventions and services to address specific needs (see [B11. Discharge Planning and Follow-Up Care](#));
- Identify community outreach, education, and services that might be helpful to specific populations;
- Explore what the community can do to promote reporting by professionals, citizens, and families when they suspect child sexual abuse, including of nonverbal children and children with disabilities; and
- Address the prevention of child sexual abuse.



See www.Kidsta.org for more information on promoting reporting and related issues for specific populations.

A5b. Confidentiality and Release of Information

These recommendations are for communities, responding agencies/facilities, and individual responders regarding confidentiality in prepubescent child sexual abuse cases and release of medical forensic exam information for investigative purposes.

Ensure that jurisdictional and institutional policies, response team protocols, and medical forensic exam procedures address confidentiality in sexual abuse cases involving prepubescent children and release of exam information for investigative purposes (including written and photo-documentation). It is useful to have mechanisms to track information shared from the medical forensic examination in individual investigations. Information to track includes but is not limited to: mandatory reports, to whom case information has been released, and communication related to case investigation.

Ensure that responders' are adequately trained to have a clear understanding of relevant confidentiality issues in cases of sexual abuse of prepubescent children.

Key Points: Confidentiality and Information Sharing

- **Records required by child sexual abuse reporting laws should be maintained as confidential and released only as permitted by applicable laws and policies of the jurisdiction.**¹¹⁷ Many state, territorial, federal, and tribal statutes specify who may access the records and under what circumstances.¹¹⁸ Responders should be familiar with applicable laws and policies to provide accurate information to children and caregivers as appropriate.¹¹⁹ They should also understand applicable laws regarding disclosure of the reporter's identity.¹²⁰
- **Most jurisdictions require some or all agencies that receive mandatory reports to share report information among relevant agencies to appropriately respond to allegations**—typically, child protective service reports are shared among social services agencies, law enforcement agencies, and prosecutors' offices (Child Welfare Information Gateway, 2013a). Jurisdictional law may permit this data to be shared among members of the multidisciplinary team that responds to child abuse (see National District Attorneys Association, 2015).

¹¹⁷ Child protective services or social services agencies typically maintain records of child abuse and neglect reports to aid in the investigation, treatment, and prevention of child abuse and neglect. In many jurisdictions, these records and investigative results are maintained in databases referred to as central registries. The type of information contained in these registries and agency records varies, as does accessibility to the information. (See Child Welfare Information Gateway (2013b).)

¹¹⁸ See Child Welfare Information Gateway (2013b) at www.childwelfare.gov/topics/systemwide/laws-policies/statutes/confide/ for details about jurisdictional statutes. Persons entitled to access records typically include involved medical providers, medical examiners, child protective services, law enforcement personnel, attorneys involved in the case, and judges and other court personnel. Some jurisdictional statutes and policies allow access to some investigative records to the person who is the subject of a report, the victim, and the child's caregiver, sometimes only at the conclusion of an investigation. Additionally, some information may be disclosed to insurance companies and/or in court, should legal proceedings occur. Some information may be used for research purposes.

¹¹⁹ Note that all states and the District of Columbia allow minors who are age 12 years and above to consent to certain health care services. Some may also allow minors to seek or receive those services without their notifying parents/guardians. For examples, see Guttmacher Institute (2015). However, in most jurisdictions, prepubescent children do not have these rights. Health care providers should become familiar with the applicable laws of their jurisdiction.

¹²⁰ The identity of the reporter is specifically protected from disclosure to the alleged perpetrator in the majority of jurisdictions in the U.S. Release of the reporter's identity is allowed in some jurisdictions under specific circumstances or to specific departments or officials (e.g., when information is needed for conducting an investigation). In some jurisdictions, reporters can waive confidentiality (Child Welfare Information Gateway, 2014b).

Key Points: Confidentiality and Information Sharing

- As discussed in *A4a. Reporting*, the duty of health care providers to report suspected child abuse is an exception to HIPAA privacy requirements, as is ongoing communication on these cases with those involved in the investigation. ***In addition to the mandatory report, medical records in child sexual abuse cases are typically requested by investigating entities.*** Records from the medical forensic examination of prepubescent children—with the exception of photo-documentation—should be shared with investigative entities as per applicable laws and policies of the jurisdiction. (Photo-documentation can be released to investigative agencies with a subpoena and preferably with interpretive consultation with the examiner or an appropriate child sexual abuse specialist. (See [B6. Photo-Documentation](#)) Records from follow-up medical forensic care will also likely become part of the investigative record. Because HIPAA allows for the release of children’s medical records to those authorized to respond to mandatory reports of child abuse and neglect, parental/guardian signature for the release is not legally required. Health care providers can use an informed consent process to ensure that information is shared in an appropriate and ethical manner (See [B1. Consent for Care](#)) Keeping a HIPAA disclosure log is important to account for disclosures of protected health information.¹²¹ The facility also should request a receipt from investigative agencies acknowledging what records were received.¹²²
- All jurisdictions have confidentiality provisions to protect abuse and neglect records from public scrutiny (Child Welfare Information Gateway, 2013b). Additionally, many jurisdictions have laws imposing confidentiality restrictions on child abuse multidisciplinary response teams (see National District Attorneys Association, 2015). To that end, ***exam facilities, investigative agencies, and multidisciplinary response teams should have policies and written agreements in place that maintain records in a child sexual abuse case as confidential outside of those entities,*** to the extent allowable by law. These policies and agreements should not only apply to case records, but also to documentation from case reviews and case-related communication among responding entities involved in an investigation. For example, some child abuse multidisciplinary teams require members to sign a form agreeing to keep information discussed confidential at every team meeting. (See [A3. Coordinated Team Approach](#)) Agencies/facilities that hold records must also consider how to securely store paper and electronic files, photographic images, and other case documentation, and limit access to those records. (See [B4. Written Documentation](#) and [B6. Photo-Documentation](#))



Many jurisdictions have confidentiality and privilege laws covering relationships such as patient/medical provider, client/mental health practitioner, and victim/victim advocate. Be familiar with your jurisdictional confidentiality and privilege laws, as well as organizational policies. Also be aware the VAWA has a confidentiality provision protecting victims served by VAWA grantees and subgrantees: Recipients of VAWA funds cannot share victims’ personally identifying information unless a court order or statute mandates the release (e.g., child abuse reporting laws) or the victim signs an informed, time-limited, written release.

Instruct pediatric examiners and other health care providers on what to communicate to children and caregivers pertinent to confidentiality of the child’s medical record. Take into

¹²¹ This log is a facility risk management tool as investigative agencies are not bound by HIPAA. It is helpful to have a log if confronted about a protected report surfacing in public forums (e.g., the press), to show that the disclosure was legitimate when it left the facility. Confidentiality agreements among multidisciplinary team members can help avoid this problem.

¹²² Bullet drawn in part from New Hampshire Attorney General’s Task Force on Child Abuse and Neglect (2008). See the AAP Committee on Child Abuse and Neglect (2010) for further information on HIPAA’s impact on clinical practice if child abuse or neglect is suspected.

consideration children's development level as well as the linguistic capacity of children and caregivers.

- **Begin interactions with children by providing clear information on confidentiality**, explaining that confidentiality of health care services may be limited in cases involving child sexual abuse. Concepts related to confidentiality and child abuse reporting can be confusing. Addressing these issues at the start of a visit and using examples to explain concepts can help to build the rapport needed to provide good care.¹²³
- **Explain to children and caregivers that information gathered during the examination and follow-up medical forensic care will be included in the medical record and shared with investigative entities.** Discuss who else might legally have access to the information based on jurisdictional statutes and policies. Children and caregivers may wrongly assume that medical records from the examination are protected health information and may be unaware that privacy laws may be overridden in cases of prepubescent child sexual abuse. Also, inform children that their caregivers will likely have access to the record at the close of the investigation¹²⁴ (unless the caregivers perpetrated the abuse, are in collusion with the perpetrator, or are otherwise abusive to the child).
- **Note that, due to mandatory reporting laws, parent/guardian consent is not required to release information to investigative agencies or others who are allowed access by applicable laws and policies.** This is an exception to HIPAA. Release of records for an investigation of child sexual abuse should not be delayed for parental signatures.
- **If developmentally appropriate, explain to children that the accompanying caregiver will be notified that a report of sexual abuse has been or will be made.** (See [A5a. Reporting](#)) However, this notification should not occur if it is suspected that the caregiver perpetrated the abuse, is in collusion with the perpetrator, or is otherwise abusive to the child. Examiners can discuss with law enforcement and/or child protective service agencies, as well as their facility legal counsel, how to navigate such a situation.
- **Explain to caregivers that, although they have access to the child's medical information from the examination, results from the evidentiary material collected will not be immediately available to them.** Investigators can review with caregivers when this information will likely be available.



Take precaution to preserve confidentiality of victims' personally identifying information outside the multidisciplinary team. Breaches of confidentiality are of particular concern in small, close-knit or rural communities where word of a crime can travel quickly. Give children and caregivers as many options as possible to avoid conflicts of interest (e.g., allow them to work with a different investigator or be examined at another facility or by another examiner, if possible). It might be helpful for examiners and other responders to explain in advance to children and caregivers that, to protect their privacy, providers will not acknowledge in public that they know or have seen the child as a patient.

¹²³ See Gudeman and Monasterio (2014).

¹²⁴ It may be useful for examiners to help children determine how to tell their caregivers about information that will be in the medical record (e.g., activities that the children think may get them in trouble or that will cause them embarrassment), as the caregivers likely will learn this information eventually via access to the investigative report.

Clarify questions about confidentiality of victim advocates. One way to protect a child's confidentiality during the exam process is to limit individuals present with the child during the history taking and the examination. However, as discussed in this protocol, children and caregivers can benefit from the presence of victim advocates during the exam process. Victim advocates, if available in a community, can offer a range of supportive services, including crisis intervention, advocacy, and referral to other resources.

HIPAA permits hospitals and other health care providers to alert an advocacy organization of the presence of a child victim of sexual abuse and caregiver at the health care facility, without giving any identifying information about the child or caregiver. Once the advocate is present at the facility, if the child and/or caregiver is informed in advance and agrees, then HIPAA permits facility staff to introduce the advocate to the child and/or caregiver. The advocate can then share information pertinent to her/his involvement during the examination and seek permission to provide services.¹²⁵

Note that the mandatory reporting obligations of community-based victim advocates vary by jurisdiction.¹²⁶ In some jurisdictions, community-based advocates are mandated reporters of child abuse. In others, they are not, and VAWA's confidentiality provisions may limit their ability to make a report without the victim's consent. For child victims, their families, and other responders to fully understand the level of confidentiality that advocates may offer, it is important to determine whether a jurisdiction's law requires advocates to report child sexual abuse.

All multidisciplinary response team members should understand the benefits of advocate involvement on the response team—mainly, to ensure ongoing support for the child and family members and promote a collective team response that is child-focused, victim-centered, and trauma-informed. At the same time, they should be aware of and respect the scope and limitations of advocacy program information sharing policies.



A free flow of case information among responders involved in the investigation is crucial to ensure that protective and investigative decisions are based on all relevant facts. However, the victim advocate's role on a multidisciplinary response team is not an investigative one. Instead, the focus of the advocate is to support the wellbeing of children and family members during and beyond the investigation.

¹²⁵ For information on the ability of a health care provider to communicate with persons identified by an individual involved in another individual's care, see www.hhs.gov/hipaa/for-professionals/covered-entities/index.html (U.S. Department of Health and Human Services, n.d.). For general information about the HIPAA privacy rule, see www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html (U.S. Department of Health and Human Services, 2003). While advocates are usually on-call and must travel to the facility, it is common practice in many jurisdictions to inform victims and their families that a victim advocate is available at the facility to offer services, rather than asking if they would like an advocate to be called in. Victims and family members may feel they are inconveniencing advocates who must come to the facility just for them. Note, however, that some advocacy programs may choose not to operate in this manner for a variety of reasons (e.g., due to limited staffing capacity or significant advocate travel time to an exam facility).

¹²⁶ Contact the state, territorial, and/or tribal sexual assault coalition with questions about jurisdictional requirements. Coalitions and local community-based sexual assault programs are encouraged to provide clear guidance for advocates on reporting requirements and confidentiality policies in cases of child sexual abuse (e.g., see WSCAP, 2015b).

A5c. Evidentiary Kits and Forms

These recommendations are for jurisdictions and entities involved in creating or customizing evidentiary kits and forms for sexual abuse medical forensic examinations of prepubescent children.

Use kits that meet or exceed minimum guidelines for contents. Many jurisdictions have developed kits for collection of forensic evidence from victims of sexual violence or purchase premade kits through commercial vendors. Kits may vary in type of samples collected, collection techniques, materials used for collection, terms used to describe categories of forensic evidence, and criteria for use. Despite variations, however, it is critical that every kit meets or exceeds the following minimum guidelines for contents.

Minimum Guidelines for Kit Contents

- **Kit container:** This container typically has a label with blanks for identifying information and documenting the chain of custody. Most items gathered during forensic evidence collection are placed in the container, after being dried, packaged, labeled, and sealed according to jurisdictional policy. Bags/containers are usually provided for more bulky items that will not fit into the container (e.g., clothing, bedding, or diapers). Some jurisdictions provide large paper bags to hold the container and additional evidence bags.
- **Instruction sheet or checklist** that guides examiners in: determining if the case meets criteria for kit use, documenting the examination, collecting forensic samples, and maintaining the chain of custody of forensic evidence. Instructions may also include tips for preparing and providing support for the child and caregiver prior to the examination, and ensuring no emotional harm to the child in the course of the examination.
- **Forms**, including: consent for the examination, medical history, exam documentation, and anatomically neutral body maps.¹²⁷ Forms included should be designed to facilitate optimal forensic evidence collection, documentation, analysis, and examiner testimony.
- **Materials for collecting and preserving the following forensic samples**, according to jurisdictional policy:¹²⁸
 - Clothing worn at the time of the abuse or immediately after, underwear/diapers, and foreign material dislodged from these items
 - Foreign materials on the child (e.g., blood, dried secretions, fibers, loose hairs, vegetation, soil/debris, fingernail scrapings and/or cuttings, matted hair cuttings, and material dislodged from the mouth)
 - Oral swabs
 - Genital swabs
 - Vaginal or penile swabs
 - Anal/perianal swabs
 - Additional body swabs¹²⁹
 - Buccal swab for DNA analysis and comparison (alternatively, saliva sample or known blood)

See [B8. Evidence Collection](#) for more detail on how kit contents are used during the examination.

¹²⁷ Other forms may be used by the jurisdiction or the exam facility (e.g., additional consent and discharge forms).

¹²⁸ Some samples that historically have been collected are no longer recommended in many jurisdictions, unless the forensic history and physical exam indicate otherwise (e.g., collection of a saliva sample for “secretor status”).

¹²⁹ Material may be present on additional body surfaces from contact with blood or body fluids. Swabs available as a standard in each kit vary by jurisdiction.

Ensure availability of materials, instructions, and forms for collecting toxicology samples. These items are typically separate from the jurisdictional forensic evidence collection kit. Investigative agencies should identify labs that have the capacity to analyze toxicology samples. Ensure that examiners¹³⁰ have the appropriate materials, instructions, and forms from those labs or those that meet lab specifications. (See [B9. Sexual Abuse Facilitated by Alcohol and Drugs](#))

A single forensic evidence collection kit is sufficient for adult and children victims, provided it accommodates aspects specific to both populations. *Although not required, a separate pediatric kit is strongly encouraged* as oftentimes the health community may not otherwise see the urgency and necessity of engaging properly trained pediatric examiners and using medical forensic care tailored to the needs of children who may have been sexually abused.

To accommodate cases involving prepubescent children, a kit should include instructions and forms for forensic evidence collection and documentation that are specific to these victims,¹³¹ and differentiate between procedures in acute versus nonacute examinations. In particular, while forensic specimens may or may not be collected during an examination of a prepubescent child, depending in part on whether the examination is acute or nonacute, documentation from the medical history and exam findings can be invaluable to an investigation and should always be completed.

Crime lab personnel who analyze forensic evidence kits should be instructed to not consider a kit invalid if certain forensic evidence was not collected. Due to the nature and circumstance of a sexual victimization, the examiner may modify or omit certain forensic samples. If a jurisdiction employs different documentation forms for the nonacute examination, documentation should not be considered invalid if acute exam forms are mistakenly used. Examiners should be encouraged to establish and maintain working relationships with crime lab personnel serving their jurisdictions to ensure that forensic specimen collection for the kit comports with how the crime lab currently tests forensic evidence and respond to any questions.

The jurisdiction should work with the multidisciplinary response team to standardize the jurisdictional evidentiary kit and documentation forms for prepubescent child sexual abuse cases. A designated entity, whether the team or a specific agency or agencies, should be responsible for oversight of the standardization process, as well as kit and form development and distribution.¹³² It is important to:

¹³⁰ First responders such as law enforcement officers, child protective service workers, and emergency medical service providers also need materials, instructions, and forms, as well as training, to collect urine from children in a suspected alcohol- or drug-facilitated case, if a child cannot wait until arrival at the health care facility to provide a sample.

¹³¹ For example, Tanner stage documentation, physical exam drawings consistent with prepubescent children, anogenital exam and knee-chest position drawings specific to prepubescent children, and forms and crime lab information specific to/for prepubescent patients.

¹³² It is important to consider costs to the state, territory, tribe, federal agencies, and local community, and the ability of the community to cover costs. In some states, one state agency (e.g., the crime lab) assumes the costs. In others, the costs are passed on to local criminal justice agencies.

- Ensure that exam facilities in the community are sufficiently supplied with kits and forms;
- If the nonacute exam documentation forms are the same as those used in the forensic evidence collection kit, ensure they are available separately from the kit so that examiners need not open a kit to access these forms;
- If different documentation forms are used for acute examinations versus nonacute examinations, ensure that all examiners understand the purpose of and have access to both forms;
- Make all exam documentation forms accessible electronically and formatted to be filled out electronically or downloaded to type in or write on by hand;
- Ensure that relevant entities (e.g., crime labs, toxicology labs, children’s protective service agencies, law enforcement agencies, exam facilities, children’s advocacy centers, and prosecutors’ offices) and professional organizations receive ongoing and updated training regarding changes in technology, scientific advances, and cutting-edge practice related to collecting forensic evidence from prepubescent children;
- Review/evaluate the kit and forms periodically (e.g., every 2 to 3 years), revising as needed for efficiency, current best practice, and usefulness; and
- Establish mechanisms to ensure that unused kits and forms at exam facilities are kept up-to-date and do not include expired materials.



See www.Kidsta.org for sample forms and kit components and other related resources. For those interested in developing kits designed specifically for the pediatric population, staff at Kidsta.org can share examples of such kits as well as offer consultation on related issues.

A5d. Timing of Evidence Collection

These recommendations are for justice system agencies to maximize forensic evidence collection. See below for general considerations. However, it is important to follow jurisdictional policy

Promptly collect forensic samples as the likelihood of obtaining viable specimens decreases over time.

- Forensic evidence can be lost from the child’s body and clothing through numerous mechanisms (e.g., degradation of seminal fluid components can occur in body orifices, semen can drain from the vagina or wash from the mouth, sperm can lose motility, bodily fluids can wash away, and dried secretions and foreign materials can fall from the body and clothing) (California Office of Emergency Services, 2001).
- Limit loss of forensic evidence on the child’s body or clothing prior to the medical forensic examination without compromising the child’s comfort. For example, if a suspicion exists that alcohol or drugs contributed to the abuse and the child needs to urinate before arrival at the exam facility, instruct first responders to collect a urine sample. If a child is thirsty, the initial health care provider may be able to obtain oral swabs before other evidence is collected so that the child may obtain a drink.

Collect forensic samples within the prescribed jurisdictional time frame (which should be a *minimum window* of 72 hours since the sexual abuse). **In addition, case circumstances and future research may indicate a need for an acute examination and forensic sample collection beyond that time frame.** (See [B3. Entry into the Health Care System](#))

- Indications for the collection of forensic samples should be considered on a case-by-case basis (e.g., unwashed clothing that the child wore during the abuse can be collected beyond 72 hours).
- Collection of internal vaginal and cervical swabs is not indicated for prepubescent children. Forensic samples are obtained from the external genitalia surfaces only, unless a medical necessity exists to use anesthesia.
- Keep up-to-date on the latest research and technological advances in DNA detection and analysis that may suggest changes in when to collect forensic samples from prepubescent children and best methods for analyzing evidence.¹³³ Involve pediatric examiners and crime lab personnel in determining how any new information results in changes in practice.

Timely medical care and treatment for all victims of child sexual abuse is critical, whether or not forensic samples are collected. Health care providers to whom the child initially presents should determine the urgency of medical forensic care needed and

¹³³ Adams et al. (2015) recommended forensic sample collection for sexual contact that may have resulted in the exchange of biologic material within 24 hours in prepubescent children (Christian, 2011). However, some children may benefit from forensic evidence collection beyond 24 hours (Christian, 2011), especially in jurisdictions where DNA amplification is performed as part of crime lab analysis (Girardet et al., 2011). Because of this potential widened window of availability of forensic samples, many jurisdictions and clinical guidelines extend the time to 72 hours post abuse for prepubescent child acute examination.

if forensic samples might be available, based on jurisdictional policy. Law enforcement and child protective service representatives should defer to health care providers to determine the medical forensic care needed and the availability of samples. Health care providers should consult with pediatric examiners on individual cases as needed. (See [B3. *Entry into the Health Care System*](#))

- The need for emergent treatment of injuries always supersedes forensic evidence collection.
- Despite whether forensic evidence on the child's body or clothing is potentially available, the child should be examined, a medical history taken, related treatment provided, and exam findings documented. Information helpful to the investigation may be obtained from the history, exam findings, and the child's medical record.
- A child should never be forced to undergo the medical forensic examination and/or have forensic evidence collected. (See [B1. *Consent for Care*](#))

A5e. Evidence Integrity

These recommendations are for examiners and law enforcement agencies regarding forensic evidence integrity.

Maintaining the integrity of forensic evidence during the exam process increases the likelihood that the evidence collected will be admissible if the case proceeds to trial. Pediatric examiners must handle forensic specimens properly from collection until turning them over to law enforcement. Transfer procedures are needed by law enforcement to ensure maximum preservation of forensic evidence collected until its analysis.¹³⁴

For Pediatric Examiners

Follow jurisdictional policies for drying, packaging, labeling, sealing, and storing forensic specimens, as well as maintaining the chain of custody of forensic evidence until released to the appropriate law enforcement agency. Contact law enforcement, prosecution, and/or the crime lab with any questions. Proper management of forensic evidence is critical to avoid loss or alteration of evidence and to potentiate its admissibility during a trial. See section [B8. Evidence Collection](#) for more information on specific steps in collecting evidence.

| General Considerations for Forensic Evidence Integrity | |
|--|---|
| Action | Rationale/Details |
| Dry forensic specimens unless otherwise indicated | <ul style="list-style-type: none"> Follow proper drying procedures for different types of specimens—proper drying and packaging prevents growth of mold and bacteria that can destroy forensic samples. Air-dry wet forensic evidence at room temperature in a clean environment and manner that prevents contamination. Note that the ever-increasing sensitivity of DNA analysis creates a greater chance that accidental contamination and dilution by foreign DNA may be detected. A swab dryer or other drying device may be used to facilitate drying. |
| Package forensic specimens appropriately | <ul style="list-style-type: none"> Follow proper packaging procedures for different types of specimens. After drying specimens, package each different type in paper envelopes. Package dry clothing evidence individually in paper bags. Follow proper procedures for packaging specimens that cannot be dried thoroughly at the exam facility (e.g., wet clothing, diapers, and condoms) to prevent leakage and contamination of other evidence. Wet evidence may be placed in plastic bags then dried later by the crime lab or designated storage facility and repackaged. Follow proper procedures for packaging liquid evidence (e.g., urine and drawn blood samples). |

¹³⁴ See the Technical Working Group on Biological Evidence Preservation (2013) at www.nist.gov/forensics/upload/NIST-IR-7928.pdf for a resource on biological evidence storage, tracking, preservation, and disposition, including recommendations and a glossary of related terms. See the National Institute of Standards and Technology at www.nist.gov/oles/ for additional resources.

General Considerations for Forensic Evidence Integrity

| Action | Rationale/Details |
|---|---|
| Label forensic specimens accurately | <ul style="list-style-type: none"> • Discuss in advance with the crime lab the most accurate methods for labeling various types of forensic specimens collected for crime lab analysis. • Label all specimens clearly, including name and date of birth of the child, the source of the specimen, date and time of collection, and examiner’s name or initials (plus any additional requirements, such as case number). • Write on the specimen label any variations or modifications in the collection. • Note any wet/moist items and whether they need to be air-dried. Communicate, upon release, the presence of any wet/moist specimen to law enforcement officials. |
| Establish and document the security and chain of custody of forensic specimens throughout the exam process | <ul style="list-style-type: none"> • Seal specimen packages to prevent tampering. However, do not lick envelopes. • Document the examiner’s signature, date, and time across the seal. • For forensic evidence to withstand judicial scrutiny, the chain of custody must be documented from the time the specimens are collected to their release to the investigating agency. • Limit the number of people who handle any forensic evidence. • Develop procedures to trigger law enforcement pick-up of forensic evidence. • Know the appropriate law enforcement entity to contact for pick-up. • Document the identity, date, and time of the law enforcement representative picking up the forensic evidence. |
| Store forensic specimens at the exam facility until released to law enforcement personnel | <ul style="list-style-type: none"> • Develop procedures to securely store forensic specimens in a locked location at the exam facility until released to law enforcement personnel. Jurisdictions may have policies on the length of time that forensic evidence kits may be stored at the exam facility and the time frame in which law enforcement must pick up the kit from the exam facility. • In addition to storing dry specimens, exam facilities should have secure, limited access refrigeration for storage of wet items and liquid samples, preferably in a locked refrigerator.¹³⁵ Some wet and liquid samples can also be frozen; however, blood cannot due to the risk of the glass tubes breaking. If a locked refrigerator is not immediately available, samples can be kept at room temperature for no longer than 24 hours. If blood is needed for other than medical or toxicological reasons, dried blood samples on blood collection cards are encouraged (and do not require refrigerated storage). |

Follow jurisdictional policy for completing written documentation to be included in the evidentiary kit. In acute cases, jurisdictional exam report forms should be completed (noting reasons if one or more sections are incomplete), labeled, and included in the sealed kit. Note that the child’s medical record, including exam photo-documentation, should not be included in the kit. In nonacute examinations, there is no evidence collection kit. However, there may be jurisdictional nonacute exam report forms—if so, complete and provide to the proper agency/agencies according to jurisdictional policies. Otherwise, medical forensic examination documentation should be maintained, secured, and released per facility policy. (See [B4. Written Documentation](#) and [B6. Photo-Documentation](#))

¹³⁵ The Technical Working Group on Biological Evidence Preservation (2013) indicated that refrigeration of dried biological samples is generally unnecessary. See page 18 for a short-term storage conditions matrix.



Policies are also needed for the collection, packaging, labeling, sealing, refrigerated storage, and handling of toxicological samples that have potential evidentiary value, as well as specimen transfer to the testing site. If needed in a case, these specimens are typically sent to private toxicology labs for analysis, rather than included in the jurisdictional evidentiary kit. Investigative agencies should ensure that pediatric examiners are instructed on designated toxicology labs and their specifications for specimen management. (See [B9. Sexual Abuse Facilitated by Alcohol and Drugs](#))

For Law Enforcement Agencies

Be familiar with procedures in prepubescent child sexual abuse cases related to transfer of forensic evidence from medical forensic exam facilities to a jurisdictional crime lab or designated law enforcement evidence storage. A few general considerations are offered below. However, follow jurisdictional policies.

General Forensic Evidence Transfer Considerations for Law Enforcement

Make sure **transfer policies** (from exam facilities to the crime lab and evidence storage) maximize preservation of forensic specimens and maintain the chain of custody

- Only a law enforcement official/duly authorized agent should transfer forensic evidence from the exam facility to the crime lab or other designated law enforcement storage site. Communicate with pediatric examiners and exam facilities regarding procedures to trigger a transfer. Note that, in some jurisdictions, the kit is mailed. In such instances, established procedures must be in place and followed to maximize preservation and maintain the chain of custody of forensic evidence.
- Avoid the potential degradation of forensic specimens by minimizing the transit time between the collection of forensic evidence and the storage of kits—this practice is particularly important with kits containing liquid and other wet specimens.¹³⁶
- The law enforcement official picking up the forensic evidence should be familiar with what items may be in the kit, confirm whether any evidence is wet or needs to be refrigerated, and ensure that the kit is properly sealed and marked.
- When forensic evidence is transported to the crime lab or other designated storage site, the law enforcement official should inform receiving personnel of any relevant information (e.g., the kit contains wet evidence that needs to be refrigerated).
- Jurisdictional procedures for transfer of forensic evidence must be in place, followed, and account for any challenges faced by law enforcement agencies in prompt pick-up of kits from the exam site, in storing evidence, or in otherwise maintaining forensic evidence integrity.



Exam facilities that perform examinations of U.S. military dependents or children from tribal communities should have MOUs with all relevant jurisdictional investigative agencies and crime labs. The goal is to ensure ready access to appropriate evidentiary kits and the transfer of forensic evidence to the appropriate crime lab or law enforcement storage facility.

¹³⁶ Note that some jurisdictions mandate a time frame for law enforcement to pick up forensic evidence.

A5f. Payment Issues

These recommendations are for communities regarding covering the costs associated with the sexual abuse medical forensic examination of prepubescent children.

Jurisdictions should explore all viable sources of funding for sexual abuse medical forensic examinations for prepubescent children. The goal is that children and their families are not charged for forensic evidence collection and have reliable sources of financial aid for related medical expenses AND that examiners and exam facilities are adequately reimbursed for their services in each case.¹³⁷



Although VAWA requires states to provide forensic medical examinations to adult and adolescent victims of sexual assault free of charge (for forensic costs), this provision does not extend to medical forensic care for children under age 11. Some states voluntarily extend their state laws to include pediatric examinations. Still, even in those states, some costs (e.g., STD testing and treatment) may not be covered.

Payment issues specific to children's families:

- **Children's families should not incur expenses related to forensic evidence collection**, even if exam facilities bill them for these costs. However, it is best practice for the payment to be handled without the families receiving bills. If families do receive such bills, they should be advised where to forward the bills (e.g., to a specified investigative agency or back to the health care facility) and how the bill will be handled so that they are not held responsible for payment. Prompt systemic assessment and improvement should also take place, to ensure that such mistakes do not continue to occur.
- **Children's families need to be advised of their responsibility for related exam expenses.** Jurisdictions vary in what they cover as part of the medical forensic examination (e.g., most do not cover costs of treatment for injuries). If children's health insurance is used to cover these costs, caregivers should understand their financial responsibility if insurance only partially covers the expense.
- **When children's families are billed by health care facilities, procedures should be in place to protect the family's privacy in the billing process.** Personnel in facility billing departments should be educated regarding appropriate billing practices and codes in these cases, as determined by facility policy.¹³⁸ They should be instructed not to bill children's families for costs that should be covered by the jurisdiction. A mechanism should be established for responders in conjunction with billing department personnel to assess whether a child's health insurance should be billed in the case that the suspect perpetrator is the insured party. The child may face safety risks if the suspected perpetrator receives an explanation of benefits from her/his insurance company indicating that exam services were provided to the child.

¹³⁷ Some examples of challenges: a jurisdiction where the law enforcement agency is responsible for reimbursement, may choose not to authorize an examination due to lack of understanding of its value outside the possibility of forensic sample collection, especially in nonacute cases, lack of understanding of the need for an exam, or budgetary constraints.

¹³⁸ For example, the code for the presenting issue is sexual abuse, not a medical or mental health disorder of the child.

- **Children’s families need to be advised of the availability and eligibility criteria of financial assistance programs that help with exam expenses**, such as state crime victim compensation programs. Families need to know if the crime victim compensation program covers both acute and nonacute examination costs for prepubescent children who are suspected of being sexually abused. Victim advocates typically can assist children’s caregivers in applying for compensation.¹³⁹

Payment practices related to exam reimbursement to pediatric examiners and exam facilities are complex and vary between jurisdictions. Unfortunately, with no one prescribed designated method of payment, many exam facilities piece together funding to provide pediatric exams. Jurisdictions need effective payment structures to ensure these examinations are available to all children who require them, free of all charges. Some issues to consider:

- **Reimbursement practices for pediatric examiners conducting examinations and medical facilities where examinations are conducted should be equitable in all jurisdictions.** Payment structures should take into consideration that pediatric examinations may differ from adult and adolescent examinations. In particular, since delayed reports are typical in child sexual abuse cases, there is forensic value to a nonacute examination. Eligibility for reimbursement in delayed reporting cases should be extended to retain exam findings and provide essential care to a child. Also, because, in some communities, specialty care programs conduct these examinations, an initial assessment to determine urgency of care may be performed at one facility that may precede the medical forensic care provided at another facility. In this case, both medical facilities should be reimbursed by the jurisdictions for services rendered, rather than just one or splitting reimbursement between the two. Funding sources should fairly reimburse examiners and exam facilities for their costs.
- **At a minimum, the following costs of a sexual abuse medical forensic examination should be included as reimbursable by jurisdictions to examiners and exam facilities:** the examination and forensic evidence collection, STD testing and treatment related to sexual abuse (including HIV testing and post-exposure prophylaxis), and related follow-up testing and medical examinations. There should be no circumstances in which the children’s families are billed because jurisdictions did not appropriately reimburse the facility or examiner.
- **Jurisdictions should provide reimbursement for examinations performed at medically-based locations**, including hospitals AND other facilities, such as children’s advocacy centers, health clinics, and other locations that offer medical services. The key is to have a trained pediatric examiner conduct the examination.
- **Jurisdictions should authorize payment for the examination to the examiner and exam facility, based on clinical judgment that medical forensic care is needed, with payment linked to reporting of child sexual abuse by the provider.** As mentioned earlier, health care providers, rather than investigating agencies, should determine the need for medical forensic care. Payment should not

¹³⁹ See www.ovc.gov/publications/factsheets/companassist/welcome.html for information on state crime victims compensation programs (OVC, 2004).

depend on the submission of a complete forensic evidence collection kit. In some prepubescent child cases, certain procedures are not applicable. In nonacute cases, only documentation forms may be completed.

- ***In the case of sexual abuse in tribal communities, a multijurisdictional effort may be necessary to collectively determine payment issues*** so that children's families are not billed for forensic costs and options exist for financial aid to help cover the cost of the examination.



See www.Kidsta.org for more information on resources to help children's families cover their examination expenses, and for reimbursement issues for pediatric examiners and exam facilities.

B. Exam Process

Overview

Section B focuses on the various components of the sexual abuse medical forensic exam process for prepubescent children. The chapters are:

- B1. Consent for care**
- B2. Initial response**
- B3. Entry into the health care system**
- B4. Written documentation**
- B5. Medical history**
- B6. Photo-documentation**
- B7. Examination**
- B8. Evidence collection**
- B9. Sexual abuse facilitated by alcohol and drugs**
- B10. STD evaluation and care**
- B11. Discharge planning and follow-up care**

B1. Consent for Care

These recommendations are for health care providers.

Be aware of which health care procedures require consent during the exam process.

Consent sought by health care providers related to the examination generally should cover the following, as applicable/indicated in a specific case:

- Initial health care assessment (see [B3. Entry into the Health Care System](#));
- The medical forensic examination;
- Testing and treatment (e.g., STDs, including HIV, and toxicology);
- Forensic sample collection;
- Photo-documentation of the exam findings; and
- Permission to contact the child and caregiver for medical follow-up purposes.

Identify who needs to provide consent for care for prepubescent children.¹⁴⁰

Prepubescent children are generally below the age to consent to their own care in a jurisdiction.¹⁴¹ Thus, health care providers need to identify the person(s) responsible for providing permission for the child's care (e.g., the parent/guardian). They also need to know the mechanisms in place at their facility to obtain consent for care if abuse or neglect of the child by the parent/guardian is suspected or if a parent/guardian refuses to consent or is absent. (In such instances, child protective services and/or law enforcement should be consulted immediately, as a court order may be needed to take the child into protective custody. Pediatric examiners are encouraged to discuss this potential situation in advance with law enforcement and/or child protective service agency representatives and facility legal counsel to determine specific procedures to follow) Be aware that consent may be withdrawn at any time during the exam process, even if consent forms have been signed.¹⁴²

In addition to seeking consent, seek prepubescent children's assent for care throughout the exam process. (See General Consent/Assent Guidelines below) Assent is the expressed willingness of an individual to participate in an activity. ***Assent should be sought from children who are by jurisdictional definition too young to grant informed consent for care, but old enough and/or developmentally able to understand and agree to participate in that care*** (IRC, 2012). Note that assent has particular relevance with sexually abused children—when their wishes are respected in health care, it can help return control that was taken away from them when they were abused or perhaps give them control for the first time (adapted from Day & Pierce-Weeks, 2013; WHO, 2003).

¹⁴⁰ This and the next paragraph were drawn primarily from Day and Pierce-Weeks (2013).

¹⁴¹ Most jurisdictions allow minors who are age 12 years and above some consent rights related to access to health care services and confidentiality of care (for examples, see Guttmacher Institute (2015)). However, in most jurisdictions, prepubescent children do not have consent rights. Health care providers should be familiar with the applicable laws of their jurisdiction.

¹⁴² Note that, as discussed in [A5a. Reporting](#) and [A5b. Confidentiality and Release of Information](#), consent is not necessary to mandatorily report suspected prepubescent child sexual abuse (a HIPAA exception), release the medical forensic report or the child's medical record to investigative agencies, or share information among investigative agencies or the multidisciplinary response team, if permitted by jurisdictional law.

Make sure that consent and assent are informed. To obtain permission to proceed with an exam procedure, health care providers should explain its full nature to the child and parent/guardian (e.g., what it entails, the rationale, possible side effects, and the potential impact of declining). Inform them that the examination is much like an annual well-check examination recommended for children (and IS NOT an invasive procedure with a speculum as a caregiver might expect). They should be informed that information and forensic evidence obtained during the examination will be released to investigative agencies. They should also be told whether others can access this information, as prescribed by jurisdictional policies (e.g., data, minus patient identity, may be collected for health or forensic purposes by qualified persons with a valid educational or scientific interest for demographic and/or epidemiologic studies). Children and parents/guardians should be told their options and encouraged to ask questions about the process, and to apprise health care providers if they wish to decline a particular exam procedure. Providers should refrain from judgment or coercive practices in seeking consent; it is contrary to ethical and professional practices to influence their decisions.

| <i>General Consent/Assent Guidelines</i> ¹⁴³ | | | | |
|---|---|--------------------------------|--|------------------------------|
| Child's Age | Child <i>(consider her/his development level and linguistic capacity and preferences when planning if/how to seek assent)</i> | Child's Parent/Guardian | If No Parent/Guardian or Parent/Guardian Is Not Acting in Child's Best Interest | Means |
| 0-5 | Generally <u>not</u> capable of informed assent <i>(but consider each child's developmental capacity)</i> | Informed consent | Follow jurisdictional/facility policies for seeking consent in these instances | Written consent |
| 6-11 | Generally capable of informed assent <i>(but consider each child's developmental capacity)</i> | Informed consent | Follow jurisdictional/facility policies for seeking consent in these instances | Oral assent, written consent |



In the case where the child and/or parent/guardian declines a component of the examination, the health care providers should assess if anything can be done to make the procedure acceptable. For example, if the child initially declines photo-documentation, the health care provider might ask if it would be acceptable to take certain photographs, but not others (anogenital images may be the specific problem and the child and parent/guardian may agree to other images being photographed). Ensuring a child-focused, victim-centered, and trauma-informed approach from the start can heighten children's comfort and trust in health care providers, which might increase their willingness to participate in the process. (See [A1. Principles of Care](#) and [A2. Adapting Care for Each Child](#))

Follow facility and jurisdictional policies related to obtaining verbal and written consent. In addition to verbally providing information and seeking assent and consent from children and parents/guardians, written consent from a parent/guardian of the child is necessary to carry out specific exam procedures (unless the child has been placed in protective custody). Health care providers should know facility and jurisdictional policies for

¹⁴³ The chart was adapted from IRC (2012).

when written consent is necessary and the methods to obtain it. Ensure all signatures and dates needed are obtained on written consent forms. Providers also need to be aware of verbal and nonverbal cues from children and guardians and adjust methods of seeking assent and consent to meet their needs. ([See A2. Adapting Care for Each Child](#)) The consent process may be enhanced if health care providers are instructed on logistically how to seek verbal consent and assent in these cases, in a way that is consistent across cases, to help facilitate the exam process. Consent and assent should be documented in the medical record, as well as the reasons for declining consent and assent.¹⁴⁴ ([See B4. Written Documentation](#))



Checklists, forms, patient brochures, and videos about the exam process can help facilitate obtaining consent and assent. Written health care consent forms developed for the purpose of the examination should be reviewed and approved by facility administration and the legal department. Documentation on consent becomes part of the child's medical record. Standardized consent forms are typically included in the jurisdictional forensic evidence collection kit, which may or may not cover all aspects of care.

Tailor the process of seeking assent and consent so it is developmentally appropriate for the child, and linguistically appropriate for children and parents/guardians. ([See A2. Adapting Care for Each Child](#)) Information provided should be complete, clear, and concise, and accommodate the family's communication skill level/modality and language. Note that some children and parents/guardians may require the use of language interpreters for verbal consent and sight translation of written documents and forms into other languages.¹⁴⁵ Children and parents/guardians with cognitive disabilities may also require accommodations to proceed with this process.

Seeking assent often requires considerable time and patience on the part of examiners. For example, it may take considerable effort to help children become comfortable enough to express themselves and feel safe to proceed with a particular procedure. Victim advocates may be useful in providing children and caregivers with support. A hospital-based child life specialist or social worker, where available, may also assist in describing needed medical procedures to the children and caregivers.

Do not proceed with an examination without the assent/cooperation of the child, even if the child's parent/guardian gives consent (with exceptions in instances of serious medical injury, pain, or trauma to be evaluated/treated). For example, do not restrain or otherwise force children to comply with any part of the examination, including sedation against their will.¹⁴⁶ If a child is not tolerating the examination, consider whether an opportunity exists for re-examination in the near future.

¹⁴⁴ As noted in [A5b. Confidentiality and Release of Information](#), release of the child's medical records for an investigation of child sexual abuse should not be delayed for parental signatures.

¹⁴⁵ See the Joint Commission's *New and Revised Standards and EPs for Patient-Centered Communication, Accreditation Program: Hospital*, RI, 01.01.03, effective January 1, 2011.

¹⁴⁶ Sedation or anesthesia should only be used in cases where an acute medical need exists for an intra-vaginal exam or intra-anal exam. This may include cases of internal injury, bleeding from the vaginal area, tears that need repair, or the presence of a mass or foreign objects. If sedation or anesthesia must be used, it should be with the child's assent, whenever possible, and in consultation with the appropriate pediatric specialists. ([See B7. Examination.](#))

Consider how to approach different consent scenarios. If the health care facility does not have policies for an individual patient situation, the child sexual abuse multidisciplinary response team might be a resource for feedback on appropriate interventions (Constantino et al., 2014). If a child presents to a health care facility and no related policy is in place to address a specific situation, a discussion and decision with involved health care providers and the child's parent/guardian should occur immediately and be documented (Constantino et al., 2014).



In the case of a prepubescent child who is unconscious and not expected to quickly regain consciousness and a suspicion of acute sexual abuse exists, or the timing of the abuse is unknown,¹⁴⁷ medical forensic care generally should not be delayed (although such a decision should be made on a case-by-case basis). Not only is it critical to promptly determine if the child has serious injuries that require immediate care and provide any necessary treatment, a limited window of time exists to collect forensic samples from this victim population. (See [A5d. Timing of Evidence Collection](#)) Also, forensic evidence may be lost in the health care setting if not promptly collected. Pediatric examiners should collaborate with the hospital emergency department and trauma teams to allow medical forensic care to proceed concurrent with emergency procedures. As discussed in [B7. Examination](#), the medical forensic examination for prepubescent children is noninvasive (e.g., it does not include speculum or swab penetration into the vaginal canal). Medical forensic care should include an assessment of the anogenital area for acute injury, bleeding, or foreign material prior to surgical preparation or treatment activities, such as bladder catheterization, which may interfere with recovering biological evidence (Pierce-Weeks & Campbell, 2008). Optimally, informed consent for medical forensic care for an unconscious child should be sought from the child's parent/guardian as per facility policies. Procedures for proceeding with a medical forensic examination should also be in place in situations where suspicion exists that the parent/guardian is the perpetrator, an ally to the perpetrator, or otherwise abusive to the child, OR the parent/guardian does not consent or is absent.

Coordinate with other responding agencies/facilities in the jurisdiction in efforts to seek consent. All responders should be clear regarding which involved professional has the knowledge to provide children and parents/guardians with information on a particular procedure or intervention. For example, law enforcement and child protective service representatives or victim advocates should not seek consent for medical forensic care. However, they may need to seek consent for activities related to the exam process, such as arranging transportation for the child and caregiver to the health care facility. Health care providers should not seek consent for children to participate in forensic interviews. Law enforcement and child protective service representatives and health care providers should not seek consent for provision of victim services to children or caregivers. While initial responders might offer an overview of various providers' roles in the exam process—and even introduce children and caregivers to other responders—they should not seek consent for interventions provided by other responders.

¹⁴⁷ Circumstances of unconsciousness that may lead to a suspicion of child sexual abuse include but are not limited to unconsciousness from (1) abusive head trauma, with associated subdural, subarachnoid, and retinal hemorrhages; diffuse axonal injury; or acute respiratory compromise or arrest with/without associated cutaneous injuries and skull fractures (Hymel & Deye, 2011); (2) traumatic internal injury (e.g., abdominal injury) or external injury (e.g., vaginal or anal laceration) associated with blood loss; (3) drug-induced unconsciousness; (4) metabolic causes associated with neglect, torture of starvation, malnutrition, and/or exposure extreme heat or cold; or (5) caregiver history that is inconsistent with the clinical presentation of injury, or radiologic or laboratory findings on the child (Hymel & Deye, 2011). For more information and research on pediatric abusive head trauma, see the CDC (2015d) at www.cdc.gov/violenceprevention/childmaltreatment/abusive-head-trauma.html.



See www.Kidsta.org for sample consent forms and patient materials that help children and caregivers with decision making in these cases, and further tips for health care providers on seeking consent and assent. Also contact staff at Kidsta.org to discuss specific scenarios where a child and/or parent/guardian are hesitant to agree to or decline a procedure, and health care responder's actions in such situations.

B2. Initial Response

These recommendations are for those involved in initial response to prepubescent child sexual abuse cases prior to a child's entry into the health care system (which is addressed in [B3. Entry into the Health Care System](#)). Emergency medical service/paramedic providers are included in this chapter as pre-health care setting initial responders.

Build consensus among entities involved in prepubescent child sexual abuse cases in a community (the multidisciplinary response team) regarding discipline-specific and coordination procedures for initial response. (See [A3. Coordinated Team Approach](#)) Procedures should address all sexual abuse cases, regardless of when the incident occurred; Procedures should facilitate timely identification of and response to children's immediate safety and health needs, and the needs of case investigation as applicable. Responders who are not from an agency designated to receive mandatory reports should know how to make a report, what to do if there are concerns of imminent danger, and how to facilitate the child's health care.¹⁴⁸

The multidisciplinary response team should ensure that first responders are educated on procedures for initial response. Examples of first responders include child protective service hotline or intake workers, 911 dispatchers, law enforcement representatives (e.g., patrol officers), emergency medical service (EMS)/paramedic providers, and advocates who answer sexual assault crisis hotlines. These persons serve on the "front line" and may be involved in these cases prior to specialized personnel, units, or teams. Note that communities differ in, if, and how they use specialized personnel. (Be aware that other health care providers beyond EMS/paramedics are also first responders, but are addressed in [B3. Entry into the Health Care System](#))



Tribal communities, military installations, and institutional settings and systems that house or care for prepubescent children may have their own procedures for handling sexual abuse disclosures and their own first responders (e.g., tribal law enforcement, child protective services/social services, victim advocates, and military installation police and family advocacy program staff). Multidisciplinary response teams from surrounding communities, as well as federal child abuse multidisciplinary teams, are encouraged to work with such entities to ensure that initial response procedures are coordinated with jurisdictional response or across jurisdictions, to the extent necessary. (See [A3. Coordinated Team Approach](#))

Identify populations in the community from a specific culture (e.g., new immigrants, or groups that have historically been marginalized) for which **it may be useful for the response team to identify professionals who are part of or provide services to that group and are willing to assist with the initial response.** For example, faith leaders may be willing to act as liaisons between first responders and families in their congregation. Sometimes, but not always, children and families will be open to interventions when they have the support of someone from their own culture (but do not assume this is what they want—ask them). Ideally, such outreach should occur as part of a team's planned efforts to build its capacity to serve all members of the community, rather than immediately prior to interventions in an individual case.

¹⁴⁸ As noted in [A5a. Reporting](#), VAWA confidentiality provisions include a requirement that VAWA grantees who are not mandated reporters of child abuse and neglect under their jurisdictional laws may only report abuse and/or neglect if the victim consents. However, if there exists an imminent risk of harm to a child, the grantee program should follow its program policies for accessing emergency assistance. The grantee program can also help connect the child with health care services, if given permission.

Professionals identified to assist in initial response to victims from specific populations should be informed that they may be called on for this reason, educated on appropriate response to child sexual abuse, and confirm their willingness to act in this capacity. (See [A3. Coordinated Team Approach](#))

Make sure the public knows what to do when a disclosure or a suspicion of child sexual abuse occurs. Citizens and all professionals in a community who interact with prepubescent children and their families should be educated on who is mandated to report child abuse and neglect, who can voluntarily report, and who to contact to report. Inform the public how entities involved in the local response to child sexual abuse work together to intervene in these cases. (See [A5a. Reporting](#))

Recognize key elements of the initial multidisciplinary team response that may occur prior to the child’s entry into the health care system, as described below. (See [Appendix 6. Initial Response Algorithm](#)) These are general elements of response—responders should follow their jurisdictional and agency policies. Note that “team response” does not mean all responders will be involved in every case; rather, they may be called to respond, depending upon case needs.

Key Elements of the Initial Multidisciplinary Team Response

Report of disclosure or suspicion should trigger the multidisciplinary response team. The team should:

- **Communicate among responders** to ensure timely, coordinated action, as needed, in a specific case.
- **Tailor the response to accommodate the needs of the child and the caregiver/family** (e.g., developmental level, abilities, linguistic needs, health conditions, housing status, and culture, to the extent possible). Response should be child-focused, victim-centered, and trauma-informed. (See [A1. Principles of Care](#) and [A2. Adapting Care for Each Child](#))
- Note that, **if a children’s advocacy center exists in a community**, center staff may play a central coordinating role for the multidisciplinary response team during the initial response.

If child protective services, law enforcement, or 911 is the first responder:

- **Assess immediate safety needs** of the child, others at scene, and others where the child or suspected perpetrator(s) lives/or those with whom the suspect may come in contact. If in imminent danger, 911 should be immediately involved.
- **Assess the child’s need for emergency medical care.** If at the child’s location, administer necessary first aid. As needed, request EMS/paramedic assistance. With recent sexual abuse, take precautions to prevent the loss of forensic evidence on the child’s body or clothing to the extent possible while treating acute injuries.
- **Explain to the child and caregiver:** Mandatory reporting, the next steps in the response, the importance of medical forensic care, and the availability of support and advocacy.
- **Seek basic information from the child and caregiver** regarding the abuse reported to ascertain a time frame and the nature of the abuse, and, as applicable, to apprehend the suspect and facilitate crime scene preservation. (Note: this limited fact-finding is not the investigative/forensic interview, which may occur before or after the medical forensic examination)
- **Arrange an initial health care assessment** to provide the child emergency medical treatment (if applicable) and/or determine the urgency of medical forensic care needed (acute or nonacute). A health care professional should determine the urgency of medical forensic care. (See [B3. Entry into the Health Care System](#)) First responders should understand that a child’s health must be assessed even if law enforcement or child protective services perceive that the child’s body or clothing contains no forensic evidence. First responders should be familiar with health care facilities that perform initial

Key Elements of the Initial Multidisciplinary Team Response

assessments (some jurisdictions designate them; others do not), and facilities that conduct prepubescent sexual abuse medical forensic examinations (many jurisdictions have designated facilities for medical forensic care). For each exam site, first responders should know whether the site offers acute and/or nonacute care, hours of operation, and staffing. If an exam facility is closed or the pediatric examiner is unavailable at one site, they should know the next closest, appropriate exam site.

- Follow jurisdictional policies for **alerting the health care facility** of the pending arrival of a child sexual abuse patient. If it is a designated exam facility, check that a pediatric examiner is available.
- **Transport the child and caregiver to ensure timely arrival at the appropriate health care facility** (e.g., via EMS, law enforcement, or child protective services), and to maximize preservation of forensic evidence on the child's body and clothing. Transportation should be offered in both acute and nonacute cases.
 - Note that, if the facility where the initial medical assessment has been performed differs from the exam site, the child and caregiver may also need to be transported to the exam site.
 - Note that children with disabilities may have specialized transportation needs and use assistive devices (e.g., motorized wheelchairs and telecommunication equipment) and/or service animals (e.g., guide dogs and hearing-assistance dogs) that need to be transported to the exam site. Do not touch assistive devices or service animals without the child's permission.
- **Facilitate preservation of crime scene and forensic evidence, as applicable.** If forensic evidence may be collected during the medical forensic examination:
 - Explain to the child and caregiver the need to preserve forensic evidence on the child's body and clothing to the best of their ability until it can be collected at the health care facility (e.g., ideally, the child should not wash, change clothes, urinate, defecate, drink, eat, brush hair or teeth, or rinse the mouth) and that clothing may be taken as evidence. Instruct the caregiver to bring a clean change of clothes for the child to the exam facility. If the child changed clothes since the abuse, collect the clothing worn during and immediately after the abuse. Other items that potentially contain forensic evidence (e.g., jewelry worn during the abuse, towels and blankets that were used after the abuse, and soiled diapers or underwear) should also be collected. Follow jurisdictional/agency policies for retrieval of clothing/crime scene items so that forensic evidence is not inadvertently destroyed or contaminated and chain of custody of evidence is maintained.
 - Note that a child who uses assistive devices and/or service animals generally cannot go without them, as the child often views them as an extension of her/himself. If considered to be potential forensic evidence in a case, they should not be taken away from the child. Rather, during the medical forensic examination, the pediatric examiner can swab and photograph these devices or animals with the same intent and process as used to collect and photo-document forensic evidence from the child's body.
 - Take precautions to avoid damaging forensic evidence while interacting with the child, at the crime scene, and when transporting the child and any assistance devices or service animals to the health care facility. Wear gloves, and avoid the transfer of responder DNA to the child (via sweat, saliva from coughing, etc), or disrupting the crime scene.¹⁴⁹
 - EMS/paramedic providers who transport the child to the health care facility should follow jurisdictional/agency policy for collecting and packaging linens used and provide them to the health care provider or law enforcement personnel (if at the health care facility).
 - For recent sexual abuse cases in which alcohol or drugs is disclosed or suspected, if the child needs to urinate or vomit prior to arrival at the health care facility, these fluids should be

¹⁴⁹ Chen and Steer (2012).

Key Elements of the Initial Multidisciplinary Team Response

collected and packaged as per jurisdictional/agency policy. Also, collect and package containers that may have been used to drug a child.

- Follow jurisdictional policies for ***activating an advocate*** (as available) to support the child and family.

If an advocacy or victim service agency is the first responder:

- ***Make a child sexual abuse report and communicate any urgent safety concerns*** to the appropriate agencies, as required by jurisdictional/agency policies.
- ***Offer assistance to children and caregivers during the initial response***, specific to the services offered by the agency: e.g., support and crisis intervention; basic information on sexual abuse, victim reactions, medical forensic care and other aspects of community response; assistance contacting responders; safety planning; medical accompaniment during the examination, and legal accompaniment.

B3. Entry into the Health Care System

These recommendations are for health care providers related to screening and initial response to prepubescent child sexual abuse (prior to medical forensic care).



Prepubescent child sexual abuse victims may be brought into health care facilities for a medical forensic examination by child protective services or law enforcement agency personnel, after they have received a report of sexual abuse against that child. But other “ports of entry” exist into the health care system for child victims. They may disclose sexual abuse directly to a health care provider in a clinical setting or a child’s caregiver or another third party may voice concern to a health care provider. Alternatively, health care providers may become suspicious of sexual abuse in the course of a pediatric patient encounter, without a disclosure from the child or third party. Sexually abused children who have not disclosed abuse may also present to health care settings with a variety of complaints, some of which may lead to a suspicion of sexual abuse.

Health care providers must be educated to (1) identify signs and symptoms of prepubescent child sexual abuse,¹⁵⁰ and (2) initially respond when there is a disclosure or suspicion, to determine the urgency of care required. Pediatric examiners and multidisciplinary response teams can take the lead in their communities for such educational initiatives. Although most health care providers are not clinically prepared to provide specialty care for child sexual abuse patients, all can be educated in these two main areas, as discussed below.

Be aware of signs and symptoms that suggest the possibility that prepubescent child sexual abuse has occurred—these typically fall into physical or emotional/behavioral categories (Day & Pierce-Weeks, 2013). A STD beyond the perinatal acquisition period and pains, sores, bleeding, injury, and discharge from the genitalia are examples of potential physical indicators (Day & Pierce-Weeks, 2013). Common emotional/behavior reactions seen in children who have been sexually abused include, but are not limited to, increased anxiety, depression, PTSD, inappropriate sexual behavior, nightmares, behavioral regression, learning problems, distrust, and fearfulness (Keeshin & Corwin, 2011). Keeshin and Corwin (2011) noted that variations and similarities occur in reactions for different age ranges of prepubescent children. For example, common reactions seen in children ages 2 to 6 years include, but are not limited to, inappropriate sexual behaviors, PTSD, withdrawal, anxiety, and depression. Common reactions seen in children ages 7 to 12 years include, but are not limited to, depression, anxiety, PTSD, and suicidal ideation. Body and weight dissatisfaction and eating disorders may also be seen in older prepubescent children.¹⁵¹

Be aware that one sign or symptom may not be indicative of sexual abuse. A significant number of children who have experienced sexual abuse do not display any associated signs or symptoms. Understanding the context of a child’s behaviors and/or

¹⁵⁰ Health care providers should also screen for other forms of violence, as it is not uncommon for child sexual abuse victims to be exposed to other forms of abuse and neglect (Day & Pierce-Weeks, 2013).

¹⁵¹ Also see STOP It Now! (n.d.) at www.stopitnow.org/ohc-content/tip-sheet-7 for signs of possible sexual abuse in children’s behaviors.

caregiver concerns is important in identifying a suspicion of sexual abuse.¹⁵² Also, sometimes the caregiver has a concern regarding sexual abuse due to the child’s sexual behavior. Health care providers should be familiar with developmentally appropriate sexual behaviors in children (see below) versus what might be inappropriate, as well as how other types of stress or trauma may impact the child’s behavior (Kellogg, 2009; Silovsky & Niec, 2002).

Examples of Common Developmentally Appropriate Sexual Behaviors Among Children¹⁵³

(Note these behaviors do not constitute sexual abuse and are distinguished from inappropriate/problem sexual

| Developmental Stage/Age | Common Sexual Behaviors |
|--|--|
| <p>Preschool (Under 4 years old)</p> | <ul style="list-style-type: none"> • Exploring, touching, and/or rubbing private parts, in public and in private • Showing private parts to others • Trying to touch mother’s or other women’s breasts • Removing clothes and wanting to be naked • Attempting to see other people when they are naked or undressing • Asking questions about their own and others’ bodies and bodily functions • Talking to children their own age about bodily functions such as “poop” and “pee” |
| <p>Young Children (4–6 years old)</p> | <ul style="list-style-type: none"> • Purposefully touching private parts, occasionally in the presence of others • Attempting to see other people when they are naked or undressing • Mimicking dating behavior (such as kissing or holding hands) • Talking about private parts and using “naughty” words, even when they do not understand the meaning • Exploring private parts with children their own age (such as “playing doctor,” “I’ll show you mine, if you show me yours,” etc) |
| <p>School-Aged (7–12 years old)</p> | <ul style="list-style-type: none"> • Purposefully touching private parts (masturbation), usually in private • Playing games with children their own age that involve sexual behavior (such as “truth or dare,” “playing family,” or “boyfriend/girlfriend”) |



See www.Kidsta.org for further resources on signs and symptoms of child sexual abuse.

Be familiar with procedures for initially assessing prepubescent children who have experienced sexual abuse. When sexual abuse is a concern, children should be promptly assessed to determine the urgency of medical forensic care needed. Urgency is

¹⁵² For example, a mother might indicate to a pediatrician that her child is recently anxious and regressing behaviorally, but then goes on to say that the child has recently started school and is having trouble separating from her caregivers. In such a context, these behaviors do not point to a suspicion of sexual abuse. On the other hand, a suspicion clearly arises if the mother indicates the child has recently been anxious and regressing behaviorally, and goes on to say that a neighbor has been babysitting the child, the child is increasingly fearful of this neighbor, and blood stains appeared on the child’s underwear after the last few times the neighbor babysat. Understanding the context of signs and symptoms does not mean that the provider needs to ascertain if the abuse occurred. A suspicion of sexual abuse is all that is required to trigger a report to legal authorities.

¹⁵³ The chart was drawn from Day and Pierce-Weeks (2013) and Hagan, Shaw, and Duncan (2008). Also see Kellogg (2009). See www.wcsap.org/sites/wcsap.huang.radicaldesigns.org/files/uploads/resources_publications/partners_social_change/PISC_June_2015.pdf (NSVRC, 2015) for an overview of healthy childhood sexual development. For related caregiver brochures, see NSVRC (2012a) at www.nsvrc.org/publications/its-time-talk-your-children-about-healthy-sexuality as well as WCSAP (2015d) at www.wcsap.org/start-the-conversation and WCSAP (n.d.) at www.wcsap.org/its-time-talk-your-kids-about-healthy-sexuality.

¹⁵⁴ For a resource on helping children with problem sexual behavior, see Cavanagh Johnson (2009).

determined by the child's presentation, the presence of injuries, and the nature and timing of abuse (Day & Pierce-Weeks, 2013). The assessment must be tailored for prepubescent rather than adolescent or adult patients. Initial assessment typically occurs in hospital emergency departments (during triage), but also in primary care settings. **See below for nine key steps in initial health care assessment/triage with these patients.** (Also see [Appendix 7. Care Algorithm](#). However, note that the majority of activities in this algorithm are tasks for the pediatric examiner rather than health care providers who are initially assessing children to determine urgency of care needed)

Key Steps in Initial Health Care Assessment/Triage

- Step 1:** *Make children who disclose sexual abuse or are suspected of being sexually abused a priority.*
- Step 2:** *Gather minimal facts during the initial assessment/triage.*
- Step 3:** *Ensure that, when prepubescent child sexual abuse is disclosed or suspected, a mandatory report is made as per jurisdictional and facility policies.*
- Step 4:** *If immediate safety concerns are identified, promptly communicate the urgency of the concern to the appropriate law enforcement or child protective service agency, as per jurisdictional and facility policy.*
- Step 5:** *Provide a medical screening exam (as per EMTALA requirements) to include vital signs and evaluation by a qualified medical provider for acute injury or pain and subsequently treat, as needed, to stabilize.*
- Step 6:** *Recognize that medical forensic care falls into two categories: acute or nonacute. All prepubescent children who disclose sexual abuse or are suspected of being sexually abused require medical forensic care due to health consequences associated with sexual abuse*
- Step 7:** *Once the urgency of medical care is determined, arrange the appropriate examination.*
- Step 8:** *Alert exam facilities according to jurisdictional and facility policies.*
- Step 9:** *Alert victim advocates to the need for their services (where available)*

Key Steps in Initial Health Care Assessment/Triage

Step 1: Make children who disclose sexual abuse or are suspected of being sexually abused a priority.

- **See children presenting with sexual abuse issues in a timely fashion.** To the extent possible, **use a private location** within the facility to initially assess/triage the child and as a waiting area for the caregiver/family. Inform the child and caregiver what will happen during the initial assessment/triage (e.g., a medical screening will confirm that no emergent conditions exist and help plan for specialty care).
- Be aware that it may be particularly uncomfortable for some children and caregivers to speak about the abuse in general, but especially with members of the opposite sex. **To the extent possible, accommodate requests for providers of a specific gender or culture.**
- This section focuses mainly on health care providers who interact with children prior to the pediatric examiner's involvement. However, **if there is a pediatric examiner at the facility, seek to involve the examiner as early as possible** (e.g., if emergency department staff knows a child victim is being transported to the facility, they may be able to reach out to the examiner at that point or the examiner could meet the patient immediately after triage).

Step 2: Gather minimal facts during the initial assessment/triage.

- The initial assessment/triage of the child should **include questions that are limited in scope**—the focus is for the health care provider to obtain sufficient information to make a mandatory report and to determine whether the urgency for medical forensic care is acute or nonacute. Questions should only include what is necessary to identify the child's presenting issues and treatment needs, and the nature and timing of the abuse. It is helpful to know whether other responders/providers are already involved in the case, as they may be able to share pertinent case information that will help limit the questions the health care provider needs to ask. Note further information will be sought from the child and caregiver during the medical history component of medical forensic care, as well as the investigative interview/forensic interview.
- **Be familiar with examples of initial assessment/triage questions to ask accompanying caregivers** (Floyed et al., 2011; Giardino & Finkel, 2005; Hornor, 2010): When did the sexual abuse last occur? What type of contact happened (e.g., oral to genital, genital to genital, or genital to anal?) Or, if unknown, what has prompted a suspicion of sexual abuse? (Often, there is no knowledge, but a behavioral issue OR a finding that the parent has observed that has raised her/his index of suspicion) Did/does the child have anogenital pain, bleeding, or discharge, or a known genital injury? What access does the perpetrator (if known) have to the presenting child and contact children? Do safety concerns exist? Are there other physical concerns (related or unrelated to the abuse)?
- **Note that the person from whom information should be obtained depends somewhat on the presenting situation.** In an emergency department setting, health care providers usually direct the question of what brings the child to the hospital to the accompanying adult. However, depending upon developmental level and communication skills, the child may be able to answer basic questions (What brings you in today? Does anything hurt?). In a primary care setting, the caregiver or the child may verbalize the chief complaint. Although providers should not pursue obtaining a detailed abuse history from the child, it is possible that a child will make a disclosure spontaneously or with little prompting. In this case, the child needs to know that it is acceptable to talk with trusted adults about what happened. Such disclosure should be documented verbatim. To the extent feasible, separate the child from the caregiver when obtaining this information. Separation is particularly important if the caregiver is a suspected perpetrator, is in collusion with the perpetrator, or is otherwise abusive to the child.¹⁵⁵

¹⁵⁵ The bullet was adapted from Jenny, Crawford-Jakubiak, and the Committee on Child Abuse and Neglect. (2013).

Step 3: Ensure that, when prepubescent child sexual abuse is disclosed or suspected, a mandatory report is made as per jurisdictional and facility policies. (See [A5a. Reporting](#))

- **Make the report** after basic facts about the nature and circumstances of the abuse are gathered.
- **Do not delay health care** due to confusion about which jurisdiction should receive the report, if there is a problem communicating with legal authorities about the report, or if the jurisdiction in which the abuse occurred differs from the one in which the health care facility is located.

Step 4: If immediate safety concerns are identified, promptly communicate the urgency of the concern to the appropriate law enforcement or child protective service agency, as per jurisdictional and facility policy.

- **If there is concern about a safety threat posed by a person accompanying the child, take steps to protect the child and the facility staff** from that individual. In addition to immediate outreach to the appropriate law enforcement and child protective service agency, follow facility policy on response to this and other types of threatening situations. It is important that facilities and providers have the ability to create a safety plan, including admission when necessary (if the facility has inpatient capacity).

Step 5: Provide a medical screening exam (as per EMTALA requirements) to include vital signs and evaluation by a qualified medical provider for acute injury or pain and subsequently treat, as needed, to stabilize.

- **Be aware that emergent treatment needs always supercede forensic evidence preservation.**
- If the abuse occurred in the recent past (see below), strive to **preserve potential evidence on the child's body for later collection during the medical forensic examination.** To that end, do not remove the child's clothing or have him/her wash or bathe. If a child must eat or drink, oral swabs can be taken—consult with a pediatric examiner as needed to ensure that swabs are collected properly. If the child needs to urinate, a sample (dirty catch) should be obtained as it may be needed for STD or toxicology testing. Soiled diapers or underwear should be maintained as part of the collection process. Procedures should be in place to facilitate the passing along of any material or samples collected to the pediatric examiner or law enforcement representative, in a manner that maintains the chain of custody of forensic evidence. (See [A5e. Evidence Integrity](#) and [B8. Evidence Collection](#))

Step 6: Recognize that medical forensic care falls into two categories: acute or nonacute. All prepubescent children who disclose sexual abuse or are suspected of being sexually abused require medical forensic care due to health consequences associated with sexual abuse (Day & Pierce-Weeks, 2013). Follow jurisdictional and facility policies for determining the urgency of care.

- Generally, an **acute examination** (emergent or urgent care¹⁵⁶) should be conducted for a child who has disclosed sexual abuse or is suspected of being sexually abused if:
 - The sexual abuse may have occurred recently (as per the jurisdictional prescribed time frame for acute medical forensic care) and there is a possibility of forensic specimens on the child's body from the contact (see [A5d. Timing of Evidence Collection](#));
 - There are symptoms of injury, anogenital or other (e.g., bleeding, bruising, abrasions, and lacerations);
 - There are symptoms of STDs (e.g., discharge from genitalia, pain, or sores), including HIV;
 - The situation (e.g., the child is unconscious) or the child's cognition (e.g., pre-verbal infant/toddler) prevents an understanding of the time frame since the sexual abuse or of the severity of injuries;

¹⁵⁶ Acute care may be further categorized at some health care facilities as emergent or urgent, with the facility assigning response time frames to each subcategory. Caution is recommended when making such assignments: If there is any question about the subcategorization in a case, then emergent care is more appropriate.

- The child was abducted and sexual abuse is suspected;
- There are imminent safety risks to the child and it is unclear where she/he will reside in the future;
- There is a concern that the family will not return the child for nonacute care on another day;
- The child is experiencing significant behavioral or emotional problems and/or a need exists for evaluation for possible suicidal or homicidal ideation; and/or
- The child or caregiver has pressing concerns that acute care can address (e.g., about STDs).
- Children should be referred for a **nonacute examination** (nonurgent care) if the sexual abuse is suspected to have occurred beyond the jurisdictional time frame for forensic sample collection and there is no indication for the need for immediate medical attention as described above. Although forensic samples are not collected in these instances, these children do require a thorough medical forensic evaluation consisting of a medical history and examination. Because child sexual abuse reports are often delayed, a nonacute examination rather than an acute exam is appropriate in many cases.
- **Recognize that the disclosure of child sexual abuse is often a crisis to the child and family**, even if it does not require emergency medical attention (Christian, 2011; Leder, 2012). **In such instances, it may be beneficial to conduct an examination acutely** to reassure the child and family (Christian, 2011), as well as to offer crisis intervention and support, and link the child and family to advocacy and mental health services.

Step 7: Once the urgency of medical care is determined, arrange the appropriate examination.

- **Follow the protocol for arranging medical forensic care, as per jurisdictional and facility policy.**
 - The multidisciplinary response team (or responding entities) should work in conjunction with local and regional health care systems and pediatric examiners to ensure that primary care providers and hospital emergency departments in the team's service area have a **consistent protocol to arrange medical forensic care**. The protocol should identify **acceptable time frames for acute and nonacute care**, once the urgency of care is established and the patient is stabilized.
 - Acute and nonacute examinations may be conducted in **designated health care facilities** in a jurisdiction or region. Some exam facilities perform acute and nonacute examinations; others perform only one type. Some have time restrictions (e.g., many children's advocacy centers' medical clinics are open only during standard business hours). (See [A4b. Facilities](#))
 - When arranging medical forensic care, **health care providers need to be informed of**: available medical forensic exam resources in the community; which location and time frame is best for different exam types and pediatric populations; transfer options and procedures if a child must be sent to another facility for acute medical forensic care (they should not send a child who requires acute medical forensic care home without a medical forensic examination); and options and procedures for arranging nonacute examinations.
 - If at all possible, develop mechanisms to provide initial responders with access to **pediatric examiner consultants** whom they can call for guidance in directing children to the right provider, facility, and services.
 - Recognize that **transportation for nonacute care** may be an issue for caregivers. The multidisciplinary response team (or responding entities) should offer accessible transportation at no cost for children and caregivers to ensure nonacute care occurs in a timely manner.

Step 8: Alert exam facilities according to jurisdictional and facility policies.

- **For acute examinations, alert the appropriate exam facility that an immediate need exists for a pediatric examiner to provide medical forensic care.** If the examination will take place at the initial health care facility to which the child presented and examiners are not based at the site or need to be

dispatched, they should be contacted as per facility policy.¹⁵⁷ Examiners are often required to arrive at an exam site within a certain period of time (e.g., one hour) after being dispatched. If the child is going to be transferred to another facility for the acute care, that facility should be alerted regarding the patient's pending arrival and then established policies should be followed for the transfer.

Communication between the health care provider performing the initial assessment and the specialty care team at the transfer site may assist in the child's plan of care and expedite the transfer. (See [A4b. Facilities](#))

- **Note that in circumstances in which patients are seriously injured, pediatric examiners must be prepared to work alongside other health care providers who are stabilizing and treating the patients.** In such cases, examiners should be prepared to perform examinations in settings such as a health care facility's emergency department, an operating room, a recovery room, or an intensive care unit.
- **For a nonacute examination, providers at the initial responding facility should follow jurisdictional policy for outreach to the exam facility** to ensure that specialty care is available and to schedule an appointment for the child.

Step 9: Alert victim advocates to the need for their services (where available)

- **Determine if/which victim advocacy services are available to children and/or family members before, during, and after the medical forensic examination** to offer crisis intervention, support, information, safety planning, counseling, and advocacy services.
 - The multidisciplinary response team should work with local and regional victim advocacy programs serving prepubescent child sexual abuse victims to ensure that children and their caregivers have access to advocates during the exam process and that informed consent is sought from the child and caregivers when involving advocates. In conjunction with the advocacy program, the team should also develop procedures for health care providers to activate an advocate in these cases to provide medical accompaniment. (See [A3. Coordinated Team Approach](#) and [B1. Consent for Care](#))
- **Follow established procedures for activating an advocate, as per jurisdictional and agency/facility policies.**

Be aware of children who may need a different approach upon entry to the health care system. Health care providers who initially respond to these cases and pediatric examiners should be familiar with jurisdictional procedures that may be in place to trigger distinct medical and investigative responses to specific types of child sexual abuse or related crimes (e.g., sex trafficking or drug endangerment). The multidisciplinary response team should communicate with those overseeing those distinct responses (e.g., task forces) to ensure initial medical assessment procedures for children in these cases are well coordinated.

¹⁵⁷ It is possible that examiners could also be dispatched by first responders at the crime scene or by triage staff after being alerted that a sexual abuse patient will be arriving at the facility. Activating examiners as early as possible seems like it would be beneficial, but such a procedure can potentially cause confusion. For example, after activating an examiner to dispatch to a particular exam facility, there may be delays in transporting the patient to the site or changes while on the way to the facility. Advance team planning for multiple scenarios in these cases can help reduce confusion.

B4. Written Documentation

These recommendations are for pediatric examiners on written documentation of medical forensic care.

Ensure completion of all documentation. Examiners are responsible for documenting the medical forensic details of the examination in the prepubescent child’s medical record. All aspects of care should be documented: consent, the medical history, the examination (including written descriptions, diagram/body map rendering, and interpretation of findings), consultant reports (if done), forensic samples collected (if done), testing done and/or treatment rendered and results as available, descriptions of photographic images taken, a discharge plan, and follow-up care scheduled and referrals given.¹⁵⁸ Examiners also need to document this data on jurisdictional exam report forms. If examiners are called to testify in a legal proceeding, they may use this report to recall their encounter with the child (Day & Pierce-Weeks, 2013).

Document physical trauma using standard terminology and descriptive language. At a minimum, descriptions should include the type of injury (see below), but not speculate on its cause. However, if the child details the origin of an injury, it is appropriate to document her/his words in quotations. In addition to written descriptions, physical findings should be noted on body diagrams/maps and photo-documented. (See [B6. Photo-Documentation](#)) Also, samples collected from injuries should be noted.

| <i>Describing Features of Physical Injuries</i> ¹⁵⁹ | |
|--|--|
| Feature | Notes |
| Classification/type | Use accepted terminology (e.g., abrasion, bruise, laceration, and incised wound) |
| Site | Record the location/direction of wound/injury |
| Size | Measure wound (using ruler) |
| Shape | Describe shape of wound: linear, curved, or irregular |
| Surrounds | Note condition of nearby tissue: bruised, swollen, or tender |
| Color | Observe any changes in color: redness, bruising, or pallor |
| Contents | Note presence of foreign material in wound: dirt, debris, or glass |
| Age | Note any healing injuries, such as scabbed cuts (do not attempt to date wounds) ¹⁶⁰ |
| Borders | Characterize wound margins: ragged, smooth |
| Depth | Give an estimate of depth of wound, if present |
| Pattern | Pattern or imprint of an object: e.g., iron, handprint, or bite mark |



See www.Kidsta.org for related medical definitions.

Accurately reflect in the written record the child’s demeanor, statements made by the child during the course of care, and the caregiver’s statements regarding the history of events. All such statements, and the examiner questions, must be recorded

¹⁵⁸ Medical records from care provided related to earlier disclosures of sexual abuse to a health care provider may also be included if available and accessible (e.g., if the patient was transferred from another facility where an initial assessment of urgency of care was performed). However, inclusions of such records will vary across jurisdiction and facilities and individual cases.

¹⁵⁹ The chart was adapted from Day and Pierce-Weeks (2013) and WHO/UNHCR (2004).

¹⁶⁰ See Atwal et al. (1998).

verbatim. Such documentation can be admitted as evidence at trial in most states. (Also see [B5. Medical History](#))

Ensure that examiners are instructed and supervised on proper written documentation. The medical record must be an accurate and thorough reflection of the examination and stand on its own (Kaplan et al., 2011). Pediatric examiners should be educated on: the importance of proper medical forensic documentation in child sexual abuse cases; the need to be objective in their documentation; the need to be consistent in documentation across these types of cases; how to access and use their jurisdictional medical forensic documentation forms; and how to document care provided in the child’s medical record. **Note the following documentation “dos and don’ts.”**¹⁶¹

| Do | Don’t |
|---|--|
| <ul style="list-style-type: none"> • Write or type legibly • Complete all aspects of the medical chart • Record the exam date and time • Record the medical history and sources • Record verbatim questions asked and quote patients and caregivers carefully • Put statements by patients and caregivers in quotation marks • Make sure duplicate copies are legible • If you did not examine something on the form, write <i>not examined</i> • Sign every page • Complete all legally required paperwork | <ul style="list-style-type: none"> • Don’t leave blank sections • Don’t cross out previously documented • Don’t use unauthorized abbreviations • Don’t draw unfounded conclusions • Don’t draw legal conclusions • Don’t fill in the form if you are not the person who completed the examination • Don’t use terms or phrases that have legal meaning, could be misleading in a legal case, or could be perceived as pejorative to the child¹⁶² |

Encourage examiners within an exam facility, jurisdiction, or region to devise an appropriate record review process tailored to their needs. In addition to having a system for peer review as discussed in [A4a. Pediatric Examiners](#), **consider having a clinical director or supervisor at the exam site systematically review documentation related to the examination.** In some jurisdictions, review of non-physician examiner’s documentation by a medical director or supervisor is required. These reviews can serve to increase overall examiner effectiveness by ensuring that reports are completed according to policy, assessing staff training needs, considering acceptable procedures for amendments to the record, troubleshooting for potential problems, and identifying trends.

Establish policies for record storage, release, and retention. (Also see [B6. Photo-Documentation](#)) Pediatric examiners, as well as those involved in health care facility records management, should understand the record storage, release, and retention issues

¹⁶¹ The chart was drawn from Day and Pierce-Weeks (2013) and the Massachusetts Department of Public Health (2005).

¹⁶² For example: Don’t use legal terms such as “alleged” or “rape.” Opt for “reported sexual abuse” or “concern of sexual abuse.” Don’t use pejorative terms and phrases such as “child refuses or is uncooperative.” Opt for “child unable to complete full exam” or “child upset, tearful, crying, and/or anxious.” Don’t use medical phrases that have different forensic meaning. For example, don’t say “in no acute distress” as it may imply that the child has suffered no psychological trauma or that the examiner doubts anything happened. Don’t say “no evidence of” as there well may be evidence that is not apparent and, in many cases of substantiated sexual abuse, there are no physical findings. Don’t use “intercourse” as it may be perceived as implying consent; instead use “penetration.” Don’t use “virginal or intact” as this is misleading terminology.

in these cases and if/how they differ for various populations of victims of sexual violence (e.g., prepubescent children, adolescents, and adults) and other patients receiving medical forensic care in which there is digital image documentation.

The privacy of the child’s medical records stored at health care facilities should be protected, in accordance with applicable laws. Health care facilities should have clear policies that address secure storage and retention of paper and electronic records and that limit access to the child’s records, as well as procedures for releasing written records only to those who are legally allowed access. Mechanisms to restrict access to a child’s medical records are important in all scenarios, but particularly in small and/or close-knit communities where health care facility employees may be acquaintances, friends, and family members of patients and/or suspects. (See [A5b. Confidentiality and Release of Information](#) and [A5e. Evidence Integrity](#))



Policies that address record storage should consider issues including but not limited to the following: How long are medical records kept in general? Is the length of time that medical records are retained different for records that involve child sexual abuse? Where are the records kept? If records are paper copies, are they kept in a locked location in files and behind doors? Who has access to those spaces? With electronic records—are firewalls used to limit access? What additional procedures are in place for photographic images? Consult with facility information technology/security and compliance departments.¹⁶³

Facility retention policies for medical records must take into account the need for access to these records in criminal and civil proceedings.¹⁶⁴ There is no single standardized retention schedule that health care facilities and providers must follow for medical forensic exam records. Instead, they typically review and consider a variety of retention requirements (e.g., federal, state, and accrediting bodies) and other recommendations (e.g., from the AHIMA) when creating such a policy. Time frames for retention requirements can be relatively short (e.g., five to 10 years after the most recent patient encounter). These limited time frames can be problematic in terms of the needs of the justice system, including in cases of delayed reporting, delayed processing of evidentiary kits, CODIS hits,¹⁶⁵ cold case investigations,¹⁶⁶ conditions that extend the statute of limitations, and the appeals process. With this in mind, ***policies for medical forensic record retention should be based on justice standards, rather than traditional medical record keeping, storage, retention, and destruction policies.***¹⁶⁷

Medical records in these cases should not be destroyed.

¹⁶³ Also see the American Health Information Management Association’s (AHIMA) e-HIM Work Group on Security of Personal Health Information (2008) at http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_039956.hcsp?dDocName=bok1_039956 for more on security issues and challenges with electronic medical records.

¹⁶⁴ See Ericksen and Knecht (2013) at <http://victimsofcrime.org/docs/DNA%20Resource%20Center/sol-for-sexual-assault-check-chart---final---copy.pdf?sfvrsn=2> for a state-by-state comparison of statute of limitations for sexual assault and abuse.

¹⁶⁵ CODIS (Combined DNA Index System) describes the FBI’s program of support for criminal justice DNA databases and the software that runs these databases. For more information on CODIS, see the Federal Bureau of Investigation (n.d.) at www.fbi.gov/about-us/lab/biometric-analysis/codis/codis-and-ndis-fact-sheet.

¹⁶⁶ A cold case is any case whose probative investigative leads have been exhausted. See National Institute of Justice (2008) at <http://nij.gov/journals/260/pages/what-is-cold-case.aspx>.

¹⁶⁷ This paragraph was adapted in part from AHIMA (2011).



Before information and/or photo-documentation from the child's medical record are released for investigative purposes, it would be beneficial for pediatric examiners to educate the recipients of the information about issues such as: digital image interpretation issues, why there may be discrepancies between a child's perception of experience and what actually happened; why there are no physical findings (if that is the case); and what symptoms might be expected with various types of anogenital contact (adapted from Kaplan, 2011).

B5. Medical History

These recommendations are for pediatric examiners related to the medical history.

Recognize the medical history is a critical component of medical forensic care, both acute and nonacute.¹⁶⁸ The pediatric examiner, prior to the examination, should seek information regarding the child's health and symptoms, including the specific circumstances of sexual abuse. The process for taking a medical history as part of medical forensic care is similar to any other medical history taking: chief complaint/history of present illness; review of systems;¹⁶⁹ and medical, family, and psychosocial history. The sexual abuse is the presenting medical issue about which the examiner needs information to provide care. The history subsequently guides the examination, formulation of a diagnosis, treatment and other health care interventions, and discharge planning, and helps determine if and which forensic evidence collection procedures are necessary (Adams et al., 2015; Day & Pierce-Weeks, 2013; De Jong, 2011; Finkel & Alexander, 2011; Kaplan et al., 2011). The medical history may provide information useful to the investigation (Adams et al., 2015).

Recognize that a forensic interview is different from the medical history. The forensic interview is a component of a comprehensive child sexual abuse investigation (Newlin et al., 2015). Forensic interviewing of children who disclose sexual abuse or for whom sexual abuse is suspected is an impartial fact-finding process that guides decision making in criminal, family, and juvenile law cases (Swerdlow-Freed, 2015). A forensic interview is a semi-structured conversation that is designed to obtain information from the child about the reported abusive event(s) (adapted from Swerdlow-Freed, 2015). During the interview, a forensic interviewer designated by the investigative team (or if not available, a law enforcement or/and child protective services investigator as applicable to the case) seeks to obtain a statement from the child in an objective, developmentally appropriate, and legally defensible manner (Davies et al., 1997). The interview is typically video-recorded. To ensure that facts are gathered in a way that will stand up in court, forensic interviews are carefully controlled: the interviewer's statements and body language must be neutral, alternative explanations for a child's statements are thoroughly explored, and interview results are documented in such a way that they can bear judicial scrutiny (North Carolina Division of Social Services and Family and Children's Resource Program, 2002).¹⁷⁰

See below for tips for pediatric examiners to keep the medical history and forensic interview separate but complementary.

¹⁶⁸ That said, circumstances may present where examiners will need to proceed with a medical forensic examination without a medical history (e.g., if a child is nonverbal/noncommunicative and a caregiver or family member is not available).

¹⁶⁹ The review of systems should include particular attention to gastrointestinal symptoms, constipation, genitourinary, and behavioral and emotional symptoms. Such symptoms could be associated with sexual abuse, although not diagnostic of it.

¹⁷⁰ In-depth discussion of forensic interviewing is beyond the scope of this protocol. See Newlin et al. (2015) for best practices in interviewing children in cases of alleged abuse. Coulborn Faller (2015) offers a history of the evolution of forensic interviewing in child sexual abuse cases. For additional resources related to investigative interviewing in child abuse cases, see the Child Welfare Information Gateway at www.childwelfare.gov/topics/responding/jia/investigation/interviewing/.

Tips to Keep the Medical History and Forensic Interview Separate but Complementary

- Pediatric examiners should limit the medical history to information necessary to address the child's health care needs and to guide the examination and collection of forensic samples (if applicable). It is not necessary for examiners to document detailed information that would normally be considered investigative in nature, as such information typically has less applicability to the components of the medical forensic examination, and would be routinely gathered by law enforcement personnel or through a forensic interview.
- Multidisciplinary response team protocols for child sexual abuse cases should delineate the roles of each team member. All involved on the team should have knowledge about and appreciation of the value of each member's contribution. (See [A3. Coordinated Team Approach](#))
- Coordination should be encouraged among examiners and investigative agencies around sharing of case information. When relevant investigative information is available prior to medical forensic care and/or the forensic interview has already occurred, the pediatric examiner should be briefed on that information prior to the medical history and examination. Likewise, if medical forensic care is completed prior to the forensic interview, investigators and/or forensic interviewers should be briefed before the interview on the relevant information gathered during the medical history and examination.¹⁷¹
- Multidisciplinary response team protocols vary widely from jurisdiction to jurisdiction as to whether to include the pediatric examiner among the professionals viewing the child's forensic interview. If the examiner observes the forensic interview and is subsequently conducting the medical forensic examination, observance of that interview does not negate the need for the examiner to conduct a medical history with the child. As noted earlier, the medical history is part of the overall assessment that guides the examination and forensic evidence collection, and when conducted by the examiner, is performed for the purposes of diagnosis and treatment. In contrast, the purpose of the forensic interview generally is to assist with the investigation and possible prosecution. In most instances, the history obtained by the examiner is information allowable in testimony as a result of the medical exception to the hearsay rule. If the examiner were to obtain the medical history by observing the forensic interview versus gathering the history directly from the child, the hearsay exception likely would no longer apply. Documentation by the examiner, particularly as it relates to statements made by the child, should be limited to information obtained directly from the interaction between the examiner and the child.
- Observing the forensic interview can assist the examiner in a variety of ways (e.g., in gaining more details of the abusive event; in assessing the child's demeanor and development; in observing what strategies employed by forensic interviewers may have successfully engaged the child and which ones did not work; and in supporting education and anticipatory guidance to the caregiver as part of the post-exam process).
- To maintain objectivity, jurisdictions should avoid having pediatric examiners assume the role of forensic interviewer. However, if a jurisdiction requires examiners to function in the role of forensic interviewer as well, it is important to consider the following: Because these roles are separate and distinct with different purposes, the examiner should be expected to adhere to all required initial education and ongoing training with regard to both roles. In addition, care should be taken to avoid role confusion that may result in impeding the examiner's ability to testify under the medical exception to the hearsay rule.

¹⁷¹ Note that, although jurisdictional and agency protocols vary regarding the timing of the forensic interview in relation to the acute and nonacute examination in child sexual abuse cases, the forensic interview usually precedes nonacute medical forensic care. If medical forensic care precedes the forensic interview, it is usually in acute cases where the immediate need to evaluate the child's medical status, provide care, and/or collect forensic evidence takes precedence over the forensic interview.

Tips to Keep the Medical History and Forensic Interview Separate but Complementary

- Investigative agencies should be educated about what an acute and a nonacute medical forensic examination entails, the purpose of the medical history, and how the medical history differs from the forensic interview. They should understand that law enforcement or child protective service representatives should not be present during the medical history or the examination. In addition, they should be provided with opportunities to ask medical questions related to a case.



For more discussion of the implications of evolving law on hearsay exceptions, see [Appendix 5. Impact of Crawford v. Washington and the Confrontation Clause](#).

Consider the following issues when preparing for and when starting the medical history:

- ***What information on the child and case is already available?*** Examiners can check the child's chart for details that are pertinent to medical forensic care, which health care providers have already documented. They can confer with investigative agencies if a forensic interview has been conducted to ascertain data already gathered.
- ***Have any injuries been identified and treated?*** (See [B3. Entry into the Health Care System](#))
- ***Have the crisis intervention and support needs of the child and caregiver been met?*** Victim advocates typically are able to provide crisis intervention and support during the exam process, including the medical history. They also can support the child while the caregiver is providing information and support the caregiver while the child gives an event history. (See [A3. Coordinated Team Approach](#)) Also, note that the medical history provides examiners an opportunity to assess related fears or concerns of children and caregivers and stress the usefulness of mental health services to help deal with the ramifications of the sexual abuse (Adams et al., 2015).
- ***Has a mandatory report been made?*** Examiners should not assume disclosures or suspicions have already been reported. Instead, they should confirm a report with child protective services and/or law enforcement as applicable to the case, as per jurisdictional and facility policies (See [A5a. Reporting](#))
- ***Is the child safe in the facility?*** To the extent possible, examiners should be cognizant of the relationship of the perpetrator to the child and the child's living situation, as these facts may speak to safety issues at the health care facility and during discharge planning, and to the urgency of conveying safety concerns to child protective services and/or law enforcement. (See [B3. Entry into the Health Care System](#)) During history taking, examiners should document any reference to perpetrators and/or persons abusive to the child. The medical history can provide information about whether the caregiver has been supportive of the child through the disclosure process (Adams et al., 2015).
- ***Is a private and comfortable setting available for history taking?*** Ideally, there should be no interruptions during history taking and no time constraints for the history or other use of the room while information is being gathered. History taking often takes place in the exam room prior to the examination. Regardless of the

space, examiners can help the child feel safe, comfortable, and relaxed as possible. Avoid rushing the child through the history.

- ***Are procedures in place to allow examiners to speak with the child and caregiver together and separately during the medical history, as appropriate in a case?*** The majority of the medical history in prepubescent child cases generally is sought from the caregiver presenting with the child, and may be supplemented by the child if she/he is developmentally able (see below). However, approaches vary to gathering information about the abusive event history: some jurisdictional protocols provide detailed instruction as to what information to obtain from the child versus the caregiver (e.g., see Washington State, 2012), while others are less specific; some do not seek the abusive event history from the children,¹⁷² while others seek this information from the child, but not separately from the caregiver; and, lastly, some first gather information about the event history from the caregiver, without the child present, and subsequently obtain the event history from the child, without the caregiver present (De Jong, 2011; Kaplan et al., 2011). This last approach gives the child who is developmentally able the opportunity to express her/his own viewpoint on what has happened, without being inhibited by the caregiver (Day & Pierce-Weeks, 2013). Being able to independently give an account of the abuse is particularly important for a child whose caregiver may be the perpetrator, in collusion with the perpetrator, or otherwise abusive to the child (but is unsuspected by responders). Examiners are encouraged to assess what is the most appropriate approach in each case, giving the child who is developmentally able to provide the abusive event history as many options as possible. Some children are not developmentally able to provide this history or are uncomfortable being separated from the caregiver.
- ***What is the child's developmental level?*** Examiners should assess the child's developmental level to tailor the history taking approach to the child. Because a child's communication ability changes dramatically, depending on her/his development, the examiner's knowledge about developmental stages can play an important role in rapport building, in communicating with the child in a developmentally appropriate way, and in the care provided. ([See A2. Adapting Care for Each Child](#)) The child's developmental level also directly affects whether the event history is sought from the child as opposed to only the caregiver or other sources. Consider (adapted from Day & Pierce-Weeks, 2013; IRC, 2012):
 - BIRTH - 4 YEARS OLD: Children in this age range have emerging communication skills (e.g., it is possible that 3- or 4-year-old children may be eloquent and descriptive in their communications). However, caregivers and other adults presenting with the child are usually the primary sources of information for the event history.
 - 5-9 YEARS OLD: Children in this age range should provide an event history if possible, if they are developmentally able. Caregivers and other adults

¹⁷² Kaplan et al. (2011) noted that some communities discourage clinicians from obtaining a medical history from the child about the abuse so as to avoid traumatizing the child. However, children can find it therapeutic to disclose to and be validated by health professionals.

presenting with the child may provide supplemental information for the event history.

- 10 AND ABOVE: Children in this age range should provide an event history, if they are developmentally able. Again, caregivers and other adults presenting with the child may offer supplemental information.

Although growth stages are often correlated with chronological age, ages at which developmental milestones occur are not the same for all children (e.g., an older child with autism may have limited communication skills). A child's development level should be assessed in multiple areas (e.g., fine motor, language, cognitive, and social skills), not merely chronological age.

- ***Are there other circumstances of the child that may impact history taking?*** (See [A2. Adapting Care for Each Child](#)) In particular, examiners need to evaluate the child for factors that may affect communication and cognition, and document skills, abilities, circumstances, and limitations. They should work with the child and/or caregiver to understand these factors and determine how best to communicate with the child. A few specific situations to consider (adapted from Day & Pierce-Weeks, 2013; IRC, 2012):

- If A CHILD HAS DISABILITIES THAT AFFECT COMMUNICATION OR COGNITION, examiners should communicate with her/him during the history in the manner that is most effective for that child (e.g., using sign language, Braille, plain language/pictures, or audio aids). They should not assume, that due to a disability, a child is incapable of communication. However, it can be difficult to understand some children with disabilities, as well as for them to understand others, which can lead to misunderstandings that further impede comprehension. Examiners should respect that some children with disabilities may not wish to have the physical examination and expose their body to a stranger.
- IF A CHILD IS NONVERBAL (not due to a disability, but because of developmental capacity, discomfort, being scared, etc) and not otherwise communicating with the examiner (using body language, facial expression, etc.), the examiner should talk with the child to build rapport and explain exam procedures, but have no expectations that the child will provide an event history. It is not unusual for a child who initially will not verbally communicate (and has the capacity) to begin to communicate as the exam progresses as she/he feels more comfortable and less afraid. However, some children may not be willing to discuss the sexual abuse. Forcing them to communicate is traumatizing and should be avoided. (Note it is also possible that a child will not give an event history because the suspected sexual abuse did not actually occur)

- ***If a child or caregiver has a need for communication aids or language assistance during history taking, have those accommodations been arranged?*** Examiners should be familiar with facility policy for making such arrangements. (See [A2. Adapting Care for Each Child](#))

- **Has there been a request for an examiner of a specific gender or culture?**
Examiners should accommodate such request to the extent possible.

Be mindful of the child’s capacity to answer questions during the information gathering process (Day & Pierce-Weeks, 2013; IRC, 2012). Examiners should take breaks as needed by the child. A child’s short attention span, due to developmental level or other circumstances, may limit the amount of time available for history taking.

Be familiar with the main areas of history taking (adapted from Day & Pierce-Weeks, 2013; Botash, n.d.). At the start of history taking, examiners should make clear to the child and caregiver that their role is to obtain a medical history for the purpose of diagnosis and treatment, and that the medical history is not an investigative interview. After building rapport and assessing the child’s circumstance and developmental level, examiners can explain that questions will focus on the sexual abuse event(s), the child’s medical condition, and the child’s family and psychosocial history (see below for the four main areas of medical history taking). Examiners should be careful to avoid the use of leading questions.



Note that the use of video and audio recording is not appropriate during the medical history.

Main Areas of the Medical History

A general principle in any history taking is to tailor questions to the child’s developmental level.

1. Getting started: Some questions to ask the child

- My name is []. I am a [doctor, forensic nurse, etc.]. My job is to make sure you are all right.
- Can you tell me your name?
- How old are you?
- Do you know why you are here today?
- *Review the child’s knowledge of body parts. “What do you call this?” Point to the child’s ear. Continue in this fashion until the child has named most body parts, including genitalia. Use the child’s language when talking about body parts.*¹⁷³

2. Event history—chief complaint

- *Write the event history in the child and/or caregiver’s exact words, using quotes.*
- *Ask open-ended questions to gain information. For example, “Tell me what happened.” Do not pressure the child to speak. It is not necessary to obtain all the details of the event from the child. If a child is reluctant to speak, and answers only “yes” or “no” or “I don’t know,” consider discontinuing efforts to obtain the history from the child at that time. (Washington State, 2012)*
- Information about the timing and nature of the event
 - When and where did it occur?
 - Did it occur more than one time?
 - Type of penetration/contact (specifically what and where on child/perpetrator)?
 - Condom use, use of objects?
 - Were photographs/videos taken or shown?
 - Perpetrator a known person or stranger?

¹⁷³ Note that while anatomically neutral body maps should be used to document exam findings, with some children, gender-specific body maps can be useful to aid examiners when discussing body parts.

Main Areas of the Medical History

A general principle in any history taking is to tailor questions to the child's developmental level.

- Perpetrator's STD status, including HIV, if known? (*Note the child likely will not know this information, but caregivers might if perpetrator is known to them*)
- Events since the event (e.g., to ascertain status—preservation of forensic evidence)

3. Past and current medical history

- Any current pain, bleeding, discharge, injuries, illnesses, or other physical symptoms
- Sexual history with awareness of gender identity and sexual orientation¹⁷⁴
- Other medical history: for example—
 - Developmental history
 - Allergies
 - Immunization status
 - Current medications¹⁷⁵
 - Past surgeries or hospitalizations
 - Active/past medical conditions, including normal bowel pattern
 - Approximate weight/height
 - Child's primary care provider

4. Family and psychosocial history

Note family and social circumstances can affect responses during the medical history.

- FAMILY: Illnesses, diseases, conditions in other family members; abuse in/by other family members
- SOCIAL: Pertaining to the child, caregivers, others in the household, child care providers
 - Child: name, including preferred name and nicknames; contact information; date of birth, sex and gender identity, ethnicity of child; place of birth/country of origin/date of arrival in USA; language(s) spoken/comprehended; school attended; and grade level
 - Caregivers: Names; contact information; country of origin; language(s) spoken; name(s) of parent/guardian if other than caregiver; others involved in the child's care
 - Others living in the home (siblings, relatives, friends, etc.)
 - Other children who may be at risk of abuse
- PSYCHOLOGICAL: (Day & Pierce-Weeks, 2013; IRC, 2012; WHO, 2003): Any signs of emotional distress or behavioral changes the child may be experiencing as a result of the abusive event. for example—
 - Sadness, depression, anger, fearfulness, and anxiety
 - Symptoms associated with PTSD, such as avoidance, numbing, and hyper-arousal
 - Inappropriate sexual behavior
 - Loss of social competence
 - Cognitive impairment
 - Regressive behaviors (e.g., loss of bladder control, reversion to thumb-sucking)
 - Changes in eating and/or sleeping habits
 - Substance abuse
 - Suicidal/homicidal ideation

¹⁷⁴ Children may be reluctant to discuss certain issues or may wish to discuss them in private, such as sexual orientation or gender identity.

¹⁷⁵ Treatment or medication a child is receiving may have direct implications on the medical forensic examination and documentation. For example, examiners need to be aware if a prepubescent child is receiving hormone treatment for pubertal suppression and anticipated subsequent gender transition.

B6. Photo-Documentation

These recommendations are for pediatric examiners related to photo-documentation during the examination.

Be aware that photo-documentation during the medical forensic examination is the standard of care in prepubescent child sexual abuse cases. In every case, examiners should take diagnostic quality still images or videos of detected injuries as well as normal, apparently uninjured anatomy. Note, however, that photographic images are not a substitute for detailed written documentation of exam findings (Adams et al., 2015).



Photo-documentation provides a record of visual forensic evidence findings at the time of the examination, before they are disturbed or collected (Green, 2013). “A good photograph is tantamount to stopping the clock” (Green, 2013). Photographic images are useful for: reassuring the child and caregiver regarding physical findings; avoiding additional examinations to confirm findings; allowing for later reviews for diagnostic, testimony preparation, quality assurance, or continuing education purposes; and creating a baseline for comparison to findings from follow-up visits or if other suspicions arise (Botash, 2009; Ricci, 2011).

Recognize that pediatric examiners—not law enforcement or child protective service investigators—should take these photographs during the examination, for several reasons: (1) Photographs taken during the medical forensic examination become part of the child’s medical record. (2) Photographs taken during the examination are highly personal in nature. As with adult and adolescent patients,¹⁷⁶ if photographs of the child are taken by nonmedical personnel, images taken should include only the child’s head and extremities and not the torso or anogenital region. Examiners are encouraged to seek training on photography techniques and procedures to use with child victims of sexual abuse.

Explain medical photography procedures to children and caregivers. The explanation should be developmentally appropriate for children, and linguistically appropriate for children and caregivers. Taking photographic images of children in the aftermath of sexual abuse can be traumatizing, especially if photography was a component of the abuse. In these cases, children might not be able to discern the difference between photography used in the sexual abuse and forensic photography. To help avoid traumatization and facilitate decision making, examiners should explain to children and caregivers: the purpose of the photography during medical forensic care; the extent to which photographs will be taken and the procedures that will be used; how photographs will be securely stored at the health care facility and to whom they can be released; potential uses of photographs during investigation and prosecution (especially anogenital images); and the possible need to obtain additional photographs following the examination. Explaining the process and welcoming questions helps to reduce reluctance to photo-documentation during the examination. In addition to being comfortable explaining this information to children and caregivers, examiners also should also be comfortable discussing sexual abuse that included still- and video-imaging, if that issue arises during the medical history or in the course of the examination.

¹⁷⁶ See OVW (2013).

Respect patient choices about photography. Consent to take photographs during the examination should be sought, as a component of the informed consent process. (See [B1. Consent for Care](#)) ***If children do not assent to all or any part of photography, their choices must be honored.*** Note that if children or parents/guardians are hesitant or decline photography, it may be due to cultural beliefs and practices—anogenital imaging, in particular, may be highly embarrassing and unacceptable. For example, certain religious communities have strong mandates about exposure or imaging of the body in public or in a non-private arena. Children may also be reluctant to be photographed during the examination if photography comprised a component of the abuse. It can be useful in these instances to explore with the child and caregiver whether procedure modifications may make photography acceptable, while respecting their cultural practices and mandates. If modifications are not acceptable, the written record may have to suffice as exam documentation. Regardless whether photography is used, examiners should document examination findings on body mapping forms and diagrams.

Maintain the child’s privacy. Strive to minimize the child’s discomfort while being photographed. Drape children appropriately while taking photographs. Children differ in what will help them be more comfortable while being photographed: For those for whom it is developmentally appropriate, examiners can offer the opportunity to explore the photo-documentation equipment prior to its use, view images taken, and even to watch the examination if video-colposcopy is utilized (Ricci, 2011). It may be helpful for a caregiver and/or other supportive person to provide comfort for the child. (See [B7. Examination](#))

Consider the photographic equipment. Examiners should be familiar with photographic equipment operation and be prepared to use it during the examination (e.g., camera supplies and instructions should be available and the equipment should be clean and in working order). If questions exist regarding what type of equipment to use, it may be helpful to consult with a professional photographer, outlining the type of photographs that will be taken. Alternatively, consult with other local examiner programs as they often have knowledge about photographic equipment used in these cases and the effectiveness in capturing images during the examination. Generally, any good-quality photographic equipment may be used as long as it can be focused for undistorted, close-up photographs and provide an accurate color rendition (California Office of Emergency Services, 2001).



Forensic photograph equipment can include many types of digital cameras or other still or video image capturing devices with magnification capabilities. Technological advances offer continuously new options for digital imaging. Advantages of digital imaging equipment is cost effectiveness, applicability for other patient care issues, and the quality of the image that can be obtained with a basic digital camera (Green, 2013). Digital single lens reflex (SLR) products offer setting options, such as image sensors and manual and automatic exposure settings, and should have at least 12 pixels for forensic evidentiary purposes (Staggs, 2014).

Take initial and follow-up photographs as appropriate in a case, according to facility policy. See below for basic photography principles. In addition to initial photographs taken in the course of the medical forensic examination, photography may be repeated as evolving injury or healing on patients’ bodies occurs following the examination (e.g.,

bruising may appear days later). Create procedures that examiners, investigators, multidisciplinary response teams, and caregivers can follow to ensure that post-exam changes are documented. In addition to documenting evolving injury or healing, follow-up photographs can clarify findings of stable, normal variants in anatomy and nonspecific findings, like redness or swelling, that could be potentially be confused with acute injuries.

Basic Photographic Principles¹⁷⁷

- **Patient identification.** Link patients' identifying information to each photographic image, according to jurisdictional and facility policy. For example, include patient name, date, and time as the first image. Follow jurisdictional policy for whether to include an image of the child's face with this identifying information.¹⁷⁸ For identification purposes, this information should book end the digital images taken during the examination of this patient (at beginning and end of images). Digital imaging can automatically embed the date/time, camera settings, and a variety of other technical data in each image. This data can be accessed when images are downloaded onto the computer. A digital image log that records each image's file number, with a description of the image, may be included as part of the patient care record.
- **Clear and accurate photographs.** Images taken that do not provide a clear and accurate depiction should be deleted. Note that this practice reflects a medical standard, as appropriate for pediatric examiners, rather than an investigative standard.
 - The examiner should strive to control every element in the photographic image to produce a clear, accurate representation of the injury or anatomy.
 - Assure adequate lighting, exposure, and that the image is in sharp focus.
- **Standard.** Use a standard or ruler for size reference in photographs, in addition to those photographs that identify patients and anatomical locations being photographed.
- **Take photographs of the child prior to the collection of forensic specimens and medical interventions,** such as cleaning or suturing, when possible. Do not alter or move forensic evidence before or during photographing.
- **Orientation of shots.** Take at least three shots at different distances from the body:
 - In some jurisdictions, a full body photograph is taken as an identification photo. It may also be appropriate to show scope of injury or state of clothing. When taking full body photographs, ensure as much modesty and privacy for the patient as possible, through draping and other techniques. Photographs taken solely for the purpose of identification should be done with patients fully clothed or in a gown.
 - Take an **overview image** of the injury's location, including anatomic landmarks for orientation of the injury.
 - Take **medium-range** photographs of each injury, providing a wide enough view to identify the specific anatomical site being photographed (e.g., a photograph of a left forearm laceration at medium range would contain the left hand and left elbow of the patient, as well as the injury itself).
 - Take **close-up images of injuries**, with and without the standard. The goal of the close-up images should be to capture subtleties in texture and color and any pattern injuries that may be observed.
- **Photographing skin.** Close-up photographs of hands and fingernails may show traces of blood, skin, or hair. Look for damage to nails or missing nails. Photograph marks of restraint or bondage around wrists,

¹⁷⁷ These principles were adapted in part from Green (2013) and OVW (2013).

¹⁷⁸ Note the child's face should never appear in photographic images where genitalia is exposed. However, facility policy may call for a separate photograph of the child's face for identification. This image may be useful in cases where it is a long time before the child goes to court. The image of the child's face can help to show the child as she/he was when the abuse occurred.

Basic Photographic Principles¹⁷⁷

ankles, or neck; they may be compared later with an object in question that made the marks. Photograph transfer evidence present on the body or clothing, such as dirt, gravel, or vegetation.

- **Bite mark evidence.** Photograph bite marks, according to facility and jurisdictional policy. (See [B8. Evidence Collection](#). Also see Riviello (2013))

Establish health care facility policies for storage, retention, and controlled release of photo-documentation in these cases. Secure storage and restricted access to photo-documentation is critical in general, but particularly important in small communities where exam facility employees may be acquaintances, friends, and family members of patients and/or suspects. The facility legal and risk management departments are sources for consultation regarding photo-documentation annotation, handling, storage, retention, and release practices.

- **Photographic images taken during the medical forensic examination should be considered part of the patient's medical record maintained by the health care facility.** As mentioned earlier, examiners should not include photographic images in the evidentiary kit sent to the crime lab.
- **Facility policy should clarify how photo-documentation in these cases will be securely stored.** Examiners should coordinate with facility information technology security, compliance, and legal departments to ensure compliance with privacy laws, rules, and regulations for storage of electronic records and images.
- **Health care facility policy should allow release of photo-documentation only in certain situations to certain entities, as legally allowable, in order to prevent misinterpretation and misuse.**¹⁷⁹ Such policies should include mechanisms that allow examiners and/or medical records departments, in concert with facility legal counsel or risk management, to evaluate in each case whether release of the requested images is legally allowable and/or could be potentially harmful to the patient (Botash, 2009). Other health care providers treating the child typically do not need access to photographic images taken during the examination. Photographic images should not automatically be turned over to investigating agencies or the multidisciplinary response team. Instead, investigators or the investigating team should be guided by body maps and diagrams used in documentation in deciding which photographs to request. When photographs are released, the release should be done in a manner that limits the chance of misinterpretation by nonmedical professionals. One approach is that, prior to release, an examiner could review images with recipients so they understand what is significant about the findings.
- **Facility retention policies for photo-documentation and other medical records must take into account the need for access to these records in criminal and civil proceedings.** These records must be retained indefinitely to accommodate cases of delayed reporting, delayed processing of evidentiary kits, CODIS hits, cold

¹⁷⁹ One concern is that routine release of photographic images in these cases, often of children's genitalia, to agencies that do not have strict methods in place for protection of these images can result in their release to people outside the investigative team, such as members of the press. Note that prosecution discovery obligations may require granting access to exam photographic images by defense/defense experts.

case investigations, conditions that extend the statute of limitations, and the appeals process. With this in mind, **facility policies for medical forensic record retention should be based on justice standards rather than traditional medical record keeping, storage, retention, and destruction policies.**¹⁸⁰ Medical records in these cases should not be destroyed. (See [B4. Written Documentation](#))



Contact staff at Kidsta.org to discuss specific issues related to establishing health care facility policies for storage, retention, and controlled release of photo-documentation in these cases.



It is helpful if exam facilities have policies and procedures related to digital imaging, including the following: procedures as part of medical forensic examination, image security and authorization for access, image enhancement details, duplication and release, storage, and a secure image back-up system. Digital images included in the medical record should be preserved in the original file format. If an image is to be enhanced, a new file should be created (original remains unchanged) and details of the enhancement recorded. The facility should make available, to those with legitimate access, image copies in an encrypted format.¹⁸¹

¹⁸⁰ This paragraph was adapted in part from AHIMA (2011).

¹⁸¹ This information on the admissibility of digital imaging was adapted from Green (2013).

B7. Examination

These recommendations are for pediatric examiners regarding conducting the examination.



One of the most invaluable benefits of the medical forensic examination is its power to promote children's healing. In many situations, children leave the exam room feeling empowered, having learned information about their bodies and been reassured that they are healthy. The vast majority of children who experienced sexual abuse—over 90 percent—have normal examinations (Adams, 2003; Berkoff et al., 2008; Heger et al., 2002; Kellogg, 2005). When findings are abnormal, medical forensic care can facilitate the treatment needed to allow children to regain their health. The exam process also provides the opportunity to begin to address children's needs related to safety, justice, and support. It is important that examiners educate the multidisciplinary response team about the positive impact that medical forensic care can have for children and their families. This knowledge allows team members to address misconceptions that children, caregivers, or others may have about the examination and to explain its benefits.

Keep the focus of the examination on the entire child. The medical forensic examination in a prepubescent child sexual abuse case includes a physical examination augmented by an anogenital examination (MD Child Abuse Medical Professionals Network [CHAMP], 2008). There are many reasons to perform such an examination, the most important of which is to medically evaluate the child's health (MD CHAMP, 2008). Focus on a full review of systems before moving to the anogenital examination. Besides being more child-focused, victim-centered, and trauma-informed (see [A1. Principles of Care](#)), this approach allows examiners to assess for all types of abuse and neglect, not just sexual abuse.

Recognize that medical components of the examination cannot be separated from evidentiary components. In acute cases, pediatric examiners must be prepared to incorporate forensic sample collection into the physical and anogenital examination as it proceeds. (See [B8. Evidence Collection](#)) In both acute and nonacute cases, exam findings should be documented—in writing, on body maps and diagrams, and through photography, as per jurisdictional and facility policies. Documentation serves both medical and evidentiary purposes. (See [B4. Written Documentation](#) and [B6. Photo-Documentation](#))

Explain the overall examination to the child and caregiver prior to the examination, as well as specific procedures during the examination. Seek consent and assent as appropriate. (See [B1. Consent for Care](#)) Convey the following (drawn from Sanford Health Dakota Children's Advocacy Center, 2014):

- The examination is a thorough physical evaluation, similar to an annual pediatric well-check visit.
- The health care provider evaluating the child is someone who has expertise with children who have been sexually abused.
- The examination is typically painless. It will include an examination of the genital and anal area. Generally speaking, a speculum will not be used. Sedation or anesthesia is necessary only in rare situations in which there are concerns of significant anogenital bleeding or injury, a mass, or a foreign body.

- Photographic images will be taken to document the physical findings and ensure the accuracy of the interpretation of these findings. The images will be securely stored at the health care facility and access to them is controlled. (See [B6. Photo-Documentation](#))
- The child is in control of what happens during the examination. The health care provider will explain what is happening during the different steps of the examination. If the child expresses an interest, exam equipment can be demonstrated. Questions are encouraged and breaks can be taken whenever needed.

In most instances, when examiners establish rapport with children, explain exam procedures to them, and welcome their questions, children are able to complete the examination without difficulty.

Modify the examination to address the specific needs and concerns of children.

(See [A1. Principles of Care](#) and [A2. Adapting Care for Each Child](#)) For example:

- Accommodate mobility and cognitive impairments and communication needs.¹⁸²
- Accommodate requests for examiners of specific genders to the extent possible—cultural beliefs may preclude a member of the opposite sex from being present when a child disrobes.
- Be aware that cultural beliefs might affect whether and how certain forensic evidence is collected and if/how photo-documentation is done. (See [B6. Photo-Documentation](#)) If children or caregivers are hesitant or opposed to a specific procedure for this reason, it can be useful to explore whether an alternate method may make the procedure acceptable while respecting their cultural practices. In general, do not interfere with cultural practices that promote healing, even if the practice may compromise forensic evidence collection.
- If certain items that are considered forensic evidence have cultural significance (e.g., sacred ceremonial garments and jewelry, and moccasins of a Native person), use of alternative collection techniques, such as swabbing the clothing, should be considered rather than taking the items as evidence.

Clarify who can be in the exam room beyond the child, examiner, and chaperone.

A chaperone is necessary during the medical forensic examination as a safeguard for children, due to their vulnerability to abuse. The chaperone may be a caregiver, a health care provider other than the examiner, or another supportive person not suspected of involvement in the abuse.¹⁸³ Beyond these individuals, it is generally good practice to limit the number of persons in the exam room, to protect patient privacy and simply because the room often cannot accommodate more than a few individuals. However, depending on preferences of the child, case facts, jurisdictional policies, healing practices of the family, etc., it may be appropriate for additional individuals to be present in the room: assisting

¹⁸² For example, a child with a physical disability that impacts mobility may need assistance in transferring on and off the exam table or in assuming positions necessary for the examination. The child may also need an alternative to the standard exam table.

¹⁸³ For references to chaperones, see AAP Committee on Child Abuse and Neglect (1999), the AAP Committee on Practice and Ambulatory Medicine (1996), and McLay (2009).

medical personnel,¹⁸⁴ a victim advocate, other supportive persons (e.g., a religious/spiritual support person), a provider to assist with communication (e.g., an interpreter), and/or a personal care attendant for a child with a disability.¹⁸⁵ **Law enforcement or child protective service representatives should not be present during the examination.**

It is important to give children the choice of whether a caregiver is present during the examination, if they are developmentally able to make an informed choice. Yet, examiners must understand that it may be difficult to impossible for children to make such a decision without being influenced by the perceived consequences (e.g., my mom will be mad if she has to leave the room). Prior to the examination, examiners should assess the relationship between the child and caregiver (if the caregiver is supportive of and able to comfort the child during the examination), explain the options to the child, and assess if the caregiver's presence could be potentially disruptive during the examination. Separately from the child, it is helpful if examiners stress to caregivers that the examination is noninvasive and generally not traumatizing for children when done in a child-focused, victim-centered, and trauma-informed way and that it will not be forced on them.

Examiners can also educate caregivers about their critical role in their child's healing and suggest and model ways to support the child during the examination.

Generally, most children find it reassuring to have a supportive caregiver or other support person present during the examination. However, a caregiver who is suspected of being the perpetrator, is in collusion with the perpetrator, or is otherwise abusive to the child should not be present. In situations where a caregiver is too emotionally distressed to support the child or does not believe the child's account of sexual abuse, it may prudent to limit her/his participation.¹⁸⁶

Take measures to protect patient privacy when others are present during the examination. In addition to documenting their presence in the child's record and appropriately draping, position additional persons appropriately and explain their roles to the child. Those providing support should understand their role is to talk to and distract the child during the examination (WA, 2012). They should not actively participate.

Document verbatim spontaneous statements made by the child in the course of the examination, if it is related to the health and wellbeing of the child, child abuse and neglect, or other purpose deemed important by the examiner.¹⁸⁷

¹⁸⁴ Note that the use of medical scribes by examiners during the medical forensic examination can be problematic in that scribes typically are not knowledgeable of child sexual abuse issues nor the medical forensic care process, and may inadvertently misrepresent statements, actions, or behavior of the child during the examination.

¹⁸⁵ Keeping the child's preferences in mind, the examiner ultimately has discretion to decide who can be in the exam room in a given case, to be able to effectively provide medical forensic care, maintain comfort and safety for the child, and interact with the child and caregiver in a respectful manner. The examiner should consider the timing of when during the exam process that individuals can best support children and caregivers. For example, depending upon the situation, a religious/spiritual support person might spend time with the child and caregiver prior or after the examination rather than being in the room during the actual examination.

¹⁸⁶ Note that victim advocates can be resources for caregivers to help them cope with their reactions to the sexual abuse.

¹⁸⁷ For example, document anti-transgender statements a child who is perceived to be transgender says were made during the sexual abuse, because of their value in possible prosecution under hate crime laws.

Conduct a head-to-toe examination, as summarized below (Day & Pierce-Weeks, 2013). The examination should proceed in a way that affords as much dignity, privacy, and comfort to the child as possible. (See [A1. Principles of Care](#)) Limit exposure of the body to the area being examined (e.g., when observing the breast, only expose that particular area). Note that an alternate light source (ALS), if available, can aid in examining the body, hair, and clothing.¹⁸⁸ (See [A4c. Equipment and Supplies](#))

Head-to-Toe Exam Steps

Note that this list is a detailed summary of common steps; jurisdictions may differ as to the specifics of steps.

| Observations | Other |
|--|--|
| Note the child's general appearance, demeanor, and developmental stage . (See Appendix 1. Tanner Stages of Sexual Maturation) | Take vital signs, height, and weight. Also obtain head circumference for children under 3 years of age. |
| Inspect the head and scalp . Observe for areas of missing hair and evidence of bruising/petechiae on the scalp. | Palpate the scalp for areas of tenderness. Gentle palpation may reveal tenderness and swelling, suggestive of hematoma. Hair loss due to hair pulling during the abuse may cause loose hair to be collected in the examiner's gloved hands or petechiae at the surface of the scalp. Gentle palpation of jaw margins and orbital margins may reveal tenderness, indicating bruising not yet visible. |
| Inspect the eyes . Observe for areas of bruising around the eyes (may be subtle). Look for the presence of conjunctival petechiae or hemorrhage. | |
| Inspect the external and internal ears . Do not forget the area behind the ears, for evidence of shadow bruising or battle signs (which may be a sign that a skull fracture exists). Bleeding or leakage of cerebrospinal fluid (CSF) from the ear may also indicate skull fractures. | |
| Inspect the nose and mouth . Look in the nose for signs of bleeding or leakage of CSF, or areas of bruising on the outside of the nose. The mouth should be inspected, including the lips, gums, and tongue, checking for injury and the buccal mucosa. Petechiae on the hard/soft palate may indicate oral penetration or strangulation. Check area of the frenulum for tearing injuries and observe for broken teeth. | Collect oral swabs, as indicated. |

¹⁸⁸ See [A4c. Equipment and Supplies](#) for appropriate types of light sources. California Office of Emergency Services (2001) instructions on use of an ALS: Use an ALS in a darkened room to examine the patient's entire body. Take care to protect the patient's eyes when using ultraviolet light. Specifically, examine these areas of the body: head, face, hair, lips, perioral region, and nares; chest and breasts; external genitalia, perineal area, inner thighs, and pubic hair; buttocks, skin, and anal folds; and, any area indicated by the patient's history. Note that dried semen stains have a characteristic shiny appearance and tend to flake off the skin. Semen may exhibit an off-white fluorescence under ultraviolet light. Fluorescent areas may appear as smears, streaks, or splash marks. Fluorescing stains can be swabbed for forensic analysis. (See [B8. Evidence Collection](#).) Note that relatively fresh dried semen is more easily seen with the naked eye than with an ALS (Anderst, 2011). In the absence of an ALS, examiners should swab based on the history of skin or body fluid contact on the child and what they observe in the course of the examination.

| Observations | Other |
|--|---|
| <p>Inspect all surfaces of the child’s neck for injury. Injuries observed on the neck can indicate a possible strangulation event warranting further questions by the provider.</p> | <p>Palpate the neck for subcutaneous emphysema and note any ligature marks. Any of these signs may indicate a strangulation event has occurred. Abrasions seen at the neck in cases of strangulation may be caused by the child when trying to protect him/herself from strangulation. Petechiae or red bruising from bites or sucking should be noted and swabbed for saliva before being touched.</p> |
| <p>Assess the child’s hands, inspecting all sides for injury. Observe general appearance. Observe wrists for signs of ligature marks.</p> | <p>Collect trace evidence from fingernails and along the cuticles, as appropriate.</p> |
| <p>Inspect the child’s forearms for injuries, appropriate circulation, sensation, and motion. Note any injuries or intravenous puncture sites.</p> | <p>Palpate for tenderness.</p> |
| <p>Inspect the inner surfaces of the child’s upper arms and axilla for signs of injury, appropriate circulation, sensation, and motion.</p> | <p>Children who have been restrained by hands may have “fingertip” bruising on their arms.</p> |
| <p>The child’s breasts and trunk should be examined. Subtle or obvious injury may be seen in a variety of places on the trunk. Breasts are frequently a target of abuse in female patients, including sucking and bite marks.</p> | <p>Swab areas for saliva if indicated. Auscultate the lungs.</p> |
| <p>Observe the child’s back; this can be accomplished by rolling the child over to complete the assessment, or by having the child stand up at the exam’s completion and doing a final observation of the back.</p> | <p>Observe for injury and bruising. Be sure to palpate for areas of tenderness.</p> |
| <p>Complete the abdominal examination, including inspection, auscultation, and palpation to exclude any internal trauma.</p> | <p>If body fluid or saliva is suspected to be present, swab for evidence. Change gloves prior to palpation to avoid examiner contamination (skin-on-skin DNA).</p> |
| <p>Examine the anterior and posterior aspects of the legs, paying special attention to the inner thighs for injury. Observe for injury and foreign materials. Assess for tenderness. Assess the feet and ankles for similar injury, foreign materials, and tenderness, including the soles of the feet.</p> | <p>Collect foreign materials, if present. Palpate for tenderness and limited range of motion.</p> |
| <p>Inspection of the posterior aspects of the legs may be easier to achieve with the child standing or sitting on the caregiver’s lap. Alternatively, the child may be examined in a supine position and asked to lift each leg in turn and then rolled slightly to inspect each buttock.</p> | <p>Any biological evidence should be collected with moistened swabs (for semen, saliva, and blood) or gloved hands (for hair, fibers, grass, and soil).</p> |
| <p>Obvious physical deformities should be noted. Piercings and other markings should be noted only if their presence is related to the crime (see “other” column).</p> | <p>Notation of tattoos is generally unnecessary unless the presence of the tattoo is related to the crime itself (e.g., the perpetrator tattooed the victim before/at the time of the crime, as may occur with trafficking victims).</p> |

Conduct the anogenital examination. The anogenital examination focuses on the external genitalia of prepubescent boys and the labia and contents of the vestibule of prepubescent girls. The presence of a chaperone for the child is particularly important during this part of the examination. A speculum examination of the vagina is not indicated for a prepubescent girl with an unestrogenized hymen unless there are concerns of bleeding, a mass, or a foreign body. If an intra-vaginal examination is required, sedation or anesthesia must be used. In this case, consult as needed with appropriate pediatric specialists.

A digital camera or colposcope and magnifying glass/visor can aid in visualizing anogenital structure detail.¹⁸⁹ As noted earlier, an ALS can aid in examining patients' bodies, hair, and clothing. (See [A4c. Equipment and Supplies](#))

Use specific exam positions and techniques to facilitate the examination of genitalia in prepubescent children. Note that modifications may be needed for children with mobility impairments, as indicated by the medical history.

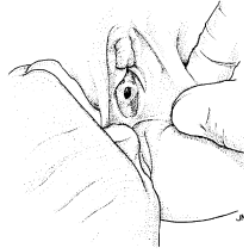
¹⁸⁹ As noted earlier, the use of a colposcope is the standard of care in many communities for magnified visualization and photo-documentation of anogenital structure detail. In communities who do not have the ability to use colposcopes, many are opting for digital cameras as the next best alternative to achieve magnification and capture still-and video images that allow for a permanent record of the anogenital examination findings. See [B6. Photo-Documentation](#) for guidance on the use of digital cameras during the examination. As noted in [A4c. Equipment and Supplies](#), toluidine blue dye (TBD) may be used to accentuate minor epithelial damage, either with or without magnification. No research is available on the use and limitations of TBD specifically with the prepubescent child sexual abuse victim population. When it is used, examiners should be instructed on application (Blackburn & Stokes, 2013): If both the anal and genital areas are to be examined using TBD, the dye should first be applied to the anal area. It should be applied with a cotton swab; excess dye should be removed by blotting the area with sterile gauze moistened with either a 1% acetic acid solution or lubricating jelly. The dye should only be applied to epithelialized skin (labia, perineum, and anal folds) and not to mucosal surfaces such as the hymen. Once the excess dye is removed, raw or abraded tissue will stain blue, while intact epithelium will be more easily wiped clean. As much excess dye as possible should be removed—residual dye may be misinterpreted as a traumatic injury. For example, inflammatory or infectious lesions will also retain the dye—the examiner will need to differentiate traumatic versus non-traumatic lesions. Patients and caregivers should be informed that the dye could be present for a few days after application and may shed traces of dye on to their clothes.

Exam Positions and Techniques¹⁹⁰

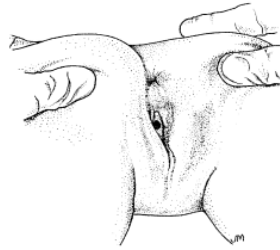
Supine Labial Separation



Supine Labial Traction



Prone Knee-Chest



NOTE: For full size illustration, see [Appendix 2](#).



Contact staff at Kidsta.org to discuss specific issues related to exam positions and techniques, as well as for suggestions regarding accommodations in situations with children with disabilities.

¹⁹⁰ The California Office of Emergency Services, author of the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims* (2001), gave permission for the use of this and several other illustrations in this chapter. It credits the drawings to J. McCann, Medical Director, CAARE Diagnostic and Treatment Center, Department of Pediatrics, UC Davis Medical Center Sacramento.

*Examination Positions and Techniques*¹⁹¹

| Position/ Technique | Description |
|--------------------------------|--|
| Supine frog-leg position | The child lies on the exam table or lap of a caregiver, with feet close together and knees loosely apart. Allows for visualization of the labia, and ease of use with labial separation and traction techniques. Allows for view of vulva, hymen, and vestibule. Abnormalities should be confirmed in prone knee-chest position (Kellogg, 2011). |
| Supine knee-chest position | The child lies on the exam table or lap of a caregiver, with feet and knees together holding knees to chest (may need assistance). Allows for visualization of the anus and surrounding tissues. |
| Prone knee-chest position | The child is on exam table in a prone position, with head and torso flush with the table, knees separated and down on the exam table, and buttocks raised. Allows for visualization of the anus, surrounding tissues, and rectal cavity during relaxation. With use of labial separation and traction, allows for assessment and confirmation of hymenal findings visualized while the child was in supine frog-leg. |
| Labial separation technique | With the child in a supine frog-leg position, gently separate the child's labia with gloved hands. Allows for visualization of the genital structures. |
| Labial traction technique | With the child in a supine frog-leg position, gently hold the child's labia majora bilaterally between thumb and forefingers with gloved hands, pulling out toward the examiner and down toward the anus of the child. This technique allows visualization of the genital structures including the hymen, vaginal opening, and posterior fourchette areas. Care should be taken to avoid injury of the posterior fourchette before, during, and after the examination. |
| Floating hymen technique | If the hymeneal tissue appears folded on itself or adhered together, the use of saline to moisten the hymen's edges may improve visualization, allowing a more complete assessment. This technique can be performed with the child in prone knee-chest position with gluteal lift (Adams et al., 2015; Kellogg, 2011). |

For children who are anxious about the anogenital examination, consider if there may be modifications that could ease their anxiety. For example, if the child is hesitant to remove her/his underwear or clothing, ask the child if the caregiver could help. In acute cases, examiners can give the caregiver gloves to use and provide instruction to preserve forensic evidence during removal. It might be reassuring for an anxious child to be examined on a caregiver's lap rather than on the exam table (see above positions). If children decline the anogenital examination altogether, they may still allow the physical examination and swabs of the head, neck, chest and abdomen. They may allow underpants to be collected, especially if new underpants are provided.¹⁹²

¹⁹¹ The chart was adapted from Day and Pierce-Weeks (2013).

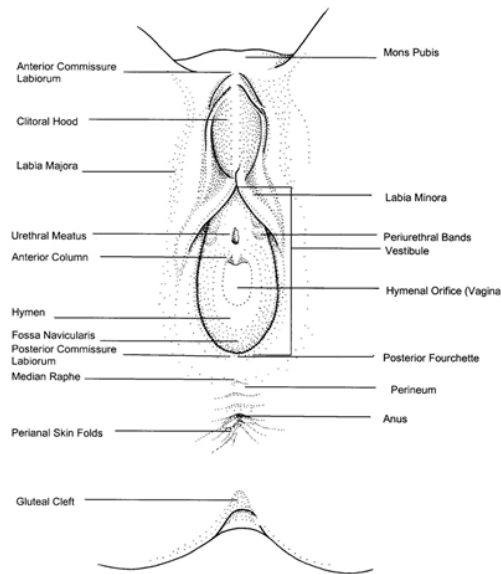
¹⁹² Examples were drawn from Washington State (2012).

Genital Examination of Prepubescent Girls

In girls, assess the following external genital structures for injury or disease process:

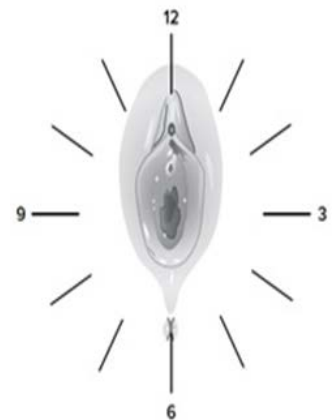
- Mons pubis
- Labia majora and minora
- Clitoral hood and clitoris
- Urethra and periurethral tissues
- Perineum
- Posterior fourchette
- Fossa navicularis
- Hymen
- Vaginal vestibule

*Female Genital Anatomy*¹⁹³



NOTE: For full size illustration, see [Appendix 3](#).

Document the genital structure assessment and findings using the clock face analogy. See illustration (Image courtesy of the New York State Department of Health). Some examiners assign the 12 o'clock position to the urethra, causing the clock position to change when the child's position changes. Others have the clock positions remain the same, and always document the position of the child when describing a finding. Each examiner should choose the method that best suits their practice and adhere to that method for each examination. The examiner superimposes the clock face and uses the appropriate time to document what is observed. Note the type of injury; size, if possible; structure upon which the injury is observed; and color of injury; discharge; foreign bodies; and/or blood.



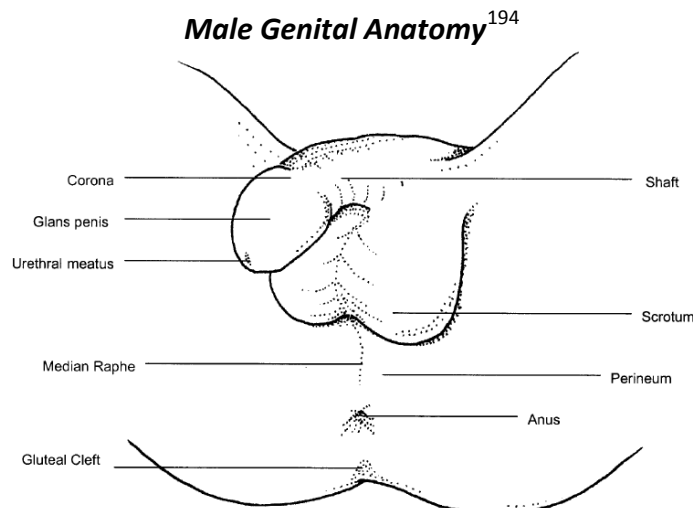
Note the hymen of prepubescent girls is sensitive and will cause the child pain if touched. Techniques used in postpubertal girls for hymenal assessment, such as the cotton-tipped swab to examine edges of the hymen or the urethral (Foley) balloon catheter technique, should not be used with prepubescent girls.

¹⁹³ The illustration is from the California Office of Emergency Services (2001), reprinted with permission.

Genital Examination of Boys

Include the following structures and tissues in the genital examination of boys, checking for signs of injury or disease process (see below for illustration):

- Prepuce of the glans
- Glans penis and frenulum
- Urethral meatus
- Penile shaft
- Scrotum
- Testes
- Inguinal region
- Perineum



NOTE: For full size illustration, see [Appendix 3](#).

Anal Examination of Girls and Boys

Utilize either the supine or prone knee-chest positions to examine the anus of children. In either position, apply gentle traction to part the buttock cheeks. Inspect the following tissues and structures during the anal examination, looking for signs of injury or disease process:

- Perianal area, paying particular attention to the perianal folds
- Anal verge/margin
- Anorectal canal
- Anus
- Gluteal cleft

A digital examination should only be performed where laxity of the sphincter is observed.

Anoscopy is not routinely used, unless there is concern of bleeding, obvious trauma, and/or a mass or foreign body. If there are such concerns, anoscopy should be done under sedation or anesthesia and performed by a qualified health care provider.

¹⁹⁴ The illustration is from the California Office of Emergency Services (2001), reprinted with permission..

Interpretation of Exam Findings

Recognize that it is normal to have normal physical findings. As discussed in the beginning of this chapter, most children who have experienced sexual abuse have normal examinations. Sexual abuse may leave no permanent scars or marks or, if a disclosure was delayed, healing may have occurred (Jenny, Crawford-Jakubiak, & Committee on Child Abuse and Neglect, 2013). When examination findings are normal, these findings neither confirm nor rule out abuse. Examiners should note this fact in the child's medical record as well as explain it to caregivers, while reassuring them the child is healthy (Jenny, Crawford-Jakubiak, & Committee on Child Abuse and Neglect, 2013).

Those who review the child's medical record for investigative purposes also need to understand: why discrepancies may exist between a child's perception and description of the event, due to developmental level, and what actually occurred; the presence or absence of exam findings; and what symptoms might be expected with various types of anogenital contact (Kaplan et al., 2011). For example, any contact against an unestrogenized hymen when the labia majora is penetrated could result in the child reporting "something hurt when it went inside."

Educate pediatric examiners on normal variants and conditions erroneously associated with sexual abuse (Adams et al., 2015). A wide range of normal findings can be expected during the medical forensic examination of prepubescent children (Day & Pierce-Weeks, 2013). At a minimum, examiners should understand anatomical variations and disease processes commonly mistaken for sexual abuse—see below for key examples (Day & Pierce-Weeks, 2013). The information gathered during the child's medical history is critical in differentiating between an injury from sexual abuse or variant.

It is critical that examiners are objective, know the limitations of clinical observations, and incorporate differential diagnosis to formulate unbiased diagnosis (Kaplan et al., 2011). Use of clinical peer review can help strengthen their skills to not overcall a normal variant finding as consistent with sexual abuse (Adams et al., 2015). (See [A4a. Pediatric Examiners](#))

Differential Diagnosis of Genital Findings¹⁹⁵ (not inclusive)

| | |
|----------------------------------|--|
| | |
| Labial agglutination or adhesion | The result of adherence (fusion) of the adjacent, outermost, mucosal surfaces of the posterior portion vestibular walls, which may occur at any point along the length of the vestibule, although it most commonly occurs posteriorly (inferiorly). A common finding in infants and young children. Unusual to appear for the first time after 6 to 7 years of age. May be related to chronic irritation. |
| Lichen sclerosis | A chronic, atrophic condition that creates patchy, white skin that is thinner than normal. Lichen sclerosis may affect skin on any part of the body, but most often involves skin of the vulva, foreskin of the penis, or skin around the anus. There is often associated itching, which can result in areas of bleeding and irritation. |
| Urethral prolapse | A condition in which the urethra protrudes through the external meatus. It may have a swollen, reddened appearance. |
| Streptococcus infection | Group A streptococci are gram-positive bacteria that produce beta-hemolysis and appear usually as a chain of two or more bacteria and have molecules on their surface known as Lancefield group A antigens. It can cause vulvitis in prepubescent girls; the peri-vaginal mucosa may be swollen, erythematous, and there may be bleeding and a discharge (Hudson et al., 2011). |
| Staphylococcus infection | Staphylococcal infections are caused by Staphylococcus bacteria, a bacteria commonly found on the skin or in the nose of even healthy individuals. It can cause vulvitis, vulvovaginitis, and vaginitis in prepubescent girls and may be accompanied by discharge (Hudson et al., 2011). |
| Straddle injury | Injury that can occur in the urogenital area from a fall, where the child “straddles” an object. It can be caused by blunt force trauma, which compresses urogenital soft tissues against the bony margins of the pelvic outlet, or less commonly, when a sharp object directly and forcefully penetrates the perineum, vagina, or anorectal opening. A common complaint is blood in underwear or on the perineum. Straddle injuries may result in abrasions, bruising, or hematoma of the labia majora, mons pubis, external urethra, perineal body, and buttock. Lacerations may occur if a child falls onto object with a hard edge. Penetrating injuries can cause profuse bleeding and pain. Straddle injuries are usually unilateral in presentation. Note that hymen injury is rare in accidental trauma. Male straddle injuries involve the scrotum. |
| Failure of midline fusion | Also known as perineal groove, congenital finding of the mucosal surface midline between fossa navicularis and anus on perineum. It is distinguished from trauma because it does not change, and resolves at puberty (Jenny, 2011). |
| Genital irritation/erythema | Difficult to differentiate erythema of nonabusive origin from erythema of sexually abusive origin. Most common causes of genital redness are poor hygiene and contact dermatitis. Increase vascularity in mucosa of vestibule in prepubertal girls that may appear erythematous (See Frasier (2011) for more details). |

¹⁹⁵ This chart was drawn primarily from Day and Pierce-Weeks (2013).



Adams et al. (2015) includes a list of medical and laboratory identification of exam findings that are: documented in newborns or commonly seen in nonabused children; have no expert consensus on interpretation with respect to sexual contact or trauma; and diagnostic of trauma and/or sexual contact. Note there are periodic updates to this list and publication, based on the implications of research.

B8. Evidence Collection

*These recommendations are for pediatric examiners to facilitate collection of forensic specimens.*¹⁹⁶



Recognize that timely medical care for all child sexual abuse victims is of paramount importance, regardless whether forensic specimens are potentially available. Physical findings from the acute or nonacute examination should also always be documented, regardless whether forensic evidence is collected.

Collect forensic evidence from a prepubescent child sexual abuse victim within the time frame prescribed by the jurisdiction,¹⁹⁷ when there is a possibility of biological or trace evidence on the child's body, or if the timing of the abuse is unknown/not clear. **In addition, case circumstances and future research may indicate a need for forensic evidence collection beyond that time frame.** (See [A5d. Timing of Evidence Collection](#) and [B3. Entry into the Health Care System](#)) Forensic specimens obtained during the medical forensic examination may be helpful in criminal justice, family, and/or juvenile justice proceedings that result from the report of sexual abuse. A standardized forensic evidence collection kit is recommended to collect forensic samples, as per jurisdictional policy. (See [A5c. Evidentiary Kits and Forms](#))

Seek as much forensic evidence as possible, guided by the medical history, information from investigative agencies, examination findings, and the children's assent to procedures. What forensic samples are collected may vary depending on details obtained during the medical history and input obtained via the initial report or forensic interview. If any forensic evidence requested in the evidentiary kit is not collected—or collection modifications are made—note reasons on documentation forms. In the instance that a child is unable to give a clear history (which is not unusual with young children) and/or a detailed account of the abuse is not available, complete all steps of the kit. Examiners are encouraged to communicate with investigators, prosecutors, and crime lab personnel to share relevant case information and seek clarification regarding forensic evidence to collect in specific cases (as well as more generally what items to collect and the preferred collection and preservation methods).



Basic evidence collection is built on the understanding that where contact between two objects exists, there also exists the possibility of material transfer (DeForest & Lee, 1983). Any contact between a perpetrator, child, and the crime scene itself may hold corroborating evidence. This evidence may be trace materials and/or body fluids from the perpetrator. During medical forensic care, forensic samples should be taken from areas of the child's body where evidence may exist. Clothing, especially underwear, and linens are the most likely positive sites for evidentiary DNA in prepubescent children (Christian et al., 2000; WA, 2012). Investigating agencies may also look for evidence on other items from the child's home and scene of abuse. Information derived from analysis of biological and trace evidence may help determine if sexual contact occurred, provide data regarding the circumstances of the incident, and be compared to reference samples collected from children and suspects for identification purposes.

¹⁹⁶ This chapter is adapted primarily from Day and Pierce-Weeks (2013).

¹⁹⁷ A [minimum window](#) of 72 hours since the abuse, noting that the window may widen with appropriate research. (See [A5d. Timing of Evidence Collection](#))

Be familiar with general forensic considerations, as outlined below. However, follow facility and jurisdictional policies as applicable.

| <i>General Forensic Considerations</i> | |
|--|---|
| Take precautions during the examination to prevent patient/health care staff exposure to blood borne pathogens and other potentially infectious materials. | Follow facility policies on washing hands, handling contaminated needles and other contaminated sharps, wearing protective equipment, and minimizing splashing, spraying, and spattering of infectious materials. Exam room and nondisposable equipment should be cleaned per facility policy between patients. |
| Wear gloves throughout the forensic evidence collection process. Also, change gloves frequently when examining different body areas. | Changing gloves between different collection points prevents possible contamination of specimens and exposure to blood/body fluids, as well as cross contamination. Due to the sensitivity of evolving DNA testing methods, it is important to stay current on additional measures to avoid contaminating specimens (e.g., wearing a mask and limiting talk during the collection of specimens). |
| Collect forensic evidence as soon as possible. | The likelihood of obtaining viable forensic specimens decreases over time. (See A5d. Timing of Evidence Collection) |
| When collecting specimens for both medical testing and forensic samples, collect forensic samples first. | There is an increased likelihood of obtaining biologic materials with the first specimens collected. |
| Handle specimens appropriately after collection. Ensure security of specimens. Limit the number of persons who handle forensic evidence. | Ensure that specimens are properly dried, packaged, labeled, sealed, and stored. Properly maintain and document chain of custody of forensic evidence. Procedures should be in place so that evidence is properly transferred to law enforcement personnel. (See A5e. Evidence Integrity) |
| Keep medical specimens separate from forensic specimens. It is not necessary to maintain the chain of custody of medical specimens. | Specimens collected for medical purposes should be kept and processed at the health care facility, as per facility policy. Specimens collected for forensic analysis should be transferred to the crime laboratory or other specified laboratories (e.g., a toxicology lab) for analysis, as per jurisdictional policy. |
| Do not put toxicology samples in the evidence collection kit, unless otherwise indicated. Maintain the chain of custody of toxicology samples. | If toxicology samples are collected, they may be analyzed at a different location than other forensic specimens. If that is the case, identify which labs the jurisdiction has selected to analyze these samples; choose a lab, if more than one option exists; and follow its policies for sample collection, preservation, and transfer. (See B9. Sexual Abuse Facilitated by Alcohol and Drugs) |

Collect forensic samples according to jurisdictional policy. The table below provides general guidance on the collection of common forensic samples. Jurisdictions may require collection of additional or different specimens and may use different collection methods (e.g., number of swabs used to collect a specific sample). It is important to follow jurisdictional policies regarding what specific forensic samples to collect for different types of sexual abuse, and when, with what, and how to collect each specimen. This instruction

is usually included in jurisdictional evidentiary kits. Consult with the crime lab if questions arise.

As noted in [A5e. Evidence Integrity](#), forensic specimens should be adequately dried where possible to prevent degradation, and packaged in material that will not retain moisture (e.g., paper versus plastic).

Follow jurisdictional policies, and toxicology lab policies as applicable, for drying and packaging forensic samples, as well as for packaging evidence that cannot be dried thoroughly at the exam facility. With wet evidence, the goal is to preserve that evidence while preventing leakage and contamination of other evidence. Dried specimens generally do not require refrigerated storage; wet items generally need refrigeration. Also, to maintain the integrity of forensic samples, it is critical to properly label, seal, and document the chain of custody during specimen collection through their release to law enforcement.¹⁹⁸



For children with disabilities who utilize assistive devices (e.g., motorized wheelchairs and telecommunications equipment) and/or service animals: If either is considered as forensic evidence in a case, they can be swabbed and photographed, with the same intent and process used to collect and photo-document evidence from the body. They should not be taken away from the child. (See [B2. Initial Response](#))

| <i>Guidance on Common Forensic Sampling</i> | | |
|---|---|--|
| Forensic Sample and Type/Nature of Abuse | Possible Material and Timing of Collection | Supplies and Sampling Instructions <i>Label/seal as per jurisdictional policies</i> |
| <p>Sample: Oral swabs¹⁹⁹</p> <p>When there may have been genital/oral penetration with or without ejaculation</p> | <p><i>Seminal fluid if oral penetration</i></p> <p>Timing: Continuous rinsing of the mouth with saliva and acts of eating and drinking fluid will limit the amount of DNA in the sample.²⁰⁰</p> | <p><i>Sterile cotton-tipped swabs</i></p> <ul style="list-style-type: none"> Use two dry swabs to swab/rub over the oral cavity (e.g., under tongue, around teeth, cheeks, and gums). |

¹⁹⁸ The Technical Working Group on Biological Evidence Preservation (2013) offers a resource at www.nist.gov/forensics/upload/NIST-IR-7928.pdf for those involved in biological evidence storage, tracking, preservation, and disposition.

¹⁹⁹ Use of dental floss is not recommended for additional forensic evidence collection in cases with oral penetration. Flossing can create increased opportunity for infection through micro-trauma to the gums.

²⁰⁰ Although there is not current research to support extended hours for collection of oral evidence, research findings may be limited due to time frame guidelines for collection utilized by jurisdictions.

Guidance on Common Forensic Sampling

| Forensic Sample and Type/Nature of Abuse | Possible Material and Timing of Collection | Supplies and Sampling Instructions <i>Label/seal as per jurisdictional policies</i> |
|--|---|---|
| <p>Sample: Buccal swabs</p> <p>In all cases of forensic evidence collection</p> | <p><i>Patient reference DNA sample</i>²⁰¹</p> <p>Note: Use buccal swab as the reference sample unless it is absolutely medically or forensically necessary to take blood. For example, in the case of recent oral penetration, a blood sample might need to be considered to avoid contamination (De Jong, 2011).</p> | <p><i>Sterile cotton-tipped swabs</i></p> <ul style="list-style-type: none"> • Use two swabs to swab/rub over the inner aspect of each cheek. • Collect the buccal swab as the patient DNA standard after the oral swab is obtained—rinse mouth after the oral swab is obtained and before collection of the buccal swab (De Jong, 2011). |
| <p>Sample: Blood</p> <p>Only if alcohol- or drug-facilitated sexual abuse is disclosed or suspected</p> <p><i>and/or</i></p> <p>If buccal swab is not acceptable for reference DNA sample²⁰²</p> | <p><i>Presence of alcohol/drugs in blood</i></p> <p>Timing: Collect if ingestion of alcohol or drugs used to facilitate sexual abuse may have occurred within 24 hours prior to the exam or if time of ingestion is uncertain (Society of Forensic Toxicologists [SOFT], n.d.).</p> <p>Note: Due to potential emotional trauma to the child, avoid taking blood samples unless absolutely necessary. If collected, use the most noninvasive methods (Ohio Chapter of the AAP Committee on Child Abuse and Neglect, 2009).</p> | <p><i>For toxicology sample:</i></p> <p><i>Alcohol-free prep pad/betadine swab</i></p> <p><i>Gray-top tube (contains preservatives sodium fluoride and potassium oxalate) or as per jurisdictional policy</i></p> <p><i>Pediatric needle and blood tube as needed</i></p> <ul style="list-style-type: none"> • Check expiration date on the tube and replace, if expired. • Collect the maximum amount of venous blood allowable by weight of child per blood draw.²⁰³ • Refrigerate when stored, as per toxicology lab policy. |

²⁰¹ Note that biological samples and DNA profiles from patients should be used only for investigation of the sexual abuse. Neither should be provided to law enforcement or prosecution for other cases in which patients may be suspected of juvenile delinquency, inadvertently given to health insurance carriers, or used for research purposes without consent. (One exception is that a forensic lab may input frequency information related to DNA profiles in its statistical database. In this case, victims' identity should remain anonymous. Another variable to consider, however, is that each state/territory's statutes determine who can have access to records of child abuse and neglect reports maintained by state child protective service or social service agencies—some may allow researchers to access some information in these records (See Child Welfare Information Gateway, 2013b.) In addition to secure storage and disposal of forensic samples as discussed in [A5e. Evidence Integrity](#), criminal justice agency policies should be in place and followed for appropriate disposal of children's DNA profiles.

²⁰² Most jurisdictions and crime labs accept buccal swabs. If they do not, however, consider dried blood sample cards, unless drawn blood is needed for medical or toxicological reasons.

²⁰³ Labs doing toxicology testing request the maximum amount of blood volume allowable by weight of child (see the chart at www.ucdmc.ucdavis.edu/clinicaltrials/StudyTools/Documents/Blood_Draws_Maximum_Allowable.doc by the UC Davis Medical Center). As noted, it is similar to ones used by: Committee on Clinical Investigations, Children's Hospital, Los Angeles, California; Baylor College of Medicine, Dallas, Texas; and Cincinnati Children's Hospital Institutional Review Board, Ohio (Adapted by: R. Jack, Children's Hospital and Regional Medical Center Laboratory, Seattle, Washington, 2001). If the child has coexisting medical conditions, it might lead to taking less than the maximum amount of blood volume by weight.

Guidance on Common Forensic Sampling

| Forensic Sample and Type/Nature of Abuse | Possible Material and Timing of Collection | Supplies and Sampling Instructions <i>Label/seal as per jurisdictional policies</i> |
|---|--|--|
| <p>Sample: Urine</p> <p>If alcohol- or drug-facilitated sexual abuse is disclosed or suspected</p> | <p><i>Presence of alcohol or drugs in urine</i></p> <p>Timing: Collect if ingestion of alcohol or drugs used to facilitate sexual abuse may have occurred within 120 hours prior to the exam (SOFT, n.d.; United Nations [UN] Office on Drugs and Crime, 2011).</p> | <p><i>Appropriate sterile container with at least 1.5% sodium fluoride preservative</i></p> <ul style="list-style-type: none"> • Collect as soon as possible after the event as drugs are quickly eliminated from body. • If collecting specimen prior to other evidence collection, instruct not to wipe (Massachusetts Department of Public Health, 2005). • Collect a minimum of 30 mL of urine (up to maximum amount that can be obtained). • Refrigerate or freeze when stored, as per toxicology lab policy. |
| <p>Sample: Fingernail swabs</p> <p>If the patient broke a fingernail during abuse or scratched or dug at the body of the assailant</p> | <p><i>Skin, blood, saliva, fibers, etc. (from assailant); and for comparison with any broken nails found at the crime scene</i></p> <p>Note: Prior to taking fingernail specimens, photograph fingernail damage that may have been related to the abuse.</p> | <p><i>Sterile cotton-tipped swabs × 2</i></p> <p><i>Sterile water</i></p> <ul style="list-style-type: none"> • Moisten first swab with water and clean under fingernails; repeat with the second dry swab (two swabs for each hand). • Only collect fingernail clippings if a nail was broken during the abuse. |

Guidance on Common Forensic Sampling

| Forensic Sample and Type/Nature of Abuse | Possible Material and Timing of Collection | Supplies and Sampling Instructions <i>Label/seal as per jurisdictional policies</i> |
|--|---|---|
| <p>Sample: Clothing</p> <p>If the patient is wearing the same clothes as at the time of the abuse (even if they have been washed)</p> <p>If the patient has changed clothes since the abuse, collect underpants only (if underpants are worn)</p> <p><i>Clothing worn during or immediately after the abuse may also be brought to the examination rather than worn by the child.</i></p> | <p><i>Adherent foreign material (e.g., semen, blood, hair, saliva, and fibers from or touched by the assailant and/or from the crime scene)</i></p> <p>Note: Although foreign matter can be washed or worn off the body, the same substances may be found intact on clothing for a considerable length of time following the abuse. There may also be alternations to clothing as a result of the abuse (e.g., a rip or loss of a button).</p> <p>Note: Carefully evaluate the need to take coats and shoes, as loss of these items may represent a financial burden to the child’s family. If necessary, the exam facility, in coordination with victim advocacy program, may be able to offer replacement clothing.</p> | <p><i>Paper bags</i></p> <p><i>Collection paper</i></p> <ul style="list-style-type: none"> • Follow jurisdictional policies for collection of clothing items. • Each piece of dry clothing and collection paper used should be placed in a separate paper bag.²⁰⁴ • Follow jurisdictional policies for packaging items too wet to dry at the exam facilities and for refrigerated storage. |
| <p>Sample: Diapers, pull-ups, or other absorbent padding, condoms</p> <p>If the patient was wearing a diaper or padding of any kind at the time of the abuse or immediately following</p> <p>If a condom is found in or on the patient's body from the abuse</p> <p><i>These items may also be brought to the examination rather than worn by the child.</i></p> | <p><i>Body fluids/DNA or other foreign material (e.g., semen, blood, hair)</i></p> | <p><i>Materials as per jurisdictional policy</i></p> <ul style="list-style-type: none"> • Collect these items if used during or after touching or any genital copulation. Dry, package, and submit as per jurisdictional policy. • For condoms: Collect, dry, and package as per jurisdictional policy, noting drying and packaging techniques that are recommended by crime labs can differ (Technical Working Group on Biological Evidence Preservation, 2013). • Follow jurisdictional policies for packaging items too wet to dry at the exam facilities and for refrigerated storage. |

²⁰⁴ For patients with mobility impairments, put the collection sheet on the exam table and leave it in place until the examination is completed. If patients prefer to disrobe in their wheelchairs, sheets can be tucked around the wheelchair to catch debris. Avoid putting chairs on paper, as debris from wheels may contaminate forensic evidence (Massachusetts Department of Health, 2005).

Guidance on Common Forensic Sampling

| Forensic Sample and Type/Nature of Abuse | Possible Material and Timing of Collection | Supplies and Sampling Instructions <i>Label/seal as per jurisdictional policies</i> |
|--|--|---|
| <p>Sample: Other body surface swabs and specimens</p> <p><i>If there are areas on the skin where saliva, semen, or other bodily fluids from assailant may have been deposited (e.g., around the mouth in the case of oral abuse), or the assailant may have touched</i></p> <p><i>If foreign material or debris is seen, collect specimen²⁰⁵</i></p> | <p><i>Body fluids/DNA; other possible foreign materials, such as vegetation, matted hair, or foreign hairs²⁰⁶</i></p> <p>Note: Use of an ALS may help guide collection of swabs. (See A4c. Equipment and Supplies)</p> <p>Note: Debris and the assailant’s body fluids/DNA could also be found on equipment used by patients with physical impairments, such as wheelchairs, scooters, canes, wheelchair pads, assistive communication devices, catheters, and service animals.</p> | <p><i>Cotton-tipped swabs × 2 per site</i></p> <p><i>Sterile water</i></p> <ul style="list-style-type: none"> • Moisten first swab with water and swab/rub over sites where semen, body fluids, or DNA may be present. • Repeat with the second dry swab. <p><i>Bindle</i></p> <ul style="list-style-type: none"> • Place foreign material in bindle, and enclose and seal in evidence envelope. |
| <p>Sample: Swabs of female genitalia</p> <p><i>If possible vaginal/penile penetration, other genital-to-genital contact, or contact that could have left biologic material including oral-to-genital</i></p> | <p><i>Body fluids/DNA; other possible foreign material</i></p> | <p><i>Cotton-tipped swabs</i></p> <p><i>Sterile water</i></p> <ul style="list-style-type: none"> • Moisten first swab with water and thoroughly swab/rub over the labia majora; repeat with the second dry swab.²⁰⁷ Alternately, two swabs can be lightly moistened and the sample sites swabbed simultaneously with both swabs. • Repeat same procedure as needed per additional sample site. |

²⁰⁵ If the patient has vomited, treat it as a supplemental specimen. Vomit samples are mainly used as a toxicological specimen in drug-or alcohol-facilitated cases. Collect as much of the sample as possible by using a spoon, eyedropper-type suction device, or other tool that is consistent with biohazard procedures. Place in appropriate container that has a lid with a tight seal. Follow jurisdictional policy for refrigerated storage. If any vomitus is on clothing, sheets, or other objects, also put the items in an appropriate container to prevent leakage and contamination (Ohio Chapter of the AAP Committee on Child Abuse and Neglect, 2009).

²⁰⁶ Although there is not current research to support extended hours for collection of such evidence on the child’s skin, research findings may be limited due to time frame guidelines for collection utilized by jurisdictions.

²⁰⁷ For example, if there was penetration of the labia into the vestibule, it would be appropriate to wet-dry swab the outer surface of the labia majora, and then to dry swab the inner aspect of the labia majora in the vestibule that is already moist, as well as the fossa (without contacting the hymen).

Guidance on Common Forensic Sampling

| Forensic Sample and Type/Nature of Abuse | Possible Material and Timing of Collection | Supplies and Sampling Instructions <i>Label/seal as per jurisdictional policies</i> |
|--|---|--|
| <p>Sample: Penile swabs</p> <p>Penile shaft and prepuce (foreskin); glans and scrotum <i>If possible penile/vaginal penetration, other genital-to-genital contact, oral contact, anal or rectal contact, or foreign material disclosed or suspected (e.g., lubricant)</i></p> | <p><i>Body fluids/DNA; other material</i></p> | <p><i>Cotton-tipped swabs</i></p> <p><i>Sterile water</i></p> <ul style="list-style-type: none"> • Moisten first swab with water and swab/rub over the shaft of the penis and prepuce/foreskin (when present); repeat with the second dry swab. • Repeat the same procedure for the glans and scrotum, avoiding the urethra (swabs from the urethra will result in obtaining the patient’s own DNA). |
| <p>Sample: Anorectal swabs (perianal and anal canal)</p> <p><i>If possible anal/penile or rectal/penile penetration, oral/anal penetration or contact, digital/object penetration or contact by assailant, or foreign material or object</i></p> | <p><i>Body fluids/DNA; other material</i></p> | <p><i>Cotton-tipped swabs</i></p> <p><i>Sterile water</i></p> <ul style="list-style-type: none"> • Moisten first swab with water and swab/rub over perianal area/folds; repeat with the second dry swab. • Using another two swabs, repeat the same procedure for the anal canal. |
| <p>Sample: Bite mark swabs</p> <p><i>If bite marks are present</i></p> | <p><i>Body fluids/DNA; other material</i></p> <p>Note: In addition to documenting, photographing, and swabbing bite marks, an odontologist may need to make casts, in order to match teeth to suspects. See Riviello (2013) for related guidelines.</p> <p>Note: Use of an ALS may help guide identification of bite mark evidence, especially if fading.</p> | <p><i>Cotton-tipped swabs × 2 per site</i></p> <p><i>Sterile water</i></p> <ul style="list-style-type: none"> • Moisten first swab with water and swab the areas inside and around the arches of the bite mark rather than from the tooth marks—this technique maximizes the yield of DNA containing material from sites where the lips and tongue of the biter would touch (Kaplan, 2011). • Repeat with the second dry swab. |

Guidance on Common Forensic Sampling

| Forensic Sample and Type/Nature of Abuse | Possible Material and Timing of Collection | Supplies and Sampling Instructions <i>Label/seal as per jurisdictional policies</i> |
|--|--|--|
| <p>Sample: Head hair</p> <p><i>If it is disclosed or suspected that the assailant has shed hair, or foreign materials from the assailant or crime scene may have been transferred to the patient's head hair</i></p> <p><i>In cases of delayed reports of suspected alcohol- or drug-facilitated sexual abuse or if chronic exposure to drugs is disclosed or suspected</i></p> | <p><i>Foreign material: hair, other; presence of drugs</i></p> <p>Note: Many jurisdictions do not routinely collect plucked hair reference samples. Some will only collect these if the lab requests it at a later time.²⁰⁸</p> <p>Note: In cases of delayed reports of suspected alcohol- or drug-facilitated sexual abuse or if chronic exposure to drugs is disclosed or suspected, collect head hair²⁰⁹ at least 4 weeks after abuse. Hair analysis might help in identifying drug(s) used or chronic drug exposure.</p> | <p><i>Fine tooth comb, scissors</i></p> <p><i>Collection paper</i></p> <ul style="list-style-type: none"> • Place paper under the patient's head. • Comb hair so that loose foreign material falls onto the paper. • Remove the paper, place comb in center, and fold the paper to retain comb and specimen. • For delayed reports/chronic exposure, collect at least 2 head hair samples (thickness of a pencil) by cutting them as close to the scalp as possible.²¹⁰ • Follow jurisdictional/toxicology lab packaging/storage policies. |



Contact staff at Kidsta.org with questions related to evidence collection and for suggestions regarding accommodations in specific situations with children with disabilities.

²⁰⁸ Whatever the jurisdictional policy, patients should be informed about the purpose of collection, procedures used to collect samples, discomfort that may be involved, and how these samples may be used during the investigation and prosecution. If hair reference samples are not collected at the initial examination, examiners should inform patients that a need might exist to collect these samples for crime lab analysis at a later date. They should be aware that hair evidence collected at a later date may not be as conclusive as if it were collected at the time of the initial examination (e.g., due to the fact that hair characteristics can change over time). When these samples are collected, the indications, timing, and techniques vary. Jurisdictional policies should be in place and followed.

²⁰⁹ Head hair is the preferred sample, but pubic, axillary, torso, or leg hair may also be collected for analysis (UN Office on Drugs and Crime, 2011). However, prepubescent children typically have limited to no hair in these areas. Analysis in such instances could also be limited because as the growth rate of non-head hair is not well established as is with head hair (UN Office on Drugs and Crime, 2011).

²¹⁰ Sufficient hair collection is needed to be able to carry out routine tests and allow for a repeat analysis or confirmation test by a second laboratory—if necessary, hair samples can be collected from one or multiple site on the head (Cooper, Kronstrand, & Kintz, 2012). See the Society of Hair Testing at www.sohr.org/index.php/statements/9-nicht-kategorisiert/85-statement-2011 for more detailed collection instructions.

B9. Sexual Abuse Facilitated by Alcohol and Drugs

These recommendations are for pediatric examiners and other involved entities for responding to child sexual abuse that is/is suspected of being facilitated with alcohol or drugs.

Recognize there are multiple ways in which the use of alcohol or drugs may contribute to an act of sexual abuse against a prepubescent child.²¹¹ Perpetrators may overtly or surreptitiously use alcohol, “drugs of choice” in drug-facilitated sexual violence, such as rohypnol and gamma hydroxy butyrate (GHB) and other illegal drugs, as well as prescription and over-the-counter medications such as antihistamines, anticholinergics, and antitussives (Bechtel & Holstege, 2007). They may seek out children who have used substances (e.g., a child who was sex trafficked may routinely be given substances).

| | |
|--|---|
| <p>Children may be intentionally sedated using alcohol and drugs specifically to facilitate sexual abuse. Caregivers may also sedate children to “knock them out” during a party, when going to work, etc., which leaves children at greater risk for abuse and neglect. Children may or may not be aware that alcohol or drugs have been administered.</p> | <p>Substances may be used to induce drowsiness and deep sleep (Bechtel & Holstege, 2007) or cause hypnotic, amnesic, even mentally clouded or dulled response to prevent the child from resisting or having any recollection (Bechtel & Holstege, 2007; Spiller et al., 2007). For example, children used in pornography may have no recall of the sexual abuse depicted in photographs or on video/film (Spiller et al., 2007). Note that it is important during medical forensic care to avoid showing these photographs or videos/films to children as it could cause a highly traumatic response.</p> |
| <p>Children may live or spend time in clandestine drug houses and be exposed to drug cultivation, manufacturing by-products, use, sale, and distribution (often called “drug-endangered” children).</p> | <p>An example of such an environment is a methamphetamine laboratory.²¹² Caregivers’ substance misuse can interfere with their ability to provide a safe and nurturing environment for their children (National Alliance for Drug Endangered Children, 2015). In these situations, there is an increased risk of child abuse and neglect, including sexual abuse (National Alliance for Drug Endangered Children, 2015).²¹³</p> |
| <p>Older prepubescent children may experiment voluntarily with alcohol and drugs, especially if they live or spend significant time in an environment where they have access to these substances.²¹⁴</p> | <p>The cognitive and physical impairment associated with substance use alone (see Russell, 2008) makes these children in particular easy targets for sexual predators. As noted by Lisak (2005), perpetrators of sexual violence in general have become extremely adept at identifying vulnerable individuals and exploiting their vulnerabilities.</p> |

²¹¹ Hartley, Mullings, and Marquart (2013) found that in 9 percent of cases with victims from age 3 to 18, victims were given alcohol/drugs before the abuse. However, most involved adolescent victims.

²¹² See Swetlow (2003).

²¹³ The Child Welfare League of America (2001) noted that children whose caregivers abuse alcohol or drugs are three times more likely to be verbally, physically, or sexually abused, and four times more likely than other children to be neglected. In addition to the risk of child maltreatment, drug-endangered children may face health risks caused by exposure to drug manufacturing (Bechtel & Holstege, 2007), witness and experience all kinds of violence, be sold or traded for drugs, and be used as decoys by drug dealers (National Alliance for Drug Endangered Children, 2015). They may be exposed to communicable diseases such as HIV and hepatitis C through exposure to needles used by IV drug users and to a range of STDs via sexual abuse (Grant, 2007). To survive, these children may resort to committing crimes such as stealing food and money and be trafficked for sex and labor (National Alliance for Drug Endangered Children, 2015).

²¹⁴ Note that children with a history of sexual abuse may be more likely to use alcohol and drugs than their nonabused counterparts (Harrison et al., 1997; Smith & Saldana, 2013).

Educate responders on appropriate practices for responding to prepubescent child sexual abuse cases where alcohol and/or drugs are suspected to be involved, as per jurisdictional policy. If they do not already exist, agency/facility and multidisciplinary response team policies should be developed to guide immediate response to various scenarios involving suspected alcohol-or drug-facilitated sexual abuse of children. Note that jurisdictions may have interagency protocols to respond to cases involving drug-endangered children. Health care personnel also need to adhere to facility policy regarding (1) asking patients about alcohol and drug use in the course of intake and treatment; and (2) testing for alcohol and/or drugs if deemed medically necessary. They also need to know lab facilities designated by the jurisdiction for toxicology testing for forensic purposes and their collection and preservation policies.

Be aware that routine toxicology testing is not recommended in prepubescent child sexual abuse cases. However, the possibility of alcohol or drug involvement in the sexual abuse should routinely be considered. ***The collection of toxicology samples may be indicated in situations including but not limited to the following*** (drawn from the Commission on the Standardization of the Collection of Evidence in Sexual Assault Investigations, 2013):

- If a child's medical condition appears to warrant toxicology screening for optimal care (e.g., the child presents with drowsiness, fatigue, light-headedness, dizziness, physiologic instability, memory loss, impaired motor skills, or severe intoxication);
- If there is a suspicion that the child was or may have been drugged or exposed to alcohol or drugs (follow jurisdictional policies for testing when children are exposed to methamphetamine laboratories); and/or
- If there is a suspicion of alcohol/drug involvement (e.g., due to the child's lack of recollection of events).

This information is gleaned in the course of the medical history taking and the examination and must take into account the child's developmental level and time frame for collection of toxicology samples.

In situations where it is revealed there is voluntary use of substances by children, this fact should not diminish the seriousness of the sexual abuse. Responders should guard against dismissing such cases. They should be aware that children might be reluctant to disclose voluntary use due to a fear of being disciplined or discounted by a caregiver or legal authorities. Children and caregivers should be informed what actions, if any, could potentially follow such a disclosure.

If there is indication for toxicology testing, inform children and caregivers of the following (in a manner that is developmentally appropriate for children and linguistically appropriate for children and caregivers):

- The purposes of toxicology testing and that testing results will be shared with the investigative team;
- The ability to detect and identify drugs and alcohol depends on collection of toxicology samples within a limited time period following ingestion;

- There is no guarantee that testing will reveal that substances were used to facilitate the abuse;
- Testing may reveal other drugs or alcohol that patients may have ingested;
- Follow-up testing and/or treatment may be necessary if testing reveals the presence of drugs;
- Not having testing done when indicated as described above may negatively impact safety planning for the child, as well as the investigation and/or prosecution;
- Who will pay for toxicology testing (noting testing done as part of forensic evidence collection typically may be paid for by a involved government entity); and
- When and how children and caregivers can have access to the results of the toxicology tests.

Collect toxicology samples as indicated. The child's urine and blood can be tested for toxicology purposes, if collected within the time frames indicated for testing, as discussed in the following list. Other samples may be sought depending on case circumstances. Some additional issues to be aware of are noted below.

- ***The length of time that alcohol and drugs remain in urine or blood is affected by a number of variables*** (e.g., the type and amount of drug ingested, child's body size and rate of metabolism, whether the child had a full stomach, and whether the child previously urinated) (American Prosecutors Research Institute, 1999). Urine is "the specimen of choice" for a toxicological investigation involving alcohol- or drug-facilitated sexual abuse as it allows for a longer window of detection of substances than does blood (LeBeau et al., 1999). The sooner a urine specimen is obtained after its ingestion, the greater the chances of detecting substances that are quickly eliminated from the body (LeBeau, 1999). Blood samples for toxicology purposes would be collected only during acute examinations; urine samples could potentially be collected during acute and nonacute care.
- ***Collect the first available urine*** within 120 hours of the abuse (SOFT, n.d.; UN Office on Drugs and Crime, 2011). The urine sample does not have to be a clean catch as bacteria in the urine will not compromise test results. If children cannot wait to urinate until arriving at the health care facility, first responders should ask them or caregivers to collect a sample and bring it to the facility, documenting the chain of custody. Law enforcement officers, emergency medical technicians, and child protective service responders should have specimen cups and instructions for collection readily available, according to agency policy. Ideally, patients should not urinate until after evidence is collected. However, the number of times that patients urinated prior to collection of the sample should be documented.
- ***Collect a blood sample if it is within 24 hours since the abuse*** (SOFT, n.d.).²¹⁵ It may pinpoint the time when drugs were ingested (American Prosecutors Research Institute, 1999). If a blood sample is collected for toxicology screening, it should be accompanied by a urine sample. If a blood-alcohol determination is needed, collect blood within 24 hours of alcohol ingestion, as per jurisdictional policy. If blood has already been taken due to suspected drug ingestion, that

²¹⁵ Note that while the SOFT time frame for blood collection is 24 hours after the sexual abuse, the UN Office on Drugs and Crime (2011) extends the time frame to 48 hours.

sample can be used to determine blood-alcohol level. Another sample usually is not required.

- **Consider if there is a need to collect a hair sample**, as it may be useful in situations where there is a considerable delay in reporting suspected alcohol/drug-facilitated sexual abuse and/or a concern about a child's chronic exposure to drugs. Unlike urine or blood, hair may be able to confirm long-term exposure to drugs over a period of weeks to months after ingestion (Cooper, Kronstrand, & Kintz, 2012). Positive hair testing is not always associated with the act of sexual abuse as far as timing, but in the prepubescent population, it can indicate use of a nontherapeutic drug or drugs (De Jong, 2011).
- **Consider if there are any other potential sources for toxicology testing**. For example, containers that may hold drug residue or samples of the child's vomit.
- **Know toxicology sampling instructions for the designated toxicology labs used by the jurisdiction**. For convenience, the guidance offered in [B8. Evidence Collection](#) is provided below (see [B8. Evidence Collection](#) for footnote references).

Toxicology Sampling Instructions

| Sample | Timing | Supplies | Sampling Instructions |
|------------------|--|--|---|
| Urine | If alcohol- or drug-facilitated sexual abuse is suspected, collect within 120 hours of the abuse. | Appropriate sterile container with at least 1.5% sodium fluoride preservative | <ul style="list-style-type: none"> • Collect as soon as possible after the event, as drugs are quickly eliminated from the body. • If collecting a urine specimen prior to other evidence, instruct the child not to wipe. • Collect a minimum of 30 mL of urine (up to maximum amount that can be obtained). • Refrigerate or freeze when stored, as per toxicology lab policies. |
| Blood | If alcohol- or drug-facilitated sexual abuse is suspected, collect within 24 hours of the abuse. | Alcohol-free prep pad/betadine swab, gray-top tube (contains preservatives sodium fluoride and potassium oxalate) or as per jurisdictional policy, and pediatric needle and blood tube | Collect maximum amount of venous blood allowable by weight of child per blood draw. Refrigerate when stored, as per toxicology lab policies. |
| Head Hair | In cases of delayed reports of suspected alcohol- or drug-facilitated sexual abuse and/or if chronic exposure to drugs is suspected, collect at least 4 weeks after abuse. | <ul style="list-style-type: none"> • Scissors • Collection paper | <ul style="list-style-type: none"> • Collect at least two head hair samples (thickness of a pencil) by <u>cutting</u> hair as close to the scalp as possible. • Store at room temperature, in a dry environment protected from light, as per toxicology lab policies. |
| Other | <p>If child vomits in a suspected alcohol- or drug-facilitated case, collect vomit samples.</p> <p>If containers might have drug residue of drugs used to facilitate the sexual abuse, collect containers.</p> | <ul style="list-style-type: none"> • Collection tool (e.g., spoon, eyedropper-type suction device, or other tool that is consistent with biohazard procedures) • Collection container has a lid with a tight seal to prevent leakage and contamination • Packaging for containers | <ul style="list-style-type: none"> • Collect vomit sample using collection tool. Place in container and seal. If vomit is on clothing, sheets, or other objects, put items in container and seal (OH Chapter of the AAP Committee on Child Abuse and Neglect, 2009). • Follow toxicology lab policies for refrigerated or frozen storage. • Containers with drug residues should be packed individually in order to avoid cross-contamination of biological samples. • Follow toxicology lab policies on storage for dry and wet items. |



For toxicology, the more urine and blood to test the better. That said, follow pediatric guidelines for collecting blood specimens from a child (B. Freeman, personal communication, June 25, 2015).

If toxicology tests are needed purely for medical care, the exam facility lab typically performs these tests. If toxicology samples are needed for both clinical and forensic purposes, one sample can be collected for immediate evaluation by the exam facility lab and another for analysis by the identified forensic toxicology lab. Collect these samples at the same time to avoid further discomfort to children.

As mentioned in [B8. Evidence Collection](#), keep toxicology samples separate from samples collected for the jurisdictional evidentiary kit and note that procedures for toxicology collection, preservation, and analysis may differ from that of other evidence analysis. Exam facility laboratories should not analyze forensic toxicology samples in suspected alcohol- or drug-facilitated sexual abuse cases. Instead, involved investigative agencies should identify forensic laboratories that can analyze toxicology samples (American Prosecutors Research Institute, 1999). Information about the identified labs (e.g., contact information; what specifically they test; and procedures for specimen collection, packaging, labeling, sealing, refrigerated storage, handling, and transfer to the testing site, including transportation and delivery) should be provided to investigating agencies, exam facilities, and examiners. As with any forensic evidence, the chain of custody must be maintained and documented.²¹⁶



Note that which toxicology lab to use depends on its testing equipment and methods. If testing methods are not sensitive enough, the small amount of substances that may be in a child's system may be missed (a perpetrator might purposely use only a very small amount to avoid detection).

However, toxicology testing with prepubescent children is often more clear-cut than with adults, since all alcohol and drugs in a child's system are problematic, beyond prescribed medications and the few substances that can cross through breast milk if the child is being breast-fed (B. Freeman, personal communication, June 25, 2015).

²¹⁶ See SOFT at <http://soft-tox.org/dfcc> for further guidance on toxicology sampling, as well as the UN's 2011 *Guidelines for the Forensic Analysis of Drugs Facilitating Sexual Assault and Other Criminal Acts* at www.unodc.org/documents/scientific/forensic_analysis_of_drugs_facilitating_sexual_assault_and_other_criminal_acts.pdf.

B10. Sexually Transmitted Disease Evaluation and Care

These recommendations are for pediatric examiners on Sexually Transmitted Disease (STD) evaluation and care.

Integrate the evaluation and care of sexually transmitted diseases (STDs) into the medical forensic examination of prepubescent children who disclose sexual abuse or for whom sexual abuse is suspected.²¹⁷ Contracting a STD from a perpetrator during sexual abuse is a risk that must be considered for this population.²¹⁸ Medical forensic care should include evaluation for STDs for two purposes: (1) to determine if a STD is present, so it can be treated; and (2) to acquire evidence for potential use in legal investigations. Mechanisms should also be in place in any setting where children are examined for STDs to ensure continuity of care, including timely review of test results, and to monitor compliance with and adverse reactions to any therapeutic or prophylactic regimens (CDC, 2010).

Recognize that the diagnosis of a STD in a prepubescent child may be evidence that the child has experienced sexual abuse. The CDC (2015e) noted the identification of sexually transmissible agents in children beyond the neonatal period *strongly suggests* sexual abuse (Jenny, Crawford-Jakubiak, & Committee on Child Abuse and Neglect, 2013).²¹⁹ However, the significance of the identification of a sexually transmitted agent in a child as evidence of possible sexual abuse varies by pathogen (CDC, 2015e): Postnatally acquired *Neisseria gonorrhoea*,²²⁰ syphilis, *Chlamydia trachomatis* infection,²²¹ and nontransfusion, nonperinatally acquired HIV²²² are *indicative* of sexual abuse; and sexual abuse *should be suspected* when *Trichomonas vaginalis*, genital herpes, or anogenital warts are diagnosed.²²³

In any case that a prepubescent child presents with a STD, conduct an investigation into the risk factors and contacts, obtain a medical and social history, and evaluate for sexual abuse (Black et al., 2009; CDC, 2015e; Jenny, Crawford-Jakubiak, & Committee on Child Abuse and Neglect, 2013; Girardet et al., 2011). Examiners should be aware of which types of STDs in children need to be reported to law enforcement or child protective services, if the case is not already being investigated as suspected abuse (American College of Emergency Physicians [ACEP], 2013; CDC, 2010).

²¹⁷ Much of the information in this chapter was drawn from the CDC's *Sexually Transmitted Diseases Treatment Guidelines* (2015)—see www.cdc.gov/STD/treatment/ (CDC general phone: 800-311-3435, TTY: 888-232-6348). The guidelines are updated periodically. Also see the CDC at www.cdc.gov offers information on related research, news, and Internet links.

²¹⁸ As for the risk of a prepubescent child acquiring a STD as a result of sexual abuse, the CDC (2015e) indicated that the issue has not been well studied. Black et al. (2009) found that 4.9 percent of prepubescent female sexual abuse victims tested positive for either *Chlamydia trachomatis* or *Neisseria gonorrhoea*.

²¹⁹ The CDC (2015e) provides several examples of exceptions to this general rule.

²²⁰ Jenny, Crawford-Jakubiak, and the Committee on Child Abuse and Neglect (2013) noted that genital and anal infections with *N gonorrhoea* are rarely acquired perinatally, and, outside the newborn period, are considered likely to be caused by sexual abuse.

²²¹ The CDC (2015e) and Jenny, Crawford-Jakubiak, and the Committee on Child Abuse and Neglect (2013) indicated that *C trachomatis* infections might be indicative of sexual abuse in children 3 years of age or older and among those less than 3 years of age, when infection is not likely perinatally acquired.

²²² Jenny, Crawford-Jakubiak, and the Committee on Child Abuse and Neglect (2013) noted HIV infection in children who have not been exposed to the virus perinatally, through blood products, or by needles, are also highly likely to be caused by sexual abuse.

²²³ Jenny, Crawford-Jakubiak, and the Committee on Child Abuse and Neglect (2013) noted that herpes simplex virus and genital warts (human papillomavirus or HPV) can be sexually transmitted in children, but these infections are not diagnostic of sexual abuse by themselves.

Provide STD information to children and caregivers (in a manner that is developmentally appropriate for the child and linguistically appropriate for the child and caregiver). As needed in a specific case, examiners should offer information about the risks of STDs for this population, symptoms, the necessity of testing, treatment options upon diagnosis (including benefits and side effects), and follow-up testing and care (adapted from CDC, 2010). As available in a community and appropriate for prepubescent children, examiners should also offer referrals for follow-up services that include free and low-cost testing, counseling, and treatment offered in the community. In addition, children and caregivers should be told that STD testing results will be shared with investigative agencies,²²⁴ and that victim advocates (as available in the community) can provide emotional support, information, and access to/referrals for counseling through follow-up treatment.

On an individual case-by-case basis, consider the need for STD testing. In each sexual abuse case, children should be evaluated for STD risk. They may or may not require diagnostic testing based on their presentation, the examination, and assessment of risk (from sexual abuse and additional exposure that might have occurred since the abuse). (See [Appendix 8. Prepubescent STD Testing Algorithm](#))

Factors that indicate the need for STD testing for prepubescent children, regardless whether the case is acute or nonacute (CDC 2015; Jenny, Crawford-Jakubiak, & Committee on Child Abuse and Neglect, 2013).

- Child had experienced penetration or there is evidence of recently healed penetrative injury to genitals, anus, or oropharynx
- Child has been abused by a stranger
- Child has been abused by a perpetrator known to be infected with a STD or at high risk for STDs²²⁵ (e.g., intravenous drug abusers, men who have sex with men, people with multiple sex partners, and those with histories of STDs)
- Child has a sibling or other relative or person in the household with a STD
- Child lives in an area with a high rate of STDs in the community
- Child has signs or symptoms of STDs (e.g., vaginal discharge or pain, genital itching or odor, urinary symptoms, and genital lesions or ulcers)
- Child has already been diagnosed with one STD
- Child or caregiver requests STD testing

Test for specific organisms if indicated. (See below) If symptoms, signs, or evidence of a STD are present, the child should be screened for commonly occurring STDs (Black et al., 2009; CDC, 2015e; Girardet et al., 2011). The health and legal implications of test

²²⁴ Formal signed agreements amongst investigative agencies (and the multidisciplinary response team, if one exists) are critical to speak to the scope of information to be shared regarding STDs, especially if it is non-forensic information (e.g., if it was due to perinatal transmission). The investigative team must protect non-forensic medical history and information. The team should consider various scenarios and plan strategies to protect this type of information, so that it is not used inappropriately in the justice system or shared with anyone outside the team who should not have access to it. For example, the team should consider what a child protective service agency might do with non-forensic medical information of a child in a sexual abuse case, how confidential it will be in that child protection system, and implications of its availability in that system across the child's lifespan. All states and the District of Columbia allow minors 12 years of age and above to consent to STD services (Guttmacher Institute, 2015). However, in most jurisdictions, prepubescent children do not have this right. Health care providers should become familiar with the laws in their jurisdiction. If a caregiver who is a parent/guardian declines STD testing and treatment for their children in cases reported as suspected sexual abuse, health care providers should discuss with legal counsel the options for providing necessary testing and treatment.

²²⁵ For more information on risk for STDs, see CDC's *Sexually Transmitted Disease Surveillance 2014* (in particular the section on special focus profiles) at www.cdc.gov/std/stats14/default.htm. Also see www.cdc.gov/STD/.

results in prepubescent child sexual abuse cases justify the time, labor, and cost of performing STD tests with high specificities and sensitivity (CDC, 2015e). If diagnostic testing is necessary, examiners should document in the medical record what tests are performed and the results of testing. Follow the designated lab’s policy on identification of the patient from whom the specimen was collected, what specific specimen to collect, and the collection method for different organisms. Legal chain of custody for medical specimens is not required as with evidentiary specimens; the testing lab’s policy should ensure proper patient and specimen identification at both collection and testing, even if the test is sent to an external lab.

| General Guidance for Testing for Common STDs²²⁶ (Note HIV is addressed in next section) | | |
|--|--|---|
| Infection | Symptoms | Testing |
| <p><i>N gonorrhoea</i> (NG)</p> <p>This infection does not ascend the genitourinary track in prepubescent girls.</p> <p>This infection IS DIAGNOSTIC of child sexual abuse, once perinatal transmission has been ruled out.</p> | <p>Children with vaginal <i>N gonorrhoea</i> can be symptomatic (vaginal discharge) or asymptomatic</p> <p>Children with pharyngeal and rectal <i>N gonorrhoea</i> may be asymptomatic (Matthers & Rein, 2015)</p> | <ul style="list-style-type: none"> • Nucleic Acid Amplification Testing (NAAT) can be used to screen for <i>N gonorrhoea</i> in prepubescent girls (Adams et al., 2015; Black et al., 2009; CDC, 2015e; Papp, Schachter, & Gaydos, 2014).²²⁷ A NAAT urine specimen can be obtained as a “dirty” catch—a random voided, non-clean catch specimen (Black et al., 2009). In the absence of NAAT, obtain culture by swabs from the vulva and beside the vaginal orifice. • Culture remains the preferred testing method for urethral drainage from boys, as well as anal and oropharyngeal specimens from girls and boys (CDC, 2015e; Papp, Schachter, & Gaydos, 2014).²²⁸ • Retain all positive specimens at the lab for additional testing (CDC, 2015e). A positive NAAT result should prompt repeat testing by culture or alternate technology NAAT (alternate sequence confirmation). • Note a positive NAAT persists for weeks after effective treatment (WA, 2012). |

²²⁶ The chart was drawn from the CDC (2015e), Day and Pierce-Weeks (2013), and Washington State (2012), as well as others cited. Note that although hepatitis B virus (HBV) may be transmitted to a child during sexual abuse via semen and vaginal fluid, most HBV in children result from household exposure to persons with chronic HBV infection rather than sexual abuse (CDC, 2015e). For that reason, it was not included on this list. If a concern exists about HBV, diagnose via serologic testing (HBsAg). Note that results of HBsAg must be interpreted carefully; HBV can be transmitted nonsexually. HBV vaccine for prophylaxis should be administered in previously unimmunized patients. See CDC (2015e) section on viral hepatitis.

²²⁷ NAAT detects genetic material that is specific for an infecting organism (Esernio-Jenssen & Barnes, 2011). Although cultures have historically been considered the “gold standard” for child sexual abuse evaluations, they are invasive and costly, require stringent transporting and handling, and usually have long turn-around times (Esernio-Jenssen & Barnes, 2011). NAAT on urine, with confirmation by second NAAT or culture, is the “new forensic standard” for diagnosis of gonorrhoea and chlamydia in children who disclose sexual abuse or are suspected of being sexually abused (Black et al., 2009). The second NAAT should not be merely a repeat of the first, but instead, a NAAT run by a different amplification sequence (alternate sequence confirmation) (Black et al., 2009; Hammerschlag & Gaydos, 2012). Adams et al. (2015) recognized that NAAT has high sensitivity, allows for collection of sample noninvasively, and can test for gonorrhoea and chlamydia with one sample and at a lower cost compared to culture. Due to low prevalence of STDs in the prepubescent population, and the lack of enough large randomized controlled trials for validation, this testing is not yet approved by the Food and Drug Administration for this population. However, the CDC (2015e) discusses the use of NAAT for this population as indicated in protocol recommendations.

²²⁸ That said, many practitioners find it difficult to access cultures (Adams et al., 2015). NAATs (especially the Strand Displacement Amplification and Transcription Mediated Amplification) have been evaluated in adult studies of pharyngeal and anorectal infections and found to have superior sensitivity to detecting infection at these sites compared to culture and specificity rates (Adams et al., 2015).

General Guidance for Testing for Common STDs²²⁶ (Note HIV is addressed in next section)

| Infection | Symptoms | Testing |
|---|---|---|
| <p><i>C trachomatis</i> (CT) This infection does not ascend the genitourinary track in prepubescent girls.</p> <p>This infection IS DIAGNOSTIC of child sexual abuse, once perinatal transmission has been ruled out.</p> | <p>Vaginal or anal infection is frequently asymptomatic, and can persist for months or years</p> <p>If symptomatic: discharge, dysuria, and abdominal and rectal pain are possible (Amaya & Kellogg, 2011)</p> | <p>Same as for <i>N gonorrhoea</i> testing, except:</p> <ul style="list-style-type: none"> • Oropharyngeal specimens are not recommended—yield is low, perinatally acquired infection may persist past age 2, and some labs do not distinguish between <i>C trachomatis</i> and Chlamydia pneumonia. |
| <p><i>Syphilis</i> This infection IS DIAGNOSTIC of child sexual abuse, once perinatal transmission has been ruled out. Lack of prenatal identification of syphilis in the mother can result in vertical transmission of syphilis for up to 4 years after birth. Children presenting with primary infections after 6 months of age or secondary after 15 months should be presumed sexual abuse victims (Amaya & Kellogg, 2011).</p> | <p>Asymptomatic at primary inoculation on vulva, labia, penile, scrotal, anal, rectal, oral, or extra-genital site signs</p> <p>Secondary cutaneous and constitutional symptoms, but most are asymptomatic (WA, 2012)</p> | <ul style="list-style-type: none"> • Prevalence in children who have been sexually abused is quite low—testing is recommended only in high-risk situations. Differentiating perinatal from later-acquired syphilis may be challenging. • Dark field microscopy or direct fluorescent antibody (DFA) testing of exudate or tissue from primary or secondary lesion. • Serology: In absence of lesions, serologic testing for antibodies to <i>T. pallidum</i> is recommended. • See CDC (2015e) section on syphilis. |

General Guidance for Testing for Common STDs²²⁶ (Note HIV is addressed in next section)

| Infection | Symptoms | Testing |
|---|---|---|
| <p>Herpes simplex virus (HSV) This infection IS SUSPICIOUS of child sexual abuse. Need to rule out self-inoculation (a child with oral herpes may self-inoculate genitalia) or inoculation by an adult with oral or genital herpes during caretaking contact such as diaper changes (WA, 2012).</p> | <p>Dysuria, genital or perianal vesicles/ulcers</p> <p>Primary infection may be accompanied by malaise and fatigue (WA, 2012)</p> | <ul style="list-style-type: none"> • Obtain specimens from all mucocutaneous lesions and send for viral culture or polymerase chain reaction (PCR) testing (CDC, 2015e). Note culture is rapidly being replaced by PCR in many labs due to cost and improved performance (CDC, 2015e). • Serology: Serologic testing in the absence of lesions will detect HSV antibody 2 to 3 weeks after infection. Providers should request type-specific HSV-2 and/or HSV-1 serologic assays. • See CDC (2015e) section on genital HSV infections. |
| <p>Human papillomavirus (HPV) Condylomaacuminata This infection IS SUSPICIOUS of child sexual abuse. The older the child, the higher the risk of acquiring HPV via sexual abuse than prenatal or perinatal transmission from mother or postnatal transmission from caregiver. Children over 4 or 5 years of age are likely at higher risk than younger children.</p> | <p>Condyloma presence in oral and/or anogenital areas</p> | <ul style="list-style-type: none"> • Clinical examination of lesions suspicious for HPV. Histological examination if clinical diagnosis is unclear. Note that biopsy and typing of HPV does not differentiate sexual from nonsexual acquisition. • Test for the potential presence of other STDs (Sinclair, Woods, & Sinal, 2011). |
| <p>T vaginalis (TV) This infection IS SUSPICIOUS of child sexual abuse. It might be the result of a perinatally acquired infection.</p> | <p>Girls with this vaginal or urethral infection can be symptomatic or asymptomatic</p> | <ul style="list-style-type: none"> • Culture for <i>T. vaginalis</i> and wet mount (must distinguish between different species of trichomonas as <i>T. vaginalis</i> is the only species specific to sexual transmission). • Alternately, consider testing a portion of the “dirty” urine specimen for <i>T. vaginalis</i>. There is no evidence suggesting that performance of NAAT for detection of <i>T. vaginalis</i> in children would differ from that in adults (CDC, 2015e). However, there is not currently an alternate sequence confirmation method available for <i>T. vaginalis</i>. |

Consider the timing of initial and follow-up testing (CDC, 2015e). STD test results after a recent exposure are likely to be negative unless the child has a preexisting condition (Day & Pierce-Weeks, 2013).²²⁹ If no infections were identified during the medical forensic examination and the exposure was recent, a repeat examination and testing should be done approximately 2 weeks after the initial testing. (Note that as gonorrhea and chlamydia can clear spontaneously in a prepubescent female, follow-up testing must be done in a timely manner) Decisions regarding which tests should be performed must be made on an individual basis. The initial screening may be sufficient in some cases (e.g., if a substantial amount of time has elapsed between the last suspected episode of abuse and medical forensic care).

In circumstances where the transmission of syphilis, HIV, hepatitis B, or HPV is a concern, but baseline tests for syphilis, HIV, and hepatitis B were negative and examination for genital warts was negative, follow-up serologic testing and an examination approximately 6 weeks and 3 months after the last sexual exposure is recommended to allow time for antibodies to develop and signs of infection to appear (CDC, 2015). HIV testing is also recommended again at 6 months after the sexual abuse (see next section).

Defer STD treatment until after initial tests are conducted and any positive results are confirmed with follow-up tests (CDC, 2015e). Presumptive treatment is not recommended for several reasons: the incidence of most STDs is low after prepubescent child sexual abuse; prepubescent girls appear to be at lower risk for ascending infection than adolescents or adult women; and regular follow-up testing and treatment of children can usually be ensured (CDC, 2015e). However, some children or caregivers might be concerned about the possibility of STDs, even if the examiner perceives the risk to be low—such concerns might be an appropriate indication for presumptive treatment in some settings and be considered after all relevant specimens for diagnostic tests have been collected (CDC, 2015e). See the CDC *STD Treatment Guidelines* at www.cdc.gov/std/tg2015/default.htm. (See below for more on treatment and care)

HIV²³⁰

The risk of the child acquiring HIV as a result of sexual abuse must be considered during medical forensic care. If there is a risk in an individual case, provision of HIV non-occupational post-exposure prophylaxis (nPEP) must be an option. The sooner nPEP is initiated after the exposure, the higher the likelihood that it will prevent HIV transmission, if HIV exposure did occur (Day & Pierce-Weeks, 2013). There is a short timeline to start nPEP—no later than 72 hours post-exposure (see below).

Understand that the decision to recommend HIV serologic testing, as well as HIV nPEP, depends on local epidemiology, a case-by-case assessment of risk factors of the perpetrator, and details of the contact (WA, 2012). The risk for an individual patient is extremely difficult to calculate, since details about the perpetrator's risk factors and HIV

²²⁹ CDC (2015e) noted that infectious organisms acquired through a recent exposure might not have produced sufficient concentrations of organisms to result in positive test results or exam findings (Gavril, Kellogg, & Nair, 2012). Also, positive test results after a recent exposure might represent the perpetrator's secretions.

²³⁰ This section is drawn from the CDC (2015e) unless otherwise indicated.

status are usually unknown (WA, 2012).²³¹ HIV infection has been reported in children for whom sexual abuse was the only known risk factor. Children might be at higher risk for HIV acquisition than adolescent and adult sexual assault victims because child sexual abuse is frequently associated with multiple episodes of abuse and mucosal trauma might be more likely. Other exposure characteristics might also influence risk, such as the following: penile, anal, or oral penetration; site of exposure to ejaculate; viral load in ejaculate; multiple perpetrators; and the presence of a STD or genital lesions in perpetrators or children (CDC, 2005; Day & Pierce-Weeks, 2013).

Be knowledgeable of current testing and prophylactic recommendations in the field and related CDC guidelines. Examiners should be aware of and able to explain to children and their caregivers, in a way that is developmentally appropriate for children and linguistically appropriate for children and caregivers (drawn in part from Day & Pierce-Weeks, 2013 ESCA-HC, 2011):

- The risks of HIV infection for child victims of sexual abuse;
- Benefits (proven and unproven) and toxicities of nPEP;
- Benefits of adherence to recommended dosage, and costs of regimes;
- The importance of follow-up testing and care with a pediatric infectious disease doctor or specialist with HIV knowledge;
- Medical referrals, including low-cost and free options in various sections of the community; and
- Where they might obtain assistance with medical expenses (e.g., pharmaceutical patient assistance programs and coupons) and transportation to/from related appointments.

Although data are insufficient concerning the efficacy of nPEP among children, treatment is well tolerated by infants and children with and without HIV infection, and children have a minimal risk for serious adverse reactions because of the short period recommended for prophylaxis (28 days).²³²

²³¹ If the suspected perpetrator is known, examiners should consider if HIV testing of that person is a possibility.

²³² See the CDC (2005) and the Panel on Antiretroviral Therapy and Medical Management of HIV-Infected Children (2012).

Post-Exposure HIV Risk Assessment of Children (within 72 hours of sexual abuse)

- Review HIV/AIDS local epidemiology, assess risk for HIV infection in the perpetrator, and test for HIV infection.
- Evaluate circumstances of sexual abuse that might affect risk for HIV transmission (as mentioned above).
- Consult with a medical specialist who treats children with HIV infection to select age-appropriate dosing and regimens if nPEP is considered. However, nPEP provision should not be delayed due to the lack of availability of a specialist. To this end, it is important for pediatric examiners to have established relationships with infectious disease specialists in their facilities and area, as well as with local HIV clinics. In addition, assistance with post-exposure prophylaxis decisions can be obtained by calling the National Clinician’s Post-Exposure Prophylaxis Hotline (PEPLINE), telephone: 888-448-4911. An HIV/AIDS Management “warmline” is available for clinical consultation at 1-800-933-3413. See the Clinical Consultation Center at <http://nccc.ucsf.edu/> for more information.
- For children determined to be at risk for HIV transmission, discuss nPEP with the child and caregiver, including its toxicity, unknown efficacy, and possible benefits. The potential benefit of treating the child should be weighed against the risk for adverse reactions. Another consideration is the likelihood of compliance with the prophylactic regimen, and whether the family has a high concern for HIV infection after discussion of low relative risk.
- If nPEP is begun, adequate doses of medication should be provided to last until the follow-up visit at 3 to 7 days after the initial assessment,²³³ at which time the child should be reevaluated and tolerance of the medication assessed.²³⁴ Consider efficient methods in individual cases to facilitate compliance with the nPEP regimen (e.g., dispensing to the patient a starter pack, incremental dosing, or the full 28-day course of medication up front).
- If nPEP is started, perform CBC and serum chemistry at baseline. DO NOT wait for lab results to start nPEP.²³⁵
- ***Perform HIV antibody testing during the initial examination and again at 6 weeks, 3 months, and 6 months after the sexual abuse.*** If the initial test is negative, it should still be repeated at the above intervals. If initial testing was declined during the examination, children and their caregivers should be told they may return for testing.

Also see [Appendix 9. HIV Testing nPEP Algorithm](#).

Follow-Up STD Testing and Care

Follow-up examinations after medical forensic care, either with the child’s primary care provider, the exam facility, or another specialist, provide opportunities to:

- Detect new infections acquired during or after the abuse;
- Complete hepatitis B and HPV vaccinations, if indicated;

²³³ Examiners and health care facilities are encouraged to collaborate with HIV clinics, insurance companies, pharmacies, justice agencies, victim advocacy programs, victim crime compensation programs, and other relevant entities to help children’s families readily access nPEP medication and manage the costs of this medication.

²³⁴ See Fleming and Wasserheit (1999), Havens and the AAP Committee on Pediatric AIDS (2003), and the Panel on Treatment of HIV-Infected Pregnant Women and Prevention of Perinatal Transmission (n.d.).

²³⁵ Also, do not wait for HIV tests on the perpetrator, even if arrested. This testing may take weeks to accomplish.

- Discuss test results, complete repeat testing as indicated, and start treatment for other STDs if indicated; and
- Discuss HIV testing results and monitor side effects and adherence to post-exposure prophylactic medication, if prescribed.

Ensure that follow-up communication with children and their caregivers includes a reminder to go to follow-up examinations and receive STD related testing, immunizations, and treatment as directed. Pediatric examiners, child advocacy center staff, and victim advocates may be able to assist patients and caregivers in making follow-up appointments, obtaining transportation to and from appointments, and identifying resources to help pay for expenses involved with follow-up testing and care. Some jurisdictions may cover follow-up treatment as part of initial care through funds such as crime victims' compensation. In such instances, patients may be more apt to seek follow-up treatment. Advocates may also be able to accompany patients to these follow-up appointments.

Coordinate with other responders. Core responders need to recognize that it is the duty of the pediatric examiner to screen, test, and treat the patient for STDs, as indicated. Examiners can help other responders understand what STD evidence is indicative of sexual abuse and what is not (and consider pre- and perinatal acquisition of STDs). Responders should be educated about the importance of encouraging children who have started a treatment regimen and their caregivers to follow up within the appropriate time frame for required additional doses, as well as any testing needed, and need to be familiar with resources for related referrals to public health and private health care providers, and time frames for treatment/testing.

As mentioned earlier in this chapter, response teams need to protect information related to STDs in a child's medical record. Investigative agencies, prosecutor's offices, and multidisciplinary investigative teams should be aware of jurisdictional policies related to legally pressuring suspects in a case to be tested for STDs, whether voluntarily or court ordered (Amaya & Kellogg, 2011).

B11. Discharge Planning and Follow-Up Care

These recommendations are for pediatric examiners for discharge planning, follow-up care, and referrals.

Recognize that pediatric examiners have critical tasks to accomplish prior to discharging a child, after completing all other components of sexual abuse medical forensic care. They can create a discharge plan with the child and caregiver, in conjunction with other responders in a case, for individualized community “wrap-around” services that address the child’s post-exam needs (see below for examples of potential resources). In recognition of the long-term health impact of child sexual abuse, particularly mental health consequences and the risk of acquiring HIV and other STDs, all responders should stress the importance of trauma-informed counseling and other supportive services as essential components of follow-up interventions, including the need for follow-up medical testing and care (adapted from Day & Pierce-Weeks, 2013).



Discharge planning should be completed without any judgment regarding whether sexual abuse actually occurred. Treat all children cared for as individuals who are deserving of follow-up care and support.

Connecting Children to Community Resources



Use tailored discharge forms and material. These forms should be inclusive of the unique needs of prepubescent children who have received sexual abuse medical forensic care. They can help examiners in verbally summarizing for the child and caregiver: the care provided, tests completed, medication provided/prescribed, follow-up testing and care scheduled, and entities involved in these cases. They can also guide in explaining common reactions of children to sexual abuse, helpful caregiver responses, and follow-up services. Those developing these forms and materials should strive to make them culturally inclusive, tailored to children’s communication capacities, and linguistically appropriate for children and caregivers (likely necessitating the need for multiple formats). ***Use of standardized forms and materials can help examiners maintain the focus on health issues during discharge planning.***



See www.kidsta.org for sample discharge forms and materials.

Address the child’s physical comfort needs before discharge. (See [A1. Principles of Care](#)) These needs differ from one child to the next, but might include: allowing them to wash and brush their teeth, providing replacement clothing if their clothing was collected as evidence, assisting them with dressing (depending on their age and the availability of a caregiver), ensuring they receive a snack and drink if they are hungry and thirsty, etc.

Facilitate discharge planning with the child and caregiver.²³⁶ If the child assents, it may be helpful if the examiner also invites other responders involved in the medical forensic exam process to participate in this “exit conference,” depending upon their availability and specific case needs: e.g., victim advocate(s) who have accompanied the child and caregiver through the examination; a hospital child life specialist or social worker; a mental health provider who counseled the child and/or caregiver or who will provide future services; or other medical specialists that were or need to be involved (e.g., infectious disease or surgery).



The involvement of other responders during and after discharge may vary depending on whether the examination was acute and nonacute—follow-up needs may be greater in acute cases. If there is a local children’s advocacy center, it may play a role in coordinating follow-up services.

²³⁶ This section was drawn in part from Jones and Farst (2011).

Address the following health and related issues during discharge:

- **Validate the child's feelings regarding the examination and alleviate related fears**, and encourage the child to reach out and receive help to stay safe and heal from the abuse (see below).
- **Review generally what was done during the examination** (depending on the child's developmental level, it might be useful to ask her/him to tell what occurred during the examination to reinforce its appropriateness and stress that it is not a secret).
- **Provide a medical explanation of care provided, exam findings,²³⁷ tests administered, medications provided/prescribed, and follow-up testing and care scheduled/needed** (see below). Although the examiner may acknowledge that exam findings and forensic specimens collected might contribute to the investigation and prosecution of the sexual abuse, they should leave explaining the investigative and prosecutorial details to investigative agencies.
- **Identify if there are any unaddressed immediate medical or mental health needs or concerns** related to the sexual abuse.
- **Discuss with the child and caregiver whether they would like a health care provider to provide a follow-up call** and, if so, the best method and time (maintaining their privacy and safety, and addressing their linguistic needs). The main purposes of such a call are to check on medical status and remind the child and caregiver of follow-up testing and care. An optimal time for a first medical follow-up contact is 24 to 48 hours following discharge. Usually examiners will conduct this follow-up contact, but some facilities may have examiners contact the children's primary care provider to conduct the follow-up contact with patients. If not examiners, health care personnel following up with patients should be familiar with the case, confidentiality issues, and potential medical needs.
- **Begin to identify psychosocial interventions** that may aid the child in dealing with her/his reactions to the sexual abuse and aid family members in supporting the child in healing. Examiners can make referrals to potentially useful resources; it might even be useful to connect them directly to health and community partners.²³⁸ In particular, examiners can *discuss the importance of mental health treatment for the child, caregivers, and other family members to mitigate the effects of the abuse* (Jenny, Crawford-Jakubiak, & Committee on Child Abuse and Neglect, 2013).²³⁹ It is important to recognize the continued need for mental health and supportive services, as the impact of sexual abuse can vary at different stages of a child's development and continue into adolescence and adulthood. Additionally, interventions may be needed to address the potential impact of family dysfunction on child victims of sexual abuse.²⁴⁰ Care should be taken to ensure that mental health professionals have expertise in child sexual abuse and can appropriately and respectfully work with children and families from diverse backgrounds and circumstances.²⁴¹

²³⁷ Examiners may make statements to reassure children and caregivers about the child's health, such as "your body is healthy" or "lack of injury does not mean an assault did not occur," but they should avoid wording that could have legal implications, such as "no evidence of abuse was seen today" or the child looked "normal."

²³⁸ A psychosocial assessment may occur after the medical forensic examination, perhaps conducted by children's protective services, a children's advocacy center, or other victim advocacy program. The International Rescue Committee (2012) offers a psychosocial assessment tool for children who have been sexually abused.

²³⁹ As referenced earlier, CrimeSolutions.gov at www.crimelutions.gov/PracticeDetails.aspx?ID=45 offers a discussion of therapeutic approaches for children who have been sexually abused and their families. Also see the National Crime Victims Research and Treatment Center's *Child Physical and Sexual Abuse: Guidelines for Treatment* (Saunders, Berliner, & Hanson, 2003) at <https://mainweb-v.musc.edu/vawprevention/general/saunders.pdf>. The Child Welfare Information Gateway at www.childwelfare.gov/topics/responding/trauma/treatment/ provides links to resources on the treatment programs to meet the needs of children, youth, and families affected by trauma.

²⁴⁰ A few examples of studies that speak to this association: Dong et al. (2003), El-Sheikh and Flanagan (2001), and Fitzgerald et al. (2008). More generally, see adverse childhood experience (ACE) studies www.cdc.gov/violenceprevention/acestudy/index.html.

²⁴¹ It can be challenging to identify mental health providers who not only have expertise in treating child sexual abuse victims and/or their families, but also who are known to appropriately and respectfully work with specific populations of children. Multidisciplinary response teams in specific communities are encouraged to consider these challenges in advance and partner with those serving diverse populations to identify "best case" mental health referrals for specific populations and to have contingency plans in place. (For example, consider the best alternative if a community lacks a mental health provider who has experience in gender identity issues and child sexual abuse.)

Address the following health and related issues during discharge:

- **Review what to expect from multidisciplinary team response.** Examiners should coordinate with other responders, if available during discharge planning, to explain the team response in these cases, agency/facility roles and services,²⁴² hours of operation, contact persons, and contact information. Child and caregivers should be informed, if relevant, if contact procedures are different for patients with limited English proficiency or for specific communities or institutions. (Responders are encouraged to coordinate their follow-up contact so as to not overwhelm or confuse the child or family)
- **Ensure that the child has a plan for physical and emotional safety after discharge.** Recognize that each child's safety needs and concerns are unique and ensure that the plan is tailored to address those needs and concerns. (Caregivers and other family members may need separate plans)
 - **IDENTIFY RESPONDERS WHO CAN PROVIDE SAFETY PLANNING ASSISTANCE** (e.g., a victim advocate, children's advocacy center staff, victim service specialist, a hospital social worker, child protective service worker, and/or investigators). Immediately involve law enforcement and/or child protective services if there are imminent physical safety risks—communicate this urgent need in the oral mandatory report of abuse or via another call to them. Children with immediate safety risks should not leave the health care facility until these concerns are adequately addressed.
 - **CONSIDER SAFETY ISSUES AND SCENARIOS.** For example: Will living arrangements or other environments the child and/or family frequents (e.g., home, school, after-school activities, child care, church, neighborhood, or peer group) expose them to threats of continued violence? Will the perpetrator have access to them in such settings? Is there a need for emergency shelter or alternative housing options/out-of-home placement? Are the child and family eligible for protection orders? Is there a need for enhanced security measures at home? If the child or family feel unsafe, what will they do to obtain help? Is there a potential for backlash against a child and family for their lack of silence about the sexual abuse (e.g., if a powerful and respected family member or member of the community has been named as the suspected perpetrator)? If a child or caregivers with physical disabilities require temporary shelter, is the shelter accessible and are the staff able to meet their needs for personal assistance with activities of daily living (adapted from Nosek & Howland, 1998)? What if it is known or suspected that images of the abuse are available online or have been shared electronically? What are the safety issues and strategies to address them? If it is inadvertently revealed to family members that a child victim is gay or transgender, what can be done to minimize the impact of the family's reactions to this revelation on the child's healing from the sexual abuse? (With all of these questions, discuss options, and help the child and caregiver develop a plan for physical and emotional safety) *Note safety planning tips and forms can be helpful; however, safety planning assistance itself should be tailored to an individual child/family's situation and plans should be re-evaluated if circumstances change.*²⁴³

²⁴² As for roles and services, the child and caregiver should be informed about the following: if there is a local children's advocacy center, its services and coordination role; investigative processes in criminal justice and child protection systems (as appropriate to the case), assistance available from those agencies, and when and how to contact investigators; child protective services to assist children with safety issues in the home; mental health counseling options for child sexual abuse victims and their families; victim advocacy—the range of services and options in the community; financial resources available to help cover medical and other costs associated with victimization, and assistance available for completing financial aid applications; and other community resources that might be applicable in a particular case (e.g., local HIV services).

²⁴³ Some related resources: Stop it NOW! (2008, n.d.) through www.stopitnow.org/help-guidance/prevention-tools offers tip sheets related to family safety planning to protect children from sexual abuse, in general and specific to children with disabilities. The West Virginia Foundation on Rape Information and Services (2012), through its Sexual Assault Services Training Academy at www.fris.org/OnlineTraining/SASTA.html, offers safety planning material and a related online course for service providers working with victims of sexual violence.

Address the following health and related issues during discharge:

- **Provide the child and caregiver with written instructions and materials** that summarize what was discussed during discharge planning and reinforce the need for follow-up testing and care, mental health counseling, and other services (as reviewed above). As discussed in [A2. Adapting Care for Each Child](#), topics to cover minimally include: exam procedures; results of exam findings; information about sexual abuse dynamics, related laws, the range of victim reactions and concerns of children and caregivers, and the process of healing from sexual abuse;²⁴⁴ costs they will be expected to cover for the examination and other related medical care, what the jurisdiction will cover, and their options for financial assistance in covering these expenses; resources available to the community to address post-exam needs related to the sexual abuse; and criminal justice and child protection investigative processes, as applicable. Also as discussed in [A2. Adapting Care for Each Child](#), facilities and the multidisciplinary response team should continuously strive to ensure that written discharge materials are developmentally appropriate for children, and culturally and linguistically appropriate for children and caregivers in the community.



See www.Kidsta.org for additional resources and guidance for safety planning.

Note that follow-up medical testing and care might include (depending upon case specifics):

- Medical follow-up treatment for health concerns identified at the examination;
- STD follow-up testing and treatment, including for HIV (see [B10. Sexually Transmitted Disease Evaluation and Care](#)); and/or
- A short-term follow-up examination for children who had acute injuries/trauma (including surgical cases) to document the development of visible findings and photograph areas of injury, and then an examination 2 to 4 weeks later to document resolution of findings or healing of injuries (follow jurisdictional policies for describing indications and procedures for follow-up for documentation purposes).

To the extent possible, schedule medical follow-up appointments prior to discharge.

The examiner, child, and/or caregiver should determine the most appropriate provider/location for each appointment (e.g., the primary care provider, return to the exam facility, specialty care provider, or a community clinic).

Partner with other responders to aid the child and/or caregiver in overcoming roadblocks to receiving follow-up health services. For example, examiners can connect the caregiver to a victim advocate or social worker to assist with transportation to and from appointments and out-of-pocket medical costs, or a mental health provider to discuss family dynamics that may impede necessary care (e.g., the child's siblings are blaming her/him for "breaking up the family" and pressuring the child to say she/he lied about the abuse).

²⁴⁴ For example, see the parent tip sheets offered in Yamamoto (2015).



When making referrals for services, examiners must take into consideration the resources available to the community and confidentiality issues. It would be problematic, for example, if the follow-up health care options were hours away from the child's home or if the child's family had a conflict of interest with the one mental health counselor in their small, rural community who had expertise in working with child sexual abuse victims. Examiners, in conjunction with the multidisciplinary response team, need to think creatively about how best to overcome resources and confidentiality challenges to ensure that children and their families have access to the follow-up care and services they need. (See [A3. Coordinated Team Approach](#))

Glossary and Acronyms

Many terms and acronyms are explained and used throughout the protocol. However, it is helpful to have a reference tool to turn to for an explanation of terms and acronyms used. Note this section is not an exhaustive list of terms pertinent to the exam process or of commonly used acronyms. Also, **explanations are listed here as they apply to this protocol and may vary from those used in protocols developed by states, territories, tribes, federal agencies, and/or local communities.**



See www.Kidsta.org for medical and forensic definitions.²⁴⁵

ADOLESCENTS: As defined in this document, adolescents are children who are Tanner stage 3 and above who have potential reproductive capability (see TANNER STAGES below and [Appendix 1. Tanner Stages of Sexual Maturation](#)). A Tanner stage 3 or 4 biological female, even if premenarchal, potentially has reproductive capacity. Adolescent victims as defined here are NOT addressed in this protocol, but in the adult/adolescent protocol available at www.ncjrs.gov/pdffiles1/ovw/241903.pdf.

ASSENT: The expressed willingness to participate in an activity (e.g., exam procedures). For younger children who are by definition too young to give informed consent to care, but old enough to understand and agree to participate, the child's informed assent is sought. (IRC, 2012).

CAREGIVER: A person exercising a day-to-day caregiver role for a child, such as a parent, guardian, foster parent, sibling, relative, or family friend. Caregivers may or may not have legal responsibility for the child. Additional persons may play a +more temporary caregiver role for a child, such as a child care provider or babysitter. (Adapted from Day & Pierce-Weeks, 2013; IRC, 2012; WCSAP, 2009).

CHAIN OF CUSTODY: A formal, chronological documentation of the custody and possession of evidence. It is used to establish the integrity of the evidence collection in a court of law.

CHILD DEVELOPMENT: Refers to how a child becomes able to do more complex tasks, as they get older, with a focus on gross and fine motor, language, cognitive, and social skills (University of Michigan Health System, 2015). In addition to physical growth, children typically experience distinct periods of development as they age. For information on developmental milestones, see the CDC (2015c) at www.cdc.gov/ncbddd/childdevelopment/facts.html.

CHILD-FOCUSED: In this document, refers to an approach to care that is developmentally, linguistically, and culturally appropriate for prepubescent children, designed with their needs and best interest in mind, and intended to reduce potentially traumatic effects of the exam process.

²⁴⁵ Also see the American Professional Society on the Abuse of Children (1995) and Technical Working Group on Biological Evidence Preservation (2013) for two resources for explanation of medical and forensic terms.

CHILD SEXUAL ABUSE (WHO, 1999): Child sexual abuse, as used in this protocol, is intended to encompass any sexual violence a prepubescent child may experience. Specifically, it refers to the involvement of a child in sexual activity that she/he does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society (WHO, 1999). Child sexual abuse can occur between a child and a person or persons of any age or relationship to the child. The intent of the abuse is to gratify or satisfy the needs of the other person(s) (WHO, 1999). (See the [Introduction](#) for a discussion on the nature of child sexual abuse acts).²⁴⁶ Note that the term “child sexual abuse” often has different meanings across jurisdictions and clinical settings.²⁴⁷

CHILDREN: A child is anyone under 18, unless majority [adulthood] is attained earlier under the applicable law of a jurisdiction (e.g., those pertaining to age of consent, child protection, and criminal responsibility) (UN Office of the High Commissioner for Human Rights, 1989). There is some variation across U.S. states regarding the age of majority—see <http://minors.uslegal.com/age-of-majority/> for information on related laws of each state. Note this document addresses only prepubescent children.

CHILDREN’S ADVOCACY CENTER: Children’s advocacy centers have been established in many jurisdictions to facilitate multidisciplinary team coordination in child abuse and neglect cases, with the goals of child safety, trauma-informed care, justice, and healing. These centers are child-friendly facilities in which a multidisciplinary team of professionals (typically comprised of law enforcement officials, child protective services, prosecutors, medical professionals, mental health providers, and victim advocates) coordinate the investigation, prosecution, child protection, and treatment of child abuse. In addition to brokering coordination among responders in individual cases, many children’s advocacy centers offer a location to provide services to children under one roof, such as forensic interviews, medical forensic examinations, victim advocacy, and mental health treatment.

CHILD PROTECTIVE SERVICE REPRESENTATIVE: An agent of the local, state, tribal, or federal government who is responsible for the assessment of risk to the child who may have been abused and to the child’s siblings. The assessment is often coordinated with law enforcement authorities. The child protective service representative has jurisdiction over the protection, placement, and long-term disposition of the child, as well as services and support for the victim’s family. In this protocol, personnel from child protective service agencies are referred to as child protective service workers or child protective service representatives, unless more specificity is required. In some jurisdictions, child protective service agencies are mandated to participate in multidisciplinary response teams that investigate child abuse and neglect.

CONFIDENTIALITY: An ethical principle associated with medical and social services professions. Maintaining confidentiality requires that providers protect information gathered about patients/clients and agree only to share information about a patient/client’s case with

²⁴⁶ Child sexual abuse acts do not encompass developmentally appropriate sexual behaviors of children, as described in [B3. Entry into the Health Care System](#).

²⁴⁷ To search for child sexual abuse definitions by state and territory, see Child Welfare Information Gateway at www.childwelfare.gov/topics/systemwide/laws-policies/state/.

their explicit permission. All written or photo-documentation from a child sexual abuse case should be maintained in a confidential place in locked or secure files. Significant limits to confidentiality exist while working with prepubescent children who have been sexually abused. In some jurisdictions, mandatory reporting laws may override health privacy laws and require sharing of information among investigative agencies. Note that confidentiality is distinguished from privileged communication, which is a legal protection of certain information. Privilege laws are jurisdiction-specific, but often include medical providers, mental health providers, and community-based victim advocates. However, as with confidentiality, privileged communication is limited in child sexual abuse cases.

CONTACT CHILDREN: All the children that may have had contact with the alleged perpetrator. Contact children include siblings, relatives, or any other child that the alleged perpetrator can access. They should be considered for medical forensic care and reported to legal authorities.

CULTURE: Generally speaking, a body of learned beliefs, traditions, and guides for behaving and interpreting behavior that is shared among members of a particular group (Blue, n.d.). Aspects of a culture include its values, beliefs, customs, communication styles, behaviors, practices, and institutions (Blue, n.d.).

CULTURAL GROUP: In this protocol, this refers not only to ethnic or racial groups, but also to other groups with distinct cultures. Examples include faith communities; Deaf and hard-of-hearing communities; children with other disabilities; populations with differing sexual orientations and gender identities or expressions; immigrants; refugees; the homeless; military personnel and their dependents; and individuals in correctional settings, foster care systems, boarding schools, and other residential settings. One culture may be closely connected to another (e.g., an ethnic group may be rooted in religious and/or spiritual beliefs of a particular faith community). Individuals often belong to multiple cultural groups. Note that cultural beliefs may or may not affect a child's experience of sexual abuse, the related reactions of the child and caregiver, and their preferred approaches to emotional support, healing, and justice (adapted from DeBoard-Lucas et al., 2013). If culture is influential in this regard, responders can offer to help children and caregivers access cultural resources during the exam process and beyond.

DISABILITY (CDC, 2015b): There are many types of disabilities, such as those that affect vision, movement, thinking, remembering, learning, communicating, hearing, mental health, and social relationships. Disabilities can affect children in different ways, even if one child has the same type of disability as another child. Some disabilities may be hidden or not easy to see. Disability can occur at any point in a child's life (e.g., an infant can be born with spina bifida, which may affect walking; a child could be in a motor vehicle accident and have traumatic brain injury, which may affect thinking and remembering; a child can have mental illnesses which may make it difficult to manage day-to-day stressful situations; a child may be born with or develop hearing or vision loss, which may affect communication; or a child may have a developmental disability, such as autism, which can affect social interactions, communications, and behavior).

DISCLOSURE: The process of revealing information. In reference to this document, disclosure refers specifically to how a person learns about a child's experience with sexual

abuse. Disclosure about sexual abuse can be directly or indirectly communicated, voluntarily or involuntarily.

EVIDENCE COLLECTION KIT: In this document, refers to a box or envelope that outlines specific types of forensic evidence requested by a jurisdictional crime lab from the body of a victim of sexual violence. It contains the necessary materials for collection, packaging, and maintaining chain of custody once the evidence is gathered, packaged, and sealed. The kit may also be referred to as an evidentiary kit in this document.

EVIDENCE-INFORMED (adapted from National Collaborating Centre for Methods and Tools, 2012): As used in this document, refers to the process of distilling the best available evidence from research, context, and experience, and then using that evidence to inform and improve policy. Evidence-informed decision making considers evidence from a variety of sources: an understanding of related community issues and local context; existing related resources; community and political climate; and the best available research findings. (Note this definition comes from a public health source, but is generally applicable to policy making related to the sexual abuse medical forensic exam process)

EXAM FACILITY: The site at which the child sexual abuse medical forensic examination is conducted.

EXAM PROCESS: In this document, refers to the child's entry into the health care system, the medical forensic examination in its entirety, and planning at the exam's conclusion to facilitate post-exam health care and referrals to address child-, family-, and case-specific needs.

FIRST/INITIAL RESPONDER: A professional who initially responds to a disclosure of child sexual abuse (there is often more than one first responder). These professionals typically follow agency/facility response policies. Those who traditionally have been responsible for immediate response to child sexual abuse include child protective service workers, 911 dispatchers, law enforcement representatives, health care providers, children's advocacy center staff, and victim advocates. A wide range of other responders also may be involved, such as emergency medical service providers, paramedics, public safety officials, prosecutors and victim—witness staff, mental health providers, social service workers, corrections and probation staff, spiritual support persons, child care providers, school personnel, employers, certified interpreters, and providers from organizations that address needs of specific populations (e.g., persons with disabilities, racial and cultural groups, the homeless, runaways, adolescents in foster care, domestic violence victims, and persons who identify as LGBTI). Families and friends of victims can play an important role in the initial response; however, they are not considered first responders in this document.

FORENSIC EVIDENCE: Information, objects, or specimens that may be admitted into court for judges and juries to consider when hearing a case. Forensic evidence may come from a variety of sources, including biological sources.

FORENSIC SCIENTIST: The forensic scientist is responsible for analyzing evidence in sexual abuse cases. This evidence typically includes DNA and other biological evidence, toxicology samples, latent prints, and trace evidence. Some forensic scientists specialize

in the analysis of specific types of evidence. In this protocol, forensic scientists working in jurisdictional crime laboratories may be referred to as crime lab/laboratory personnel. Forensic scientists analyzing drug and alcohol samples are also referred to as toxicologists. Forensic scientists in some communities may respond to crime scenes to collect evidence and to process the scene.

JURISDICTION: A community that has power to govern or legislate for itself. For example, a jurisdiction may be a local area, state, territory, or tribe. Jurisdiction also describes the authority to interpret and apply laws—it is used in this context when identifying who has jurisdiction over a particular case.

INFORMED CONSENT: Refers to explaining all aspects of the exam process to the prepubescent child and her/his parents/guardian (as applicable), in a manner they can fully understand. When working with children, keep in mind that the explanation must be developmentally appropriate. It is crucial that child patients and their parents/guardians are aware of the options open to them and given sufficient information to enable them to make informed decisions about care during the exam process. Even if the child cannot legally give consent, she/he can still give informed assent.

LANGUAGE ASSISTANCE SERVICES: Oral language services for interpretation and written language services, including translation of written materials into languages other than English for limited English proficient (LEP) individuals.

LAW ENFORCEMENT REPRESENTATIVE: Different types of law enforcement agencies exist at the local, state, territory, tribal, and federal levels (e.g., state, county, tribal, or local police or sheriff, sworn police on college campuses, the FBI, the Bureau of Indian Affairs (BIA), and military police). Any of these agencies could potentially be involved in responding to child sexual abuse cases. Also, in areas without a local law enforcement agency, public safety officials may assist in immediate response to child sexual abuse. Some agencies may have staff with specialized education and experience in child sexual abuse who may be dedicated to investigating sexual abuse cases and/or part of special units for investigating child sexual abuse. Dedicated staff and special units may more broadly address child abuse and neglect. In this protocol, personnel from law enforcement agencies are referred to as law enforcement officers or law enforcement representatives, unless more specificity is required. Some are mandated to participate in jurisdictional multidisciplinary response teams that investigate child abuse and neglect.

LIMITED ENGLISH PROFICIENT (LEP): Refers to individuals who do not speak English as their primary language and have a limited ability to read, speak, write, or understand English. LEP individuals may be entitled to language assistance services to ensure they have meaningful access to a benefit, program, or service that receives federal financial assistance.

LOCARD'S EXCHANGE PRINCIPLE: A principle of forensic science, developed by Edmund Locard, in which he found that every contact, no matter how slight, between two items will result in an exchange between the two. Any contact between a perpetrator and child, as well as the crime scene itself, may have potential corroborating evidence left behind (trace materials and/or body fluids from the perpetrator). As the body of the child is

assessed, forensic samples should be taken from the areas where potential evidence may exist.

MEDICAL FORENSIC EXAMINATION: In this document, refers to an examination of a prepubescent child who has disclosed or is suspected of being sexually abused. It is conducted by a health care provider, ideally one who has specialized education and clinical experience in the collection of forensic evidence and treatment of pediatric patients who have been sexually abused. The examination includes: evaluating the child for acute care needs; gathering information from the child and her/his caregiver, as appropriate, for the medical history; a physical and anogenital examination; coordinating treatment of injuries; documentation of exam findings; collection of forensic samples from the child, when applicable; information, testing, treatment, and referrals for STDs (including HIV); assessment of suicidal ideation and other nonacute medical concerns; and follow-up as needed to provide additional healing, treatment, or collection of forensic evidence. It is also essential during the exam process for the health care provider conducting the examination to coordinate with other involved responding entities to ensure that any concerns regarding the child's safety that are identified in the course of the examination are addressed, as well as to offer emotional support, crisis intervention, education, and advocacy to children and their caregivers, as needed.

MANDATORY REPORTING: Refers to jurisdictional laws and policies, which mandate certain agencies and/or persons in helping professions (teachers, social workers, health staff, etc.) in that jurisdiction to report to child protection and/or criminal justice authorities actual or suspected child abuse (e.g., physical, sexual, neglect, emotional and psychological abuse, unlawful sexual intercourse). Some jurisdictional laws require all citizens to report child sexual abuse.

MULTIDISCIPLINARY RESPONSE TEAM: Refers to a multidisciplinary team response to child sexual abuse that seeks to foster coordination and communication among those agencies/facilities in a community that respond to child sexual abuse. This protocol focuses on the multidisciplinary team response related to the exam process. A team structure provides a mechanism to link key entities and allows them to consistently coordinate their interventions whenever there is a report, disclosure, or suspicion of child sexual abuse. It also helps them communicate about what is happening in individual cases. The team structure is a quality assurance mechanism, promoting regular meetings of responders, case review, education, and activities to prevent vicarious trauma. Jurisdictions vary in the extent and formality of team coordination, as well as in team purposes, and may refer to these teams by a variety of names. In many jurisdictions, multidisciplinary teams are statutorily mandated to coordinate all child abuse and neglect investigations. The development of coordination protocols to guide their response is also often required.

Note that teams should include MULTIJURISDICTIONAL representation if cases typically involve responding entities from more than one jurisdiction.

PEDIATRIC (adapted from Stanton & Behrman, 2011): Generally concerned with all aspects of the wellbeing of children. Note the pediatric population addressed in this protocol is solely prepubescent children as described below. Pediatric health care must be

concerned with particular organ systems and biological processes, developmental issues, and environmental and social influences that affect the health and wellbeing of children and families.

PEDIATRIC EXAMINER: Refers to the health care provider conducting the pediatric sexual abuse medical forensic examination. Jurisdictions across the country rely on a range of health care providers (e.g., physicians, registered nurses, and advanced practice providers, such as advanced practice nurses and physician assistants) who have been specially educated and completed clinical requirements to provide medical forensic care for prepubescent children. Communities may refer to their trained pediatric examiners by specific terms and acronyms based upon the discipline of practitioners and/or specialized education and clinical experiences.

PERPETRATOR: In this document, refers to a person who directly inflicts or supports sexual abuse of prepubescent children. Perpetrators may be adults or children who have power over the victim, including caregivers; other family members living in the home; nonresident relatives (e.g., uncles/aunts, grandparents, cousins); friends, acquaintances, and neighbors (of the family but also the child's peers); strangers; and authority figures (e.g., teachers, spiritual leaders, health care workers, youth group leaders, and adults from organizations that work with children). The suspected perpetrator may be referred to in this protocol as a suspect. When litigation is discussed, the suspected perpetrator may be referred to as a defendant. When talking more broadly about perpetrators, they may also be referred to as offenders or assailants.

PREPUBESCENT: A child's stage of pubertal development is determined by assessing secondary sexual characteristics rather than chronological age. Although the onset and timeline of the pubertal process is unique to each child, the stages are identifiable and predictable (Fritz & Speroff, 2011; Jenny, 2011; Kaplowitz et al., 1999). Tanner stages detail the physical signs of breast, pubic hair, and male genitalia development for each of the five sexual maturation stages (see [Appendix 1. Tanner Stages of Sexual Maturation](#)). Prepubescent children's sexual characteristic development is reflected as stage 1 or stage 2 of Tanner stages (Child Growth Foundation, n.d.; Marshall & Tanner, 1969). Prepubescent children require interventions during the medical forensic examination that are tailored to their developmental stage. In addition, these interventions must be based on population-specific knowledge of differences between normal variants and healed injuries from prior abuse. Note that while the onset of puberty should not be correlated to a chronological age, concerns about precocious or delayed sexual development should be referred to the appropriate pediatric specialist.

PROSECUTOR: Different types of prosecution offices exist at the local, tribal, state, territory, and federal level (e.g., tribal prosecutor's office, county prosecutor's office, district attorney's office, state attorney's office, United States Attorney's office, and military judicial branches). Any of these offices could be involved in responding to child sexual abuse. In addition, some offices may have personnel with specialized education and experience in child sexual abuse who may be dedicated to prosecuting child sexual abuse, or more broadly, child abuse and neglect and/or part of special units with the same goal. In this protocol, attorneys from prosecution offices will be referred to as prosecutors unless more

specificity is required. Some are mandated to participate in jurisdictional multidisciplinary response teams that coordinate child abuse and neglect investigations.

SEXUALLY TRANSMITTED DISEASE (STD): The term refers to a variety of clinical syndromes and infections caused by pathogens that can be acquired and transmitted through sexual activity (CDC, 2015). Although the term STD is used in this protocol, STDs are also commonly referred to as sexually transmitted infections (STIs). See the American Sexual Health Association (2015) at www.ashasexualhealth.org/stdsstis/ for related discussion.

TANNER STAGES: A scale of physical measurements of development, based on external primary and secondary sex characteristics. The scale was first identified by James Tanner, a British pediatrician. Tanner staging characterizes a scale from 1 to 5, based on secondary sex organ development. Considered in the scale for girls is development of breasts and pubic hair, and for boys is testicular volume and pubic hair. The scale was developed with reference to a single ethnic group and a relatively small sample of only 200 children, so using this as a measure may not apply to all ethnic groups. (Blackemore, Burnet, & Dahl, 2010). Different ethnic groups may have variations in breast development, pubic hair growth, distribution, or growth patterns. Care should be taken to assess children for pubertal development based on knowledge of local ethnic variations and common characteristics. (See [Appendix 1. Tanner Stages of Sexual Maturation](#))

TRAUMA-INFORMED: In this document, refers to an approach to care that seeks to support the healing and growth of children who have experienced sexual abuse, while avoiding their retraumatization (RSP & NSVRC, 2013). It considers and evaluates all interventions in light of a basic understanding of the role that sexual abuse plays in the lives of child victims (Harris & Fallot, 2001; RSP & NSVRC, 2013). It integrates an understanding of the victim's history and the entire context of their experience. It recognizes the effects that trauma can have on the child's behavior, coping strategies, relationships, and ability to interact with health care providers, law enforcement, and other professionals involved.

URGENCY OF MEDICAL FORENSIC CARE: In this document, this phrase refers to whether the need for medical forensic care is acute versus nonacute. Generally, an ACUTE EXAMINATION should be conducted within the time frame prescribed by the jurisdiction for the collection of forensic samples, if there is a possibility of evidence on the child's body or clothing OR if there are factors beyond that time frame that indicate acute medical forensic care is necessary. In most jurisdictions, a child is referred for a NONACUTE EXAMINATION if the abuse occurred beyond the jurisdictional time frame for an acute examination AND there is no indication for acute medical forensic care. The protocol directs health care providers, rather than law enforcement or child protective service representatives, to determine the type of care appropriate for a child. (See [B3. Entry into the Health Care System](#))

VICTIM: This protocol focuses on prepubescent child victims of sexual abuse. The victim can be a female or male, a person whose gender identity does not conform to her/his biological sex, or someone who does not identify as either female or male. In many instances, prepubescent children do not actually disclose that they have been abused.

Individuals who suspect sexual abuse may seek help for these children. Note that because the protocol addresses a multidisciplinary team response, the term “victim” is not used in a strictly criminal justice context. The use of this term simply acknowledges that children in sexual abuse cases should have access to certain services and interventions designed to help them be safe, recover, and seek justice. The terms “victim,” “survivor,” and “patient” are used interchangeably.

VICTIM ADVOCATE: A victim advocate typically can offer child sexual abuse victims and their family members a range of services before, during, and after the exam process. These services may include support, crisis intervention, information and referrals, counseling, and advocacy to ensure the child’s interests are represented, their wishes respected, and their rights upheld. In addition, victim advocates may provide follow-up services, such as support groups, counseling, accompaniment to related appointments (e.g., medical and legal), and legal advocacy (civil, criminal, and immigration) to help meet the needs of victims and their families. Numerous types of victim advocacy agencies may offer some or all of these services, including: community-based sexual assault victim advocacy programs; children’s advocacy centers (see explanation above); criminal justice system victim-witness offices at the local, state, territorial, tribal, and federal levels; military family advocacy programs; tribal social services, and others. In some communities, patient advocate programs at health care facilities also may be enlisted to provide some of these services when a child victim is a patient.

Note that criminal justice system based advocates/victim service providers, such as those in law enforcement or prosecution offices, generally cannot offer confidential services, while community-based advocates/victim service providers generally can (to the extent permissible by jurisdictional law and their program policies).

VICTIM-CENTERED: In this document, refers to an approach to care that is grounded in an awareness of and commitment to addressing the needs of child victims of sexual abuse during the exam process. It recognizes that child victims deserve timely, compassionate, respectful, and appropriate care to promote their healing, as well as information to allow decision making. Care is informed by the child’s circumstance. Medical personnel may refer to this as patient-centered care.

Acronyms Used in the Protocol

General

| | |
|----------|--|
| ALS | alternate light source |
| ASL | American Sign Language |
| CT | <i>C trachomatis</i> |
| GHB | gamma hydroxy butyrate |
| HBV | hepatitis B virus |
| HIV | human immunodeficiency virus |
| HPV | human papillomavirus |
| HSV | herpes simplex virus |
| HIV nPEP | human immunodeficiency virus nonoccupational post-exposure prophylaxis |
| LEP | limited English proficient |
| LGBTI | lesbian, gay, bisexual, transgender, and/or intersex |
| MOU | memorandum of understanding |
| MOA | memorandum of agreement |
| NAAT | nucleic acid amplification test |
| NG | <i>N gonorrhoea</i> |
| PTSD | post-traumatic stress disorder |
| SANE | sexual assault nurse examiner |
| SAFE | sexual assault forensic examiner |
| SART | sexual assault response team |
| STD | sexually transmitted disease |
| TV | <i>T vaginalis</i> |

Legislation

| | |
|--------|--|
| ADA | Americans with Disabilities Act |
| EMTALA | Emergency Medical Treatment and Labor Act |
| HIPAA | Health Insurance Portability and Accountability Act |
| HITECH | Health Information Technology for Economic and Clinical Health Act |
| PREA | Prison Rape Elimination Act |
| VAWA | Violence Against Women Act |

Organizations

| | |
|--------|--|
| AAP | American Academy of Pediatrics |
| AHIMA | American Health Information Management Association |
| CALiO | National Children's Advocacy Center's Child Abuse Library Online |
| CDC | Centers for Disease Control and Prevention |
| DoD | U.S. Department of Defense |
| DOJ | U.S. Department of Justice |
| FBI | Federal Bureau of Investigation |
| IAFN | International Association of Forensic Nurses |
| IRC | International Rescue Committee |
| NCA | National Children's Alliance |
| NSVRC | National Sexual Violence Resource Center |
| OJJDP | Office on Juvenile Justice and Delinquency Programs |
| OVW | Office on Violence Against Women |
| OVC | Office for Victims of Crime |
| RSP | National Sexual Assault Coalition Resource Sharing Project |
| SAFEta | Sexual Assault Forensic Examination Technical Assistance |
| WCSAP | Washington Coalition of Sexual Assault Programs |
| WHO | World Health Organization |

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Attributions for Images Used in the Protocol

California Office of Emergency Services. (2001). Exam positions and techniques. In *California medical protocol for examination of sexual assault and child sexual abuse victims*. Sacramento, CA: Author.

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Icons (note and exclamation) credit: Presenter Media

Appendix 1. Tanner Stages of Sexual Maturation

Tanner Staging Ranges from 1 (Prepubertal) to 5 (Adult Development)²⁴⁸

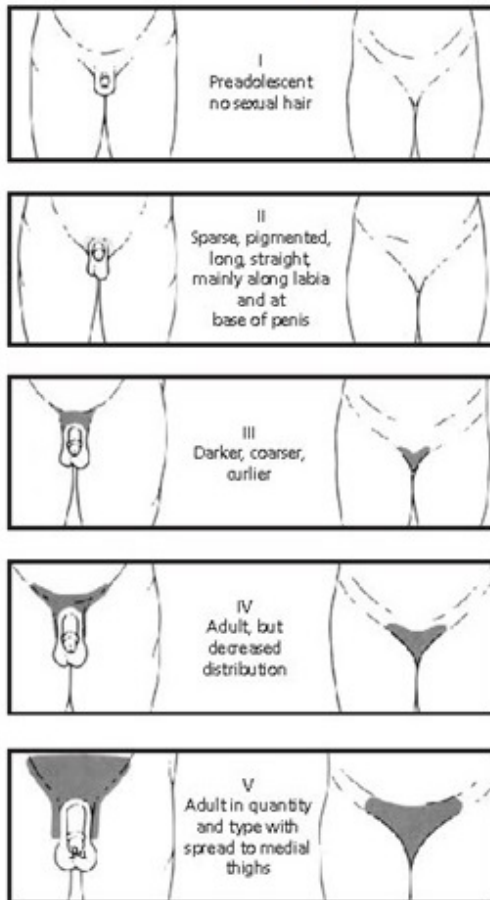
| Stages | Girls—Breast Development | Girls and Boys—Pubic hair | Boys—External Genitalia Development |
|-----------------------|---|--|---|
| <i>Tanner Stage 1</i> | <i>Prepubertal Only the papilla is elevated above the level of the chest wall</i> | <i>Prepubertal (velus hair similar to abdominal hair)</i> | <i>Prepubertal (velus hair similar to abdominal hair) Testes, scrotal sac, and penis have size similar to early childhood</i> |
| <i>Tanner Stage 2</i> | <i>Breast budding, elevation of breasts as small mounds, enlargement and widening of areolae. May be tender and not symmetrical bilaterally</i> | <i>Sparse growth of long, slightly pigmented, downy, straight or curled hair on labia majora or at the base of the penis</i> | <i>Enlargement of scrotum and testes; scrotum skin will thin and may be redder</i> |
| <i>Tanner Stage 3</i> | <i>Breast enlarges, elevating beyond the areolae</i> | <i>Pubic hair becomes curly, coarser, extends outward over junction of pubes</i> | <i>Penis lengthening, testicles continue to grow</i> |
| <i>Tanner Stage 4</i> | <i>Breast enlarges and areolae and papilla form secondary mounds</i> | <i>Hair adult in type, but covers smaller area, no spread to the medial surface of thighs</i> | <i>Penis and testicles grow, scrotum darker in color</i> |
| <i>Tanner Stage 5</i> | <i>Breast achieves adult contour</i> | <i>Hair adult in type and quantity extends onto medial thigh</i> | <i>Adult genitalia</i> |

²⁴⁸ The scale was developed with reference to a single ethnic group and a relatively small sample of only 200 children, so using this as a measure may not apply to all ethnic groups (Blackemore, Burnet, & Dahl, 2010). Different ethnic groups may have variations in breast development, pubic hair growth, distribution, or growth patterns. Care should be taken to assess children for pubertal development based on a knowledge of local ethnic variations and common characteristics.

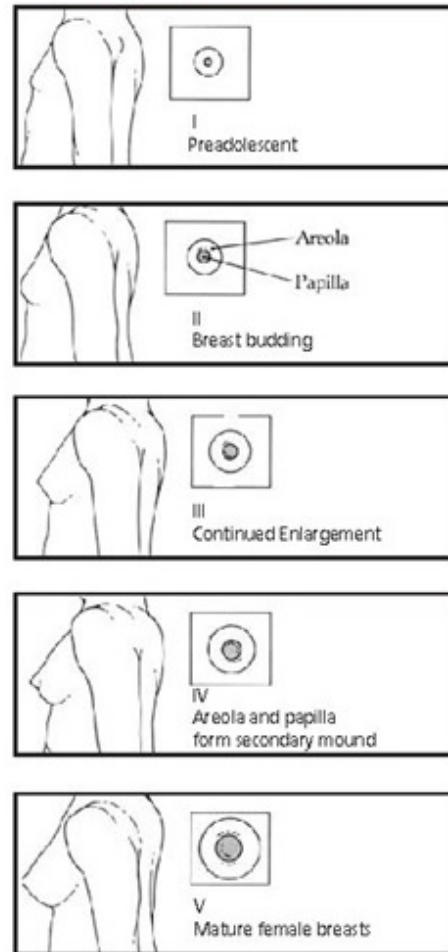
Changes in Girls and Boys at Various Stages of Sexual Maturation

(Original illustration from Johnson, Moore, & Jefferies. (1978). Permission to use obtained from Abbott Laboratories, Nutrition Research and Development.)

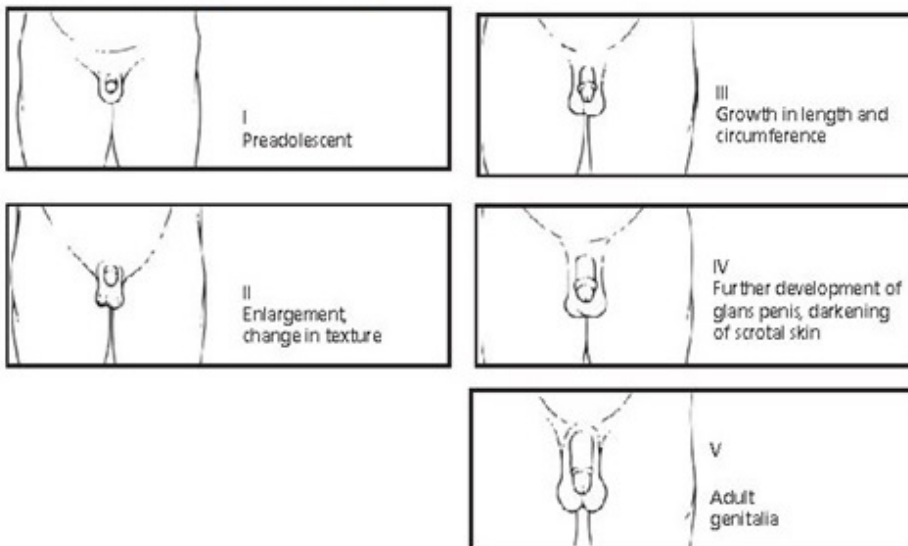
Pubic Hair Growth in Boys and Girls



Breast Development in Girls

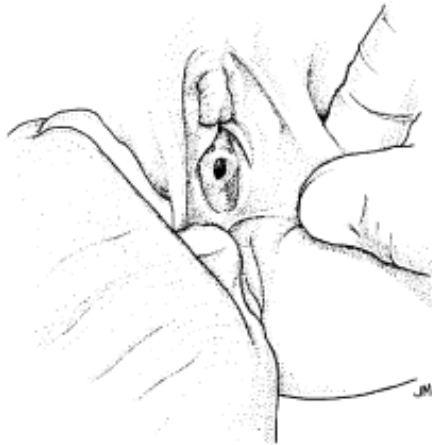


Genitalia Development in Boys



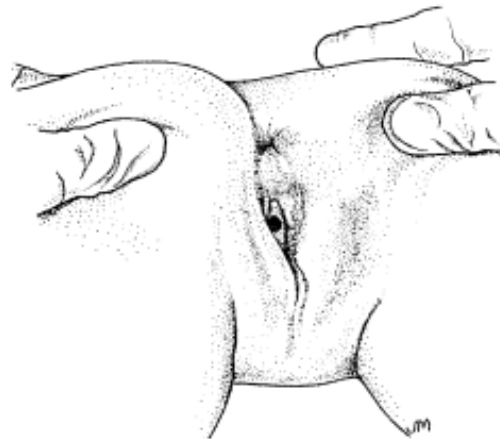
Appendix 2. Illustrations of Exam Positions and Techniques

Supine Labial Separation



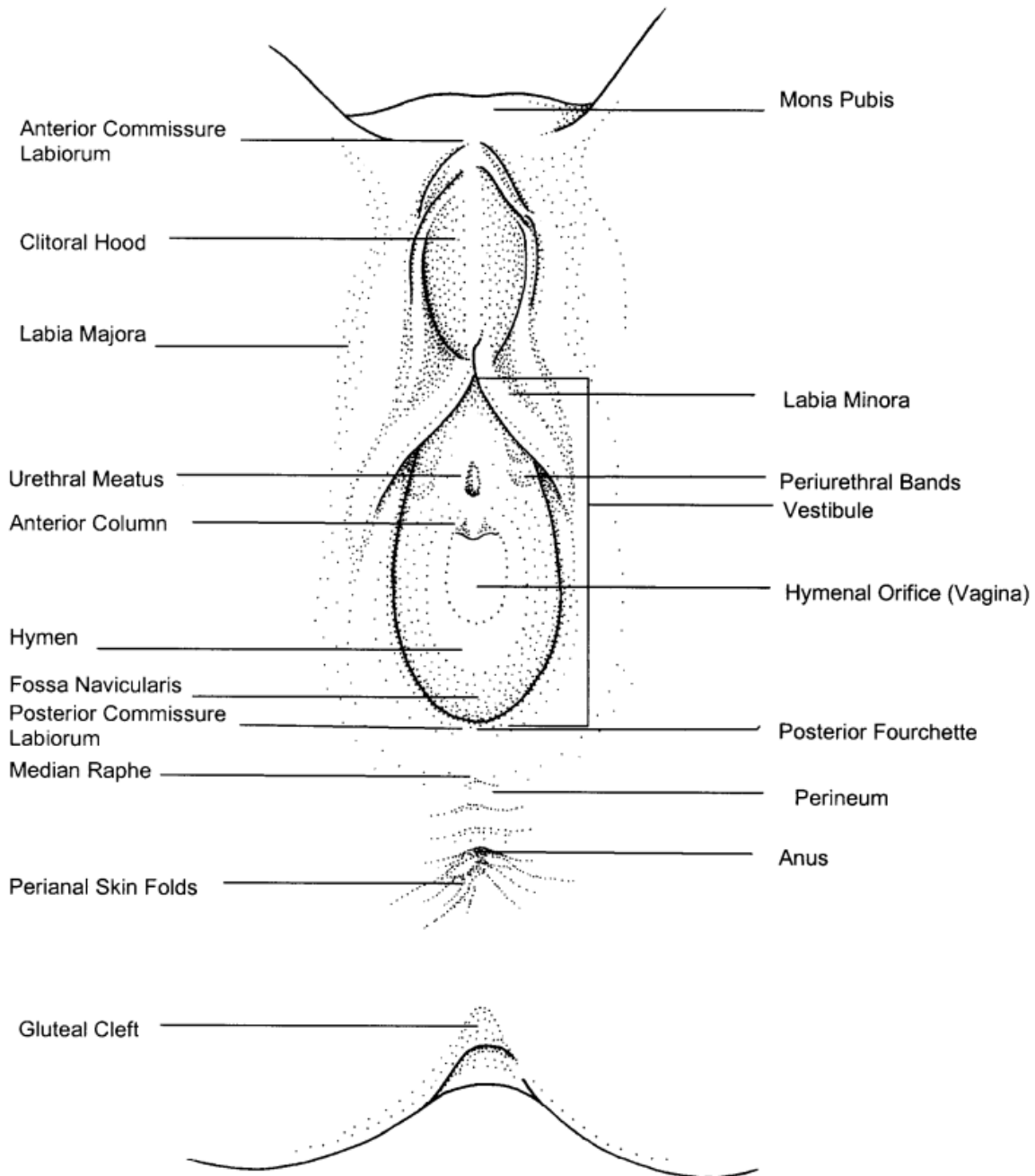
Supine Labial Traction

**Prone
Knee- Chest**



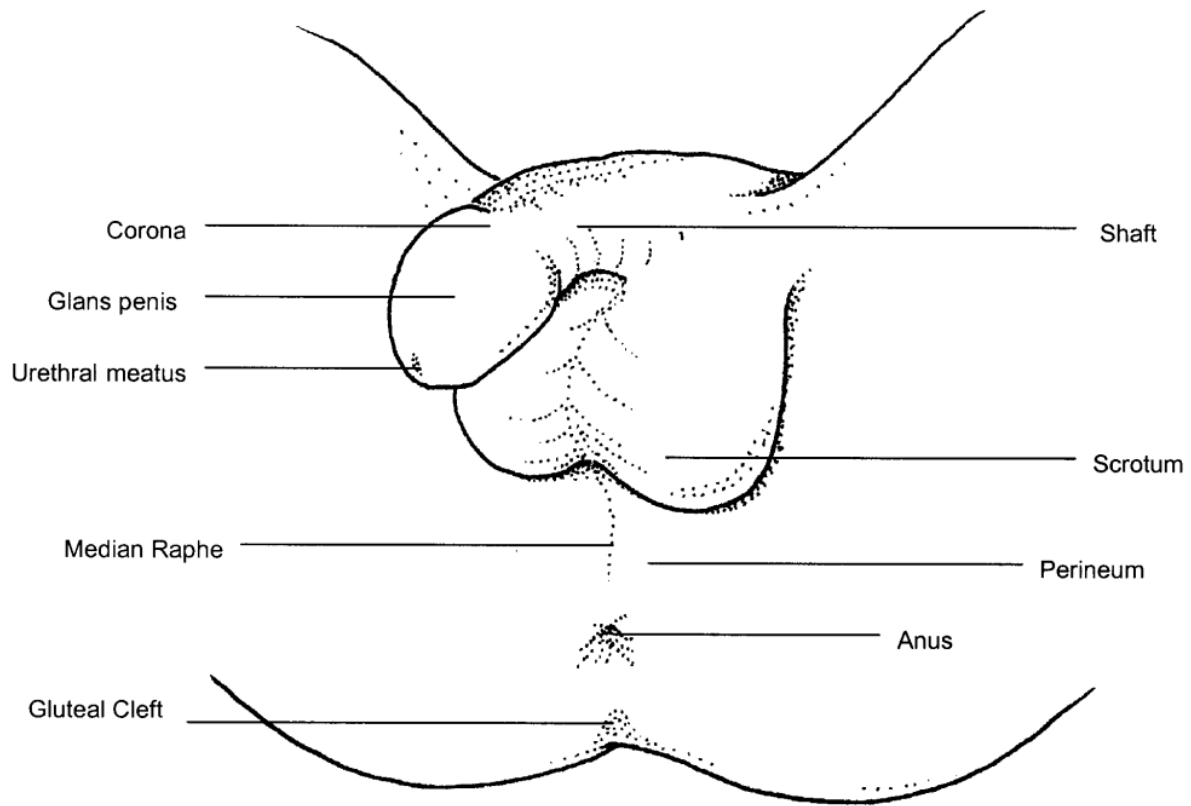
Appendix 3. Labeled Diagrams of Genital Anatomy

*Female Genital Anatomy*²⁴⁹



²⁴⁹ The illustration is from the California Office of Emergency Services (2001), reprinted with permission.

Male Genital Anatomy²⁵⁰



²⁵⁰ The illustration is from the California Office of Emergency Services (2001), reprinted with permission.

Appendix 4. Customizing a Community Protocol

Communities starting from scratch in developing pediatric sexual abuse medical forensic exam protocols are encouraged to consider the recommendations in this national protocol in their entirety and tailor them to fit local needs, challenges, statutes, and policies. Communities that have existing protocols can consider whether any of the protocol recommendations or the tasks below could improve their response to prepubescent child sexual abuse or address gaps in services or interventions.



Contact staff at kidsta.org for technical assistance to help communities address questions that arise during the process of developing, implementing, refining, and enhancing pediatric exam protocols.

Tasks to Customize a Community Pediatric Exam Protocol

- **Form a core planning team.** This team should include representatives from core responding entities involved in the pediatric exam process in the community. (See [A3. Coordinated Team Approach](#)) Representatives should have authority to make policy decisions on behalf of their agencies. If there is already a multidisciplinary response team, it can serve as the core protocol planning team. Make sure your core team seeks input on exam process coordination issues from representatives from tribal lands or military installations within or neighboring the community, as well as institutions within the community that house prepubescent children or place them in housing. (See [A2. Adapting Care for Each Child](#))
- **Seek input from other responders to child sexual abuse.** (See [A3. Coordinated Team Approach](#)) In addition to other professionals directly involved in comprehensive response, organizations serving specific child populations in the community should also be involved. (See [A2. Adapting Care for Each Child](#)) Their input regarding practices related to initial response and the exam process could be sought at least at two points. First, prior to protocol writing, solicit their thoughts about what is essential to include in the protocol and what areas of practice could be improved. Second, once the protocol is drafted, share it with them for their review and comment.
- **Identify roles in planning.** Early in the process, it is important to determine which entities and individuals will be responsible for coordinating overall protocol development planning and related research/information gathering, drafting the protocol, seeking approval for the protocol across entities, and periodically evaluating and updating the protocol.
- **Assess needs.** Before initiating policy changes, the planning team should assess the jurisdiction's current response to child sexual abuse, with a focus on the exam process. (Contact staff at kidsta.org to discuss strategies for community assessment related to improving local response to child sexual abuse specifically around the exam process)
- **Devise an action plan and create/revise the protocol.** The planning team can take what it learns through needs assessments and translate it into an action plan for improving the exam process via the protocol. The plan should identify the steps that need to happen to finalize the protocol, who is responsible for coordinating or carrying out each action, possible resources, desired outcomes, and how the effectiveness of the action will be evaluated. As far as the specifics of identifying practices to include in the protocol and protocol writing, the team should consider (Littel, Malefyt, & Walker, 1998): What process will be used to facilitate decision making on (1) protocol development or revision, (2) protocol drafting and review by partners in response to child sexual abuse, and (3) adoption of the protocol by individual agencies/facilities or the community? How will protocol compliance be monitored and what mechanisms will be employed to solve problems that arise? The planning team should review the national protocol to determine what it wants to adapt for its protocol. It must consider jurisdictional

Tasks to Customize a Community Pediatric Exam Protocol

statutes and policies and how to address community-specific needs and challenges. The action plan can be revisited periodically to assess progress and evaluate outcomes.²⁵¹

- **Distribute the protocol.** The planning team should determine the most efficient method to disseminate the protocol to all professionals in the jurisdiction who are involved in the initial response to child sexual abuse and the exam process. The planning team needs an up-to-date contact list of these professionals, and it should agree upon a specific distribution plan. If electronic distribution is employed, make sure that professionals who do not have Internet access get a hard copy.
- **Build the capacity of involved entities to implement the protocol.** (See Littel, Malefyt, & Walker, 1998) A protocol's effectiveness depends on individual agencies/facilities having adequate resources (e.g., funding, personnel, child-friendly approach, multi-language capacity, equipment, supervision, training, professional development opportunities, and community partnerships) to carry out their responsibilities and coordinate efforts with other involved responders. Agencies/facilities can assist one another in building individual and collective capacity to respond to child sexual abuse and participate in coordinated interventions.
- **Promote accountability.** To help with validating the protocol as a legitimate tool and promoting resource allocation to implement the protocol, consider asking responding agencies/facilities to supplement the protocol with interagency agreements or memorandums of understanding. Using the protocol as a basis, these agreements can outline roles and articulate how responders should work together to coordinate response. These documents should be jointly developed, agreed upon, and signed by agency/facility policymakers. They can be revised and signed on a periodic basis to ensure all agency personnel involved in the response are aware of protocol changes and reaffirm agency/facility commitment to carrying out agreements. Role checklists and performance outcome measures related to protocol practices for all team members can also be useful.
- **Promote training.** Agency/facility-specific, multidisciplinary, and cross-trainings are crucial components of protocol implementation. Involved responders must be informed of any changes in how they carry out agency/facility-specific responsibilities during the exam process and understand why these changes are needed. If they are being asked to coordinate their efforts formally with other entities, they must understand their role in coordination, the benefits of a collaborative response, the challenges such an effort involves, and ways to overcome challenges. (See [A3. Coordinated Team Approach](#))
- **Set up an evaluation system.** The planning team should take the time to consider how to best compile data related to the pediatric exam process in order to evaluate effectiveness of response and make improvements to the protocol as needed.
- **Revise the protocol periodically.** Revisions may be based on feedback from responders and victims, evaluation recommendations, changes in laws, identification of new crime trends and prevention efforts, technology, research, and identification of new promising practices. The planning team should keep track of protocol areas needing improvement and meet periodically to discuss pertinent issues such as language to be used, how to resolve controversies, and, ultimately, to make needed changes.

²⁵¹ See www.tribal-institute.org/download/Completed%20Protocol%20Guide%202003.pdf for a child abuse protocol development resource for tribal communities from the Tribal Law and Policy Institute.

Appendix 5. Impact of Crawford v. Washington and The Confrontation Clause

AEquitas: The Prosecutors' Resource on Violence Against Women contributed this Appendix. Also see *AEquitas* (2012).

The Confrontation Clause of the Sixth Amendment to the United States Constitution guarantees a criminal defendant the right to confront the witnesses against him. This right is always satisfied when a victim testifies at trial and is available for cross-examination.²⁵² However, when the victim is unable to testify at trial (because, for example, she/he is too young or would be too traumatized by testifying), the question arises whether the young victim's statements to a pediatric sexual abuse medical forensic examiner can be admitted at trial.

Whether such statements will be admissible is determined by a line of cases arising in the wake of *Crawford v. Washington*,²⁵³ a landmark decision by the United States Supreme Court that determined when an out-of-court statement made by a non-testifying witness can be admitted at trial without violating the Confrontation Clause. In *Crawford*, the Court held that whether prior statements of a non-testifying witness will be admissible depends upon whether that prior statement is "testimonial" or "nontestimonial." Only nontestimonial statements can be admitted at trial without offending the Confrontation Clause.²⁵⁴ *Crawford*, and subsequent cases, including *Davis v. Washington*²⁵⁵ and *Michigan v. Bryant*,²⁵⁶ provide limited guidance as to when statements will be considered testimonial or nontestimonial. (Note, however, that this case law is not necessarily applicable in tribal courts, as tribes are sovereigns and can look to their own codes and laws for guidance in their court rulings)

Certain categories of statements are typically considered testimonial (and, thus, inadmissible unless the witness testifies), including affidavits, formal or structured statements to law enforcement, and testimony in court or at a deposition. These statements are considered testimonial because their purpose is to provide information that might be relevant to future prosecution.

Nontestimonial statements—those that can be admitted at trial, even if the witness is unavailable, without offending the Confrontation Clause—are generally less formal, not given under oath, are usually made to someone other than a law enforcement authority, and are not given for purposes of providing information relevant to future prosecution. Examples include statements to family members and friends and *statements to medical professionals for purposes of diagnosis or treatment*.

²⁵² It is important to note that even when victims do testify at trial, statements to a pediatric professional still must satisfy a state's hearsay exception. Where the statement is made for purposes of medical diagnosis or treatment, such statements will most often be admissible; however, the "forensic" aspects of the examination may still preclude admission of statements found to be insufficiently related to the medical purpose of the examination. See, e.g., *State v. Mendez*, 242 P.3d 328, 339-343 (N.M. 2010) (requiring courts to carefully scrutinize statements to SANE for trustworthiness in light of the purposes of the hearsay exception for statements made for purposes of medical diagnosis and treatment).

²⁵³ 541 U.S. 36 (2004).

²⁵⁴ 541 U.S. 36 (2004).

²⁵⁵ 547 U.S. 813 (2006).

²⁵⁶ 562 U.S. 344 (2011).

One exception to the general rule that statements to law enforcement will be considered testimonial are statements made to law enforcement *for the purpose of responding to an ongoing emergency*. To the extent that a victim or witness communicates with law enforcement for purposes of requesting help, or so the law enforcement can respond to an emergency, the statement will be considered nontestimonial (and, thus, admissible under *Crawford*).

The difficulty that arises with respect to a child victim's statements to a pediatric examiner arises from the dual purpose that such professionals serve in the context of examining and treating the victim. In addition to conducting a thorough examination for purposes of identifying and treating any injury the victim may have suffered, pediatric examiners are trained to preserve forensic evidence for possible future prosecution. The victim may be brought in for examination accompanied by law enforcement and law enforcement may have specific questions they hope to have answered. While it is not recommended, it is also possible that law enforcement in some instances may even be present for or observe examinations.

Because the U.S. Supreme Court has not specifically ruled on *Crawford's* applicability in the context of such medical forensic examinations, the admissibility of a victim's statements to a pediatric examiner will be controlled by the case law of the jurisdiction where the prosecution is being conducted. The results of these cases have been mixed, and not all jurisdictions have considered the specific question, so the law may not be clear in every jurisdiction. There are a few jurisdictions that have taken the position that any statements made to a sexual assault nurse examiner (SANE) or sexual assault forensic examiner (SAFE) will be considered testimonial under virtually all circumstances, simply because one of the roles of a SANE or SAFE is to document and collect forensic evidence.²⁵⁷ Far more common, however, is a nuanced, fact-sensitive analysis that will result in some statements being considered testimonial and others considered nontestimonial. Sometimes a court will rule that statements made during one portion of the examination are testimonial while statements made during a different portion are nontestimonial. Some courts also focus more on the victim's purpose in making the statement than on the examiner's purpose in asking the question that elicited it. Thus, a statement by a very young victim who does not appreciate the fact that statements might be used for prosecution purposes is more likely—at least in some courts—to be held nontestimonial than a similar statement by an older victim who might understand that the statement could be important at trial.

Generally speaking, the more that questioning in a medical history as part of medical forensic care is directed toward medical treatment, rather than law enforcement or evidentiary purposes, the more likely a victim's statements will be held to be nontestimonial (and thus admissible). Pediatric examiners who perceive their primary role as one of assisting law enforcement, and who focus their practice accordingly, risk having

²⁵⁷ See, e.g., *Hartsfield v. Com.*, 277 S.W.3d 239 (Ky. 2009) (adult victim); *Medina v. State*, 143 P.3d 471 (Nev. 2006) (adult victim); *State v. Ortega*, 175 P.3d 929 (N.M. Ct. App. 2007) (overruled in part on other grounds, *State v. Mendez*, 242 P.3d 328 (N.M. 2010) (overruling *Ortega's* analysis of the states' hearsay exception but leaving undisturbed the Court of Appeals' confrontation analysis)). The *Ortega* court characterized a SANE exam as "a forensic exam with medical features." 175 P.3d at 934. The court's analysis would appear to preclude, under the confrontation clause, virtually all statements made to a SANE, at least in the absence of a medical emergency.

their patients' statements excluded as testimonial under *Crawford* and the Confrontation Clause. Conversely, examiners who perceive their primary role as one of providing appropriate medical care and treatment are more likely to elicit statements that will be admissible as nontestimonial statements made for purposes of medical diagnosis and treatment. Pediatric examiners should be able to articulate a practice philosophy that is patient-centered and medically focused when being questioned as a witness at trial. For health care providers, *Crawford* and its progeny do not change the priorities of the medical forensic examination, which should continue to hold the health and wellbeing of patients of primary importance.

It is also important to note that even when statements to pediatric examiners are considered to be testimonial, and thus normally inadmissible, those statements might nevertheless be admissible if the defendant is found to have engaged in wrongdoing that caused, and was intended to cause, the victim to be unavailable for trial. The doctrine of "forfeiture by wrongdoing"²⁵⁸ will allow any hearsay statements of a victim (including any testimonial statements to a pediatric examiner) to be admitted at trial if the defendant has intentionally caused the victim to be unavailable by, for example, intimidating or manipulating the victim or the victim's caregivers.²⁵⁹

For health care providers, the Confrontation Clause, as interpreted in *Crawford* and its progeny, should not alter the relative importance of the dual purposes served by the medical forensic examination, which should continue to prioritize the health and wellbeing of patients over concerns about documentation or forensic evidence-gathering for purposes of prosecution. Still, it is helpful for practitioners to be aware of the factors that might affect the admissibility of statements made in the course of their examination.



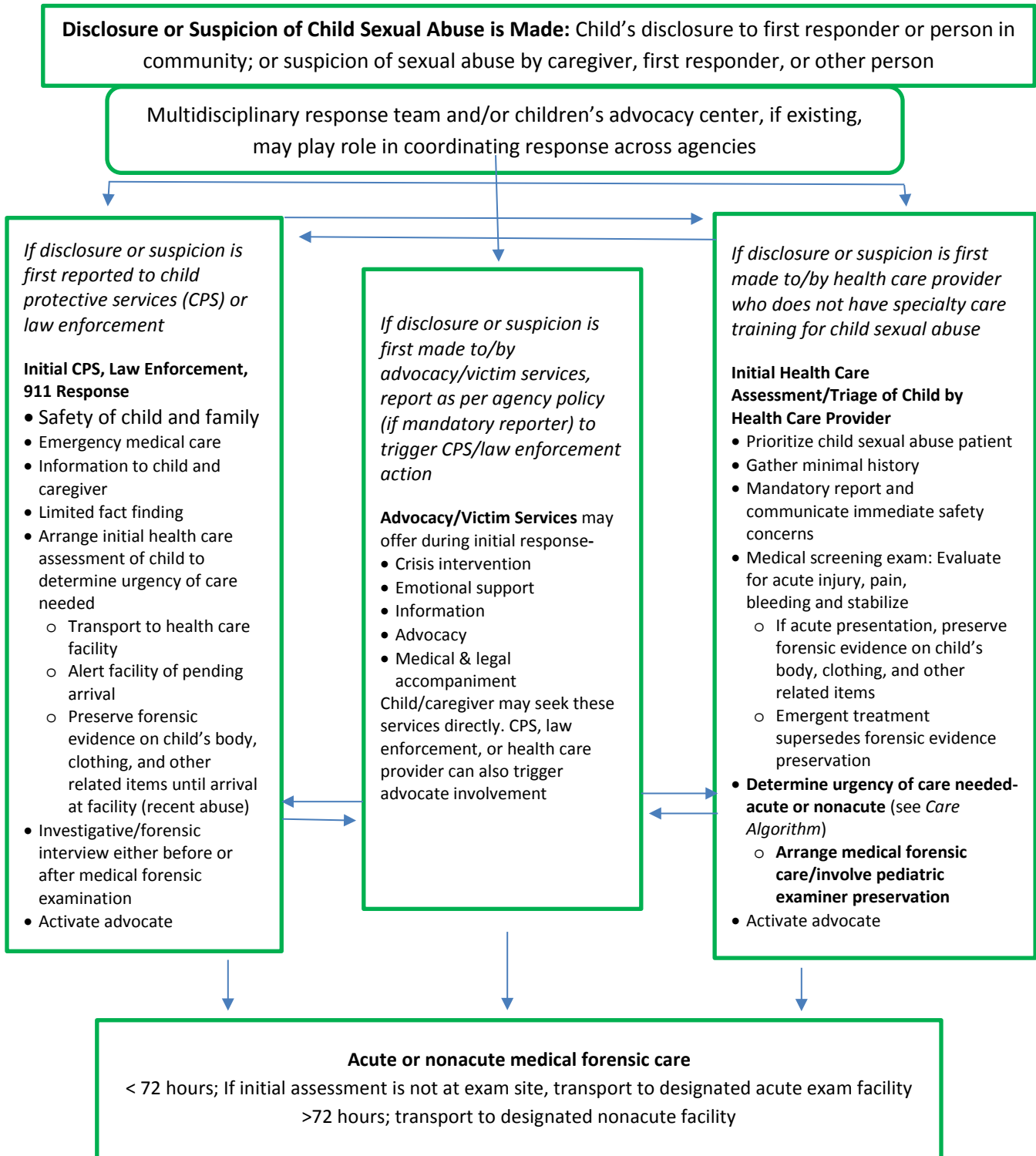
See www.Kidsta.org for related case law examples.

²⁵⁸ See, e.g., FED. R. EVID. 804(b)(6); *Giles v. California*, 554 U.S. 353 (2008).

²⁵⁹ See Lyon and Dente (2012). The authors, who describe many forms of possible "wrongdoing" in the sense of manipulation and exploitation of young victims of sexual abuse, note that "defendants subvert justice not only through overt threats and violent acts, but also through exploitation and manipulation of our most vulnerable citizens. When exploitation ensures that a child victim will not testify, a finding that the defendant has forfeited his confrontation rights is a fair means to let the child be heard." *Id.* at 1232.

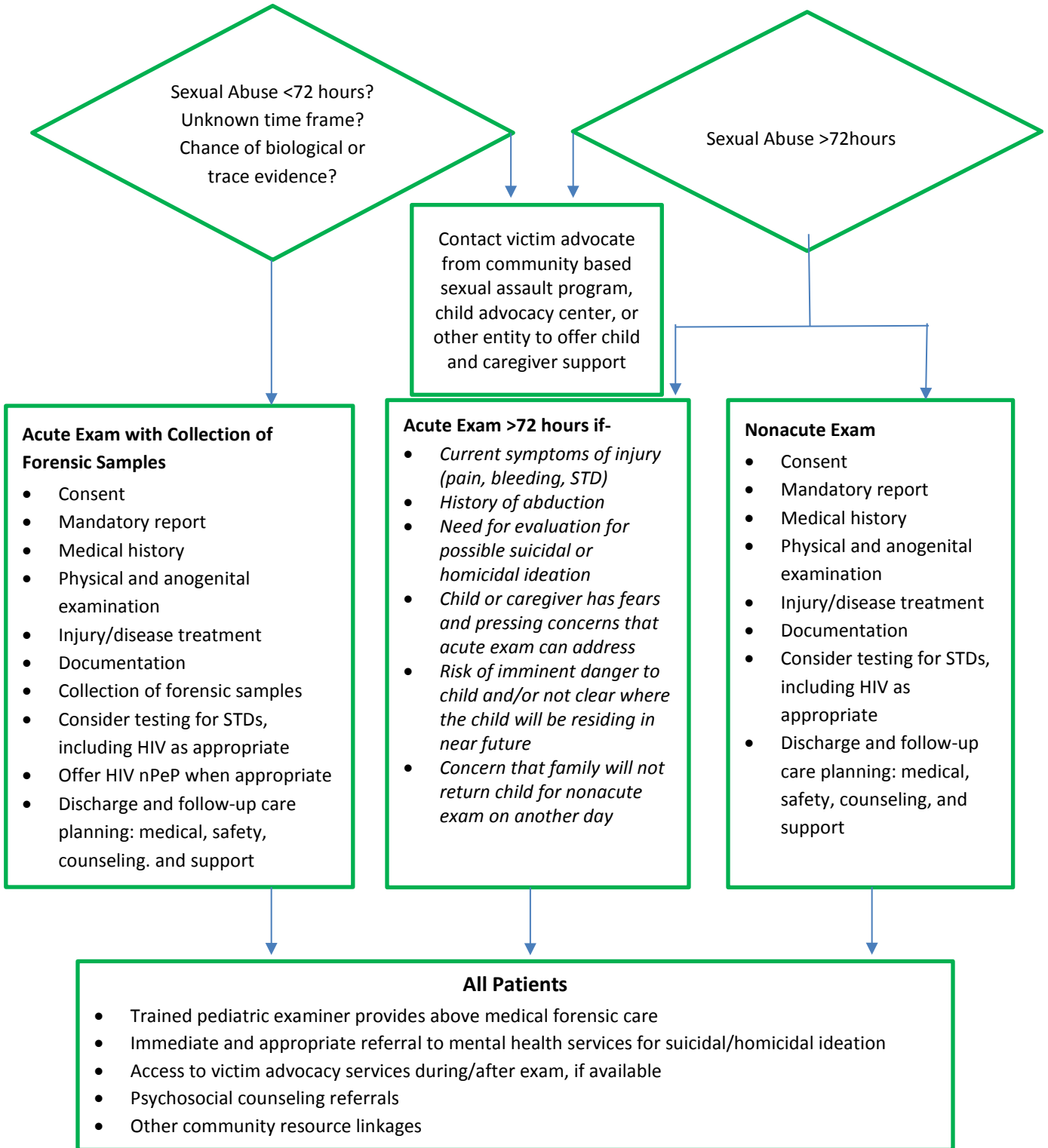
Appendix 6. Initial Response Algorithm

This algorithm, based on [B2. Initial Response](#), is meant to illustrate the general flow of and procedures involved in initial response in prepubescent child sexual abuse cases. However, flow and procedures are subject to jurisdictional and agency/facility policies.



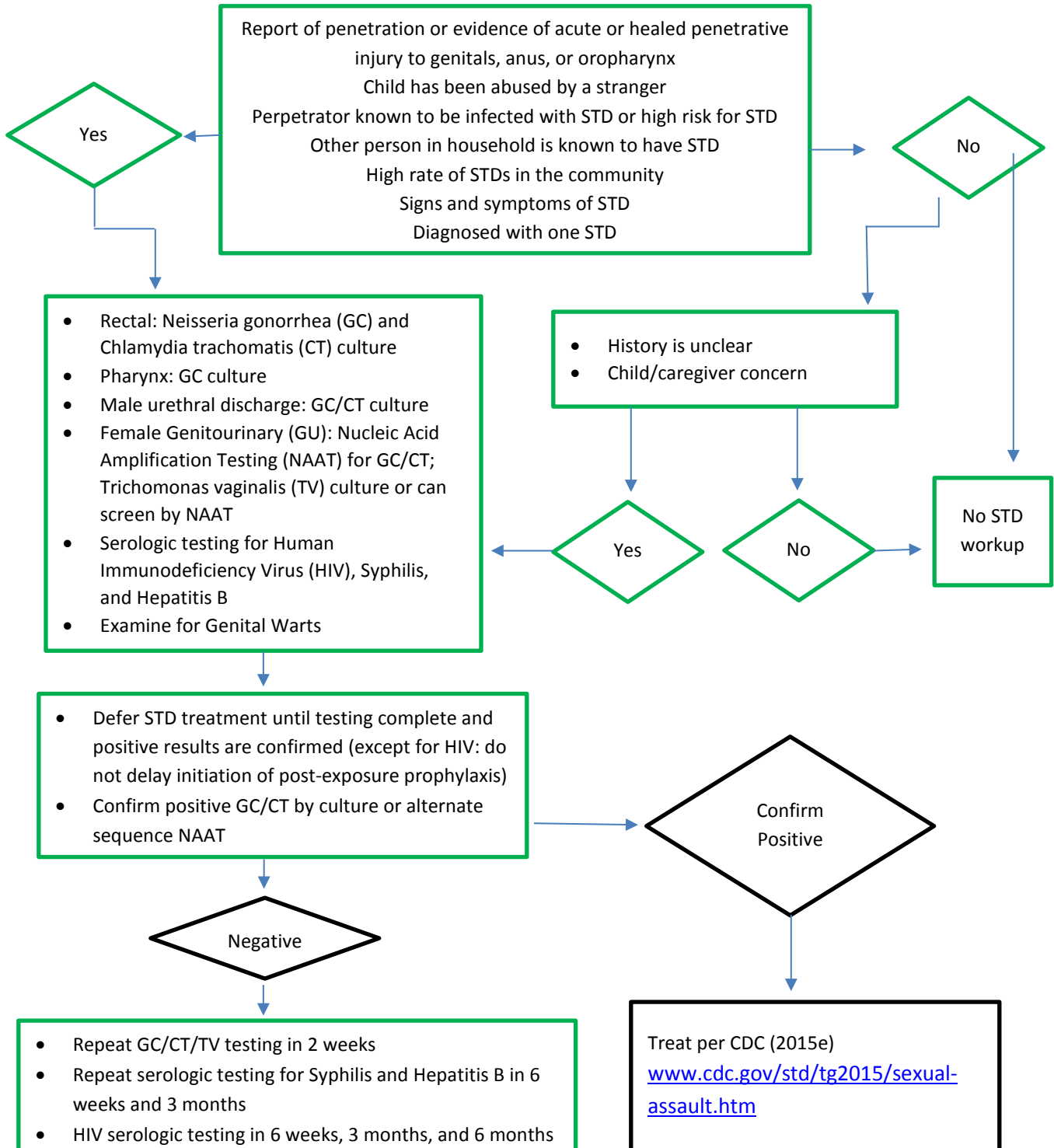
Appendix 7. Care Algorithm

The algorithm, adapted in part from Day and Pierce-Weeks (2013), illustrates the general flow of and procedures involved in medical forensic care in prepubescent child sexual abuse cases. However, flow and procedures are subject to jurisdictional and agency/facility policies.



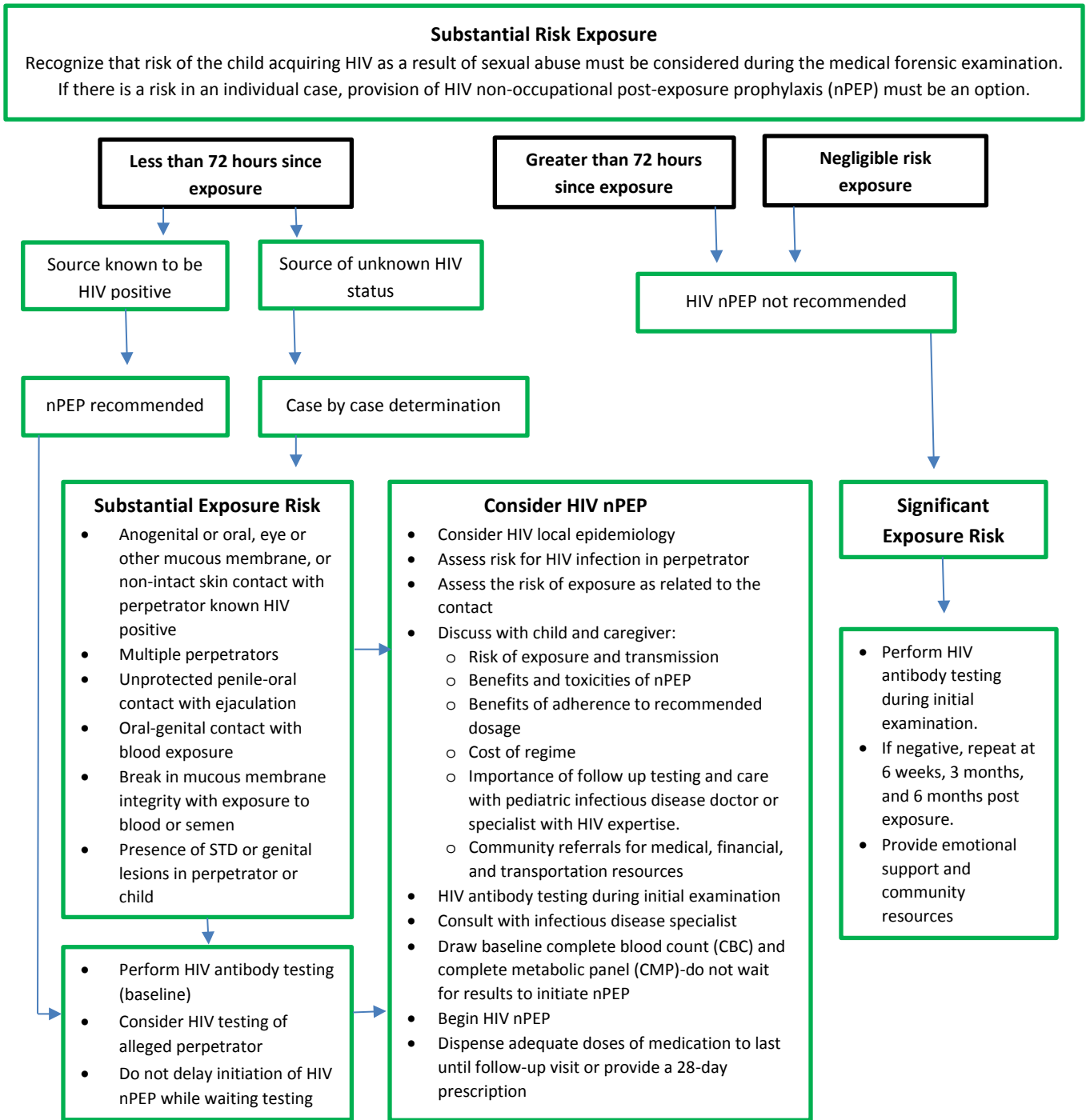
Appendix 8. Prepubescent STD Testing Algorithm

This algorithm is based on [B10. Sexually Transmitted Disease Evaluation and Care](#), and adapted from/supported by sources including the CDC (2015e), Esernio-Jenssen and Barnes (2011), Farst (2011), Jenny, Crawford-Jakubiak, and Committee on Child Abuse and Neglect (2013), and Hammerschlag and Gaydos (2012). It is meant to illustrate the general flow of and procedures involved in STD testing in prepubescent child sexual abuse cases. However, flow and procedures are subject to jurisdictional and agency/facility policies.



Appendix 9. HIV Testing nPEP Algorithm²⁶⁰

The algorithm, based on information provided in [B10. Sexually Transmitted Disease Evaluation and Care](#), illustrates the general flow of and procedures involved in post-exposure HIV risk assessment in prepubescent child sexual abuse cases. However, flow and procedures are subject to jurisdictional and agency/facility policies.



²⁶⁰ The algorithm was drawn from information from the CDC (2015e), Jenny et al. (2013); the Ohio Chapter of the AAP Committee on Child Abuse and Neglect (2009); and the State of New Hampshire (2015).

Appendix 10. Participants in Protocol Development

Individuals Participating in the Protocol Development Process

(This list includes those who participated on the advisory committee, in work group meetings and additional phone consultations, and/or as protocol draft reviewers. It does not include representatives of federal agencies. Note that while protocol development benefited immensely from the input of all involved individuals, the views expressed in this publication do not necessarily reflect the views of all individuals participating in the process.)

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Civil Rights Division

Federal Bureau of Investigation

Executive Office for U.S. Attorneys

Office of Justice Programs

- Office of the Assistant Attorney General
- Office for Victims of Crime
- Office of Juvenile Justice and Delinquency Prevention
- Office for Civil Rights
- National Institute of Justice

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