Wisconsin Chapter – International Association of Forensic Nurses

SEXUAL ASSAULT NURSE EXAMINER (SANE) / FORENSIC NURSE EXAMINER (FNE) EVALUATION OF THE PEDIATRIC VICTIM OF SEXUAL ASSAULT

This guideline was developed/completed by the WI-IAFN Pediatric Protocol / Documentation Committee on July 18, 2012

SEXUAL ASSAULT NURSE EXAMINER (SANE) / FORENSIC NURSE EXAMINER (FNE)
EVALUATION OF THE PEDIATRIC VICTIM OF SEXUAL ASSAULT

This guideline was developed by the Wisconsin Chapter of the International Association of Forensic Nurses. This guideline is recommended for the care of the prepubertal child when there is a history or concern of sexual abuse or assault. The guideline is not intended to include all the triage issues, medical evaluations, tests, and follow-up that may be necessary for appropriate care for an individual patient. The guideline represents the basic steps in the assessment and care of the sexual assault patient. Not all the steps outlined in this guideline will be appropriate for every patient. The purpose of this guideline is to provide direction for SANE / FNE in the care of the pediatric sexual assault patient. The goal is to provide compassionate and sensitive services and care in a non-judgmental manner. The physical and psychological well-being of the sexual assault patient is given precedence over forensic needs. A review of the guideline by the members of the Wisconsin Chapter of the International Association of Forensic Nurses Pediatric Protocol / Documentation Subcommittee will be conducted periodically.

I. GENERAL INFORMATION

Purpose of Exam

Medical/Forensic

1. Identify and treat injuries. Injuries that require intervention beyond scope of practice of SANE/FNE should be referred to the physician for treatment
2. Assess risk of pregnancy and sexually transmitted infections
3. Provide prophylaxis for sexually transmitted infections, when indicated
4. Document medical history
5. Document physical findings
6. Assess for other forms of abuse
7. Identify, collect, document forensic evidence

Social/Psychological

1. Respond to patient's and family's immediate emotional needs and concerns
2. Assess patient safety and immediate mental health needs
3. Explain mandatory reporting process, Crime Victims Compensation, resources for advocacy, counseling, and follow-up

Consult/Report/Refer

1. A SANE/FNE Program and a Child Advocacy Program / child abuse pediatrician / expert nurse practitioner should have a relationship and agreement in place for the care of the child and consultation as needed. It is recommended that a peer review of photographs with a child abuse pediatrician / expert nurse practitioner occur with children with a physical finding related to possible abuse / assault.
2. Refer for follow-up medical care
3. Refer for advocacy and counseling
4. Report to Child Protective Services (CPS) and/or law enforcement ASAP

Mandated Reporting

1. Nursing and medical providers are mandated to report suspected child abuse to CPS and/or law enforcement ASAP when the victim is under 18 years of age (WI Statute)
2. Mandatory reporting applies even when minor has signed consent for their own care
3. Report to law enforcement in the jurisdiction where crime occurred. Contact CPS in the county in which child resides
4. Advise patient/parent/caregiver of mandated reporting to CPS and/or law enforcement unless doing so would jeopardize the safety of other children.
5. All mandated reporting must be documented within the medical record

Consent

1. No parental consent is needed to conduct a child abuse medical evaluation including evidence collection, photographs, examination and laboratory tests.
2. Assent from the child is needed when the child is verbal.
3. Follow hospital/agency policy regarding consent.
4. Wisconsin law specifically exempts need for consent when photographs are taken for child abuse medical evaluation. WI Statute 48.981(4).

II. TRIAGE DECISIONS

Medical stabilization always precedes forensic examination

Triage

1. The following history or conditions should be evaluated medically prior to the sexual assault exam:
   - History of loss of consciousness
   - Head injury
   - Altered consciousness or mental status
   - Abnormal vital signs
   - Respiratory distress
   - Significant facial injury
   - Possible fractures
   - Blunt or penetrating injury to chest, abdomen or back
   - Active bleeding
   - Strangulation
   - Pregnancy
   - Acute pain
   - Any other injury or condition which may endanger life or health of patient
2. Psychiatric illness
   - If apparent psychiatric illness complicates assessment of reported sexual assault, both psychiatric assessment and medical exam may be necessary. Proceed according to patient tolerance and needs

Medical/Forensic Examination

Current research shows that it is unlikely that DNA/trace evidence will be found on the prepubertal child beyond 24 hours (from time of the assault) except for non-body specimens such as underclothing and bed linens. However, the collection of DNA/trace evidence is best done at the discretion of the individual SANE/FNE who is knowledgeable of the particulars of the assault. The Wisconsin State Crime Laboratory allows for the collection of evidence up to 120 hours post assault.

Acute (If assault within 120 hours)

1. Medical/forensic exam is considered urgent. Patients with injury, bleeding, and/or pain should always be considered acute.
2. Advise patient or parent/caregiver, if possible:
   - Do not bathe before exam
   - Bring in clothes worn at time of assault and immediately after assault, especially undergarments

Non-Acute (If assault greater than 120 hours)

1. Forensic Exam
   - Forensic exam is generally NOT indicated on emergency basis. Consider community protocol regarding order of forensic interview and examination.
   - Individual case circumstances may warrant urgent evidence collection beyond 120 hours after an assault (i.e., little or no post assault hygiene, held captive, etc.) or when requested by law enforcement
2. Medical Exam
   - Medical evaluation is indicated for all patients at any time following sexual assault
     - Patients may be evaluated by the SANE/FNE or referred to a Child Advocacy Center or other appropriate clinic for medical care

- Refer to sexual assault center, advocacy organization or mental health counselor for psychological support for patient and/or parent/caregiver/family.

Advocacy

SANE / FNE Programs will contact advocacy when the SANE/ FNE is called and together will respond as a team

III. HISTORY AND INITIAL EVALUATION

See the WI-IAFN Sexual Assault Nurse Examiner (SANE) / Forensic Nurse Examiner (FNE) Pediatric Sexual Assault Documentation Form

Patient Information

Document the following information if it is available and pertinent:

1. Routine demographic data: patient name, gender, ethnicity/race, age, birth date, medical record number, home address, phone number/contact information
2. Parent/caregiver name, home address, phone number/contact information, custody status
3. Date and time of arrival
4. Who accompanied patient, and their relationship
5. Interpreter name, if used, and language
6. Name of advocate and agency
7. Name of law enforcement personnel and agency
8. Law enforcement case number, if available
9. Name of CPS worker and agency

History of Assault

The forensic interview of the child is investigative, performed to gather facts regarding suspicions, allegations or specific incidents. Forensic interviewing is conducted only by those specifically trained in the forensic interviewing of children. Forensic interviewing is NOT included in the education of the pediatric SANE/FNE. Whenever possible follow community protocol regarding the timing of the forensic interview and SANE/FNE exam. Consider obtaining minimal facts from the child at the time of the acute SANE/FNE exam and referring to Child Advocacy Center for a forensic interview. Interviewing of the parent/guardian or other adult who accompanies the child should not be performed in front of the child. Document the following ONLY if known or spontaneously disclosed:

Facts about assault

1. Source of information (patient, CPS, CAC provider, family, police, or other person)
2. Nature of assault
3. Time, place of assault, and jurisdiction/location if known
4. Time since assault
5. Number of assailants and identity of assailants, if known
6. Relationship of assailant(s), if known
7. Record narrative history of assault
8. Photographs taken by assailant

Methods used for control

The child by definition is in a vulnerable position if the assailant is an adult, is significantly older or in a position of power.

1. Patient had impaired consciousness
2. Known or suspected alcohol/drug ingestion
3. Verbal threats
4. Use of physical force
5. Use of restraints, including body weight
6. Use of weapon
7. Use of coercion, manipulation, grooming
8. Strangulation and/or suffocation

Physical facts of sexual assault

1. Location of physical contact on patient by assailant
2. Body parts or objects used by assailant
3. Whether condom was used
4. Whether lubrication was used
5. Physical injuries
6. Whether bleeding or pain was reported
7. Physical contact made by patient on assailant

Post assault activity of the patient

1. Showered or bathed
2. Rinsed mouth, urinated, defecated
3. Changed clothes, gave clothes to police at scene, or brought clothes worn at time of assault to hospital/agency

Medical History

1. Significant medical problems, surgery, major injuries, chronic diseases, immune problems, developmental, cognitive, mental health and/or physical disabilities
2. Current medications including over-the-counter drugs and herbal supplements
3. Recent ingestion of other drugs, including over-the-counter drugs, legal and illegal substances, and/or alcohol
4. Allergies
5. Immunizations status
6. Review of systems
7. Current complaints/symptoms including vaginal, urethral, anal discharge, anogenital itching, bleeding, pain, odor, dysuria, encopresis.
8. Items which may affect physical findings – Toilet training, bowel / bladder history, recent UTIs, hygiene, enuresis, constipation, bubble baths, diarrhea, recent antibiotics, any prior surgery/injury to anogenital area
9. Prior sexual abuse/assault

Plan of Care

1. Discuss medical and forensic examination with patient and parent /caregiver
2. Consider child's developmental stage
3. Rapport building
4. Inform patient that written information and educational literature will be provided
5. Discuss use of medical photography for documentation.

IV. MEDICAL EXAMINATION

General Information

1. All patients should receive a complete head-to-toe physical examination.
    - Document mental status, general appearance, any physical or cognitive disability.
    - Document objective observations
    - Vital signs, height, weight, pain (age appropriate scale) per hospital/agency protocol
    - Document Sexual Maturity Rating (SMR)
2. It is the patient's right to consent or refuse any aspect of the exam and evidence collection.
3. The patient may have a support person (relative, friend, or advocate) present during the exam. Document who was in the room during the examination.
4. Explain all procedures prior to performing them.

Injury Photodocumentation

The use of photodocumentation during the examination of the prepubuteral child is highly recommended for the purpose of peer review, case review, and consultation. Prior to photodocumentation, an agency should have policies for consent for photographs, and a procedure of how photographs will be taken,

stored, and released. SANE / FNE should take photographs regardless if law enforcement has taken photographs. Careful documentation with drawings is necessary even when photographs are taken.

Exam Procedure

The following sections outline the steps for the exam and collection of evidence. The order of these steps may vary by examiner preference or patient need.

Oral Exam

1. Document lacerations, abrasions, petechiae, and bruises and how injury acquired, if known.
2. Document sites of pain even if no injury is noted. Document how pain acquired, if known.
3. Check mucosa, palate, upper/lower frenula, tongue and teeth.
4. Collect forensic swabs (*See section **V. Evidence Collection & Storage***)

Skin Exam

1. Document bruises, petechiae, abrasions, lacerations, bite marks, and suction ecchymosis and how injury acquired, if known.
2. Document sites of pain even if no injury is noted. Document how pain acquired, if known.
3. Describe traumatic lesions and marks on anatomical sheets.
4. Ask patient how each injury occurred and document patient's statement.
5. Using alternative light source with room lights dimmed, scan patient's skin surface, including breasts, abdomen, perineum, hair, face, buttocks, and thighs:
    - Document presence/absence and location of fluorescence
    - If history indicates presence of evidence, collect blind swab from area even if no fluorescence is noted
6. Assess areas of the skin that are easily missed including behind the ears, soles of the feet, palms of the hands, scalp.
7. Collect forensic swabs (*See section **V. Evidence Collection & Storage***)

Genital Exam – Female

The child will be examined in two different positions, if tolerated. The use of magnification is recommended to aid in the identification of injury.

1. Document sexual development (SMR) including estrogenation of hymen
2. Document hymen shape, presence of posterior rim of hymen.
3. Document genital lacerations, abrasions, bruises, petechiae, erythema, inflammation, bleeding, edema, discharge, etc.
4. Document sites of pain even if no injury is noted. Document how pain acquired, if known.
5. Collect forensic swabs (*See section **V. Evidence Collection & Storage***)
    - Swabs of the external genitals (vulvar and vestibular) should be obtained.

A speculum examination is NOT recommended with prepubertal children. However, an examination under anesthesia (consultation with physician) may be necessary in cases in which there are significant lacerations, bleeding, hematoma, presence of foreign body is suspected or it is considered medically necessary.

Factors to consider prior to performing speculum examination without anesthesia:

- Estrogenization of hymen (may be premenarche but fully estrogenized)
- SMR
- Patient's ability to tolerate, cooperate

Genital Exam – Male

1. Document penile, scrotal or perineal abrasions, bruises, lacerations, petechiae, bleeding, edema, discharge, erythema, inflammation, tenderness and SMR.
2. Document sites of pain even if no injury is noted. Document how pain acquired, if known.
3. Document if circumcised or not.
4. Retract foreskin to examine glans penis

5. Collect forensic swabs (*See section **V. Evidence Collection & Storage***)
6. The use of magnification is recommended to aid in the identification of injury

Perianal and Anal Exam

1. Document perianal bruising, petechiae, edema, discharge, bleeding, tenderness, abrasions, lacerations, erythema, inflammation, and visible anal dilation.
2. Document sites of pain even if no injury is noted. Document how pain acquired, if known.
3. Collect forensic swabs (*See section **V. Evidence Collection & Storage***)

Exam Technique

- Use good light source
- Separate anal folds to visualize injuries
  - The use of magnification is recommended to aid in the identification of injury
- Anoscopy is NOT routine in the assessment of the prepubertal child. Anoscopy is indicated if there is a report of anal assault and active rectal bleeding, suspected foreign body or rectal pain. This procedure should be done under anesthesia and by a physician.

Anogenital findings may be classified using guidelines published by Adams et al. See resource list.

V. EVIDENCE COLLECTION & STORAGE

Forensic Evidence Collection

Standard Sexual Assault Evidence Collection Kit is used for evidence collection.

- May be purchased from the Wisconsin State Crime Laboratory
- Someone is available at the Crime Lab 24/7 to answer questions at (608) 266-2031

Chain of Custody of Forensic Specimens

One staff member must be responsible for maintaining chain of evidence at all times. That staff member:

1. Observes specimens OR
2. Designates another staff member to watch specimens OR
3. Stores specimens in secured refrigerator, cabinet, or specific area (per hospital/agency policy) until they are picked up by law enforcement personnel.

Evidence Collection

General Information

1. It is the patient's right to consent or refuse any aspect of the exam and evidence collection.
2. The physical and psychological well-being of the sexual assault patient is given precedence over forensic needs.
3. Change gloves frequently during all phases of evidence collection and processing.
4. The proper collection of evidence is dependent upon the history of the assault and examiner discretion. Children often do not report the full extent of the abuse on initial disclosure.
5. Envelopes may be relabeled when used to obtain swabs from sites other than those outlined in the kit.
6. The kit does not include everything that one needs to collect evidence. Materials such as scissors, tape, etc. will need to be collected from hospital stock.
7. Drying of collected materials is very important as moisture enhances the proliferation of bacteria and mold which will destroy biological and trace evidence. Drying may be accomplished by air drying (in the boxes included in the kit) or by the use of a drying box. Use of a drying box requires the development of policy which addresses the cleaning of the box and the methods used to prevent cross contamination of the swabs. Law enforcement should be informed of items which require further drying.
8. Collect evidence which may be compromised by time or examination FIRST such as oral swabs and smear (in cases of an oral assault) and fingernail debris/scraping.
9. NEVER LICK evidence envelopes to seal.
10. NEVER store evidence in plastic bags or airtight containers.

Sexual Assault Report Form (included in WI State Crime Lab kit)
1. Fill out all information requested on form.
2. Have parent / caregiver / child protection worker sign and date consent section, the SANE/FNE must sign and date form where indicated.

Oral Swabs and Smear
Collect ASAP when:
1. Abuse/assault occurred or visible oral injury or history of oral/genital contact.
2. Collect 2 swabs, thoroughly swab the oral cavity, especially between the cheeks and gums.
3. Using swabs, rub a dime-sized area on center of slide/smear.
4. Allow swabs and slide/smear to thoroughly air dry.
5. Place swabs in swab box, check off site on box.
6. Return slide to slide holder and close.
7. Return swabs and slide/smear to envelope.
8. Unwaxed dental floss can be used for areas between the teeth. Have the patient or SANE/FNE floss the teeth *using a minimal amount of floss*. Do not return the used floss to the plastic bag – place in oral swabs envelope.*
9. Seal and fill out all information requested on the envelope.

*An HIV risk assessment is standard procedure in a SANE examination. If this risk assessment determines that the patient is at risk for the possible transmission of HIV, the use of dental floss should be omitted.
Reference – *IAFN Position Statement on DNA Evidence Collection from the Oral Cavity*, September 2013

Buccal Cell Standard (DNA)
Collect reference oral standard swabs to establish patient DNA
1. Rinse mouth with water prior to collecting sample.
2. Using one swab, place the swab in solid contact with the inner cheek and gum surface.
3. Gently move the cotton tip in and out five or six times, rotating the swab while rubbing.
4. Repeat process with the second swab on the other inner cheek and gum surface.
5. Do not collect from the teeth or along the edges of the teeth.
6. Place the swabs on the sterile swab package to thoroughly air dry.
7. Return the dried swabs to the envelope.
8. Seal the envelope and fill out all information requested on envelope.

Fingernail Evidence
Collect if patient reports scratching assailant or examiner believes nail debris may be related to assault. Obtain when visible debris or blood under nails, nails broken during assault and/or history suggests patient scratched assailant.
1. Evidence from each hand should be collected individually. Place small paper sheet on flat surface.
2. Using disposable plastic scraper or tapered swab, scrape / swab under all five fingernails of left hand (or right), allowing any debris to fall onto paper.
3. Bindle paper (fold all edges inward so that there are no open edges) to retain debris and scraper.
4. Place paper and scraper from each hand in a separate labeled envelope.
5. Place envelopes from both hands in the larger envelope.
6. Seal the envelope and fill out all information requested on envelope.
7. Fingernail swabbings may be obtained if the fingernails are short. Use one moistened swab and one dry swab for each set of nails/hand.

Debris
Collect when foreign material is visible on patient's skin or hair and patient reports, or examiner believes, debris is related to the assault.
1. Collect any foreign debris (dirt, leaves, fiber, hair, etc.).
2. Separate debris – DO NOT collect unlike debris from one site or like debris from different sites in the same envelope.
3. Note site from which debris is obtained on the envelope.
4. Seal the envelope and fill out all information requested on envelope.

Trace Evidence/Collection Paper
To collect foreign material that may fall when patient undresses:
1. Place bed sheet or large paper sheet on floor. This is to prevent floor debris from adhering to evidence collection paper.
2. Place evidence collection paper sheet over the bottom sheet (sheet on floor).
3. Instruct patient to stand in the center of paper and remove clothing.
4. Bindle paper (fold all edges inward so that there are no open edges) where patient stood, retaining any foreign material, and place in paper bag as forensic evidence
5. Seal the envelope and fill out all information requested on envelope.

Clothing Collection
If assault occurred out of doors, or clothing was stained or damaged during assault, collection is particularly important.
1. Collect the clothes the patient was wearing during or immediately after the assault.
2. Always collect patient's underwear even if changed after assault.
3. Do not cut through any existing holes, rips, or stains on clothing.
4. Do not shake out victim's clothing or trace evidence may be lost.
5. Do not fold wet or bloody clothing in a way which will transfer the blood or fluid to another site on the clothing – layer paper and/or linen prior to folding to prevent transfer
6. Consider taking photographs of clothing if any unusual findings are present i.e., rips, tears, body fluids, debris, etc.
7. Place each item of clothing in a separate paper bag labeled with contents
8. Place patient identifying information on each bag, fold top of bag multiple times, tape bag closed securely to avoid tampering, and sign over tape
9. Document all clothing collected and document anything unusual about clothing i.e., rips, stains, bites which occurred through clothing, etc.
10. Maintain chain of evidence for clothing bags. Place in secured area when not directly observed

Other Items
Collect items which may contain forensic evidence, such as diaper, wet wipes, condom, etc. These should be collected on a case-by-case basis. Contact Crime Lab for further drying and storage instructions if needed.
1. Air dry the item if possible. If unable to air dry, package the item in a non-air tight container, such as a urine cup with holes in the lid to allow the item to dry. Contact law enforcement for transport ASAP.
2. Place patient identifying information on container / envelope and store with kit or in separate paper bag.

Dried Secretions
Examples of dried secretions may be vaginal secretions on a penis, saliva on a bite mark, penis or external genital area and dried blood. Consider collecting swabs from the abdomen/umbilicus and thighs in children as an assailant performing vulvar coitus may ejaculate onto the abdomen/thighs of the child.
1. Use sterile cotton swabs.
2. To obtain swabs from dry areas (i.e., skin, fingertips, rectum, and any areas that may contain DNA):
   - Lightly moisten a swab with distilled water (soaking in water will prolong drying time and increase likelihood of specimen molding) and swab area of interest.
   - Then swab moistened area with a dry swab.
   - Collect both swabs.
3. When collecting a penile swab, the entire external area of the penis should be swabbed. Care should be taken to avoid the area around the urethral opening.

   As each swab is obtained
   a. Place swabs in drying rack from kit or drying box
   b. Allow swabs to thoroughly air dry.

   When swabs are dry

a. Place all swabs from same site in one swab box or envelope and then into appropriate envelope.
b. Document on swab box and envelope site from which specimen is obtained.
c. Seal the envelope and fill out all information requested on envelope.

Pubic Hair Collection (Presence of pubic hair is not usual in the prepubertal child. Omit if not present or has been shaved)

Pubic Hair Combings for Male and Female

To collect foreign hairs and debris:

Patient should be sitting or lying in dorsal lithotomy position.

1. Place paper sheet under the victim's buttocks.
2. Using disposable comb, comb pubic hair in downward strokes so that any loose hairs and/or debris will fall onto paper.
3. Bindle paper to retain both comb and any evidence present and place in appropriate envelope.
4. Seal the envelope and fill out all information requested on envelope.

Pubic Hair Collection Male and Female

DO NOT PLUCK PUBIC HAIR!

1. Obtain by cutting them at the skin surface. The hairs should be collected from various areas within the pubic region.
2. Place the hairs in the Pubic Hair Standards envelope.
3. Seal the envelope and fill out all information requested on envelope.

Speculum Exam

A speculum exam is NOT recommended with prepubertal children. However, an examination under anesthesia (consultation with physician) may be necessary in cases in which there are significant lacerations, bleeding, hematoma, presence of foreign body is suspected or it is considered medically necessary. A speculum exam should not be done solely for the purpose of evidence collection.

Genital Evidence

Swabs of the external genitals (vulvar and vestibular) should be obtained. Vulvar swabs are collected by swabbing (see dried secretion swabbing method) the external female genitalia (mons and labia majora). Vestibular swabs are collected by swabbing (see dried secretion swabbing method) the interior part of the vulva avoiding the hymen and urethral opening.

Vaginal Swabs and Smear – Swabs of the vagina should only be considered if such evidence is likely/essential and this swabbing is tolerated by the child. Consider anesthesia – see Speculum Exam.

Collect when:

1. Assault occurred within prior 120 hours AND
2. History of penile-vaginal penetration OR
3. Visible acute genital injury associated with penetration

Procedure:

1. See **Speculum Exam** above.
2. Never touch the unestrogenized hymen with a swab.
3. Four swabs are provided. Lightly moisten one swab with distilled water.
4. Using 1 swab, swab the vaginal canal.
5. If obtaining a vaginal swab immediately prepare one smear using the swab.
6. Allow swab and smear to thoroughly air dry.

When swab/smear are dry:

1. Return smear to slide holder and snap shut.
2. Place swab in swab box and label with specimen site.
3. Place in appropriate envelope and affix patient label to front of envelope.
4. Seal the envelope and fill out all information requested on envelope

Cervical Swabs and Smear are NOT recommended in the prepubertal child.

Anoscope Exam
An anoscope exam is NOT recommended with prepubertal children. However, an examination under anesthesia (consultation with physician) may be necessary in cases in which there are significant lacerations, bleeding, hematoma, presence of foreign body is suspected or it is considered medically necessary. An anoscope exam should not be done solely for the purpose of evidence collection.

Rectal Swabs and Smear (Collection of this specimen is from the anal area without using an anoscope.)
Collect when:
1. Assault occurred within prior 120 hours AND
2. Report of contact to anus by any part of assailant's body OR
3. Ejaculation occurred near anogenital area OR
4. Visible acute anal injury OR
5. Alternative light source scan is positive

Procedure:
1. Lightly moisten swabs with distilled water if area is dry.
2. Using one - two swabs, thoroughly swab the anal area.
3. Immediately prepare one smear using both swabs simultaneously.
4. Allow swabs and smear to thoroughly air dry.

When swabs/smear are dry:
1. Place all swabs from same site in one swab box / envelope and then into appropriate envelope.
2. Label swab box with specimen site.
3. Affix patient label to front of envelope.
4. Seal the envelope and fill out all information requested on envelope

Crime Lab Toxicology
If drug facilitated sexual assault is suspected, specimens for analysis should be collected as soon as possible.
1. Collect when drugs are suspected of being ingested (i.e., victim lost consciousness or had a significant period of memory loss that is not explainable, unexplained lethargy noted by parent / caregiver).
2. Blood and urine should be collected within 24 hours of suspected drugging. If greater than 24 hours since drugging ONLY urine should be collected. Urine should be collected up to 96 hours.
3. Blood sample – Fill a 10ml gray-top tube (State Lab of Hygiene Implied Consent Collection Kit) with blood. An alternative is to use 2 (7ml) lavender-top tubes. The minimum amount of blood needed is 5ml.
4. Urine sample – Obtain urine as soon as possible. Collect the urine from the patient according to hospital/agency protocol. Fill a 10ml gray-top tube (State Lab of Hygiene Implied Consent Collection Kit) with the collected urine. An alternative is to use 2 (7ml) lavender-top tubes.
5. Seal and initial samples by placing patient label or evidence tape over stopper to avoid tampering and place inside an appropriate biological mailing container (State Department of Hygiene Implied Consent Collection Kit). Fill out all information requested on the Optional Toxicology Samples label. Affix the label to the mailing container.
6. Transfer specimens to law enforcement to be processed by the Crime Lab. DO NOT send these samples to the State Laboratory of Hygiene.
7. Blood and urine samples must be kept refrigerated if not taken to the Crime Lab immediately.
8. Crime Lab toxicology results are not reported to healthcare and do not become a part of the medical record.

Completing Evidence Collection Kit

1. Once all evidence has been placed inside the kit:
    a. Complete information requested on the front of the kit.
    b. Place a patient label on the kit, seal and initial.
    c. Give the kit to the law enforcement representative and have him/her sign the front of the kit.
2. If no law enforcement representative is available:
    a. Follow hospital/agency policy in place
    b. Store the kit in a secure area.
    c. Contact law enforcement immediately and give them the location of the completed kit so they can pick it up ASAP.

Evidence Storage

Temperature

1. Dry evidence may be kept at room temperature.
2. Damp or wet evidence specimens should be thoroughly air dried. If this is not possible, these specimens must be given to law enforcement with instructions for further drying.
3. Blood tubes and/or urine samples (toxicology) must be kept refrigerated if not taken to Crime Lab immediately.

Clothing

1. Each piece of dry clothing should be placed in a separate paper bag, sealed with tape, signed over seal, and labeled with patient ID and contents.
2. Wet clothing should be dried completely – this may be done by law enforcement after SANE/FNE exam.

Drying Box

1. Clean drying box with antimicrobial cleaning solution per institution protocol.

VI. DIAGNOSTIC TESTS

Pregnancy Test

Obtain urine or serum pregnancy test on all patients at risk of pregnancy

Urinalysis

Request that lab check and report presence of sperm

Toxicology Tests

Obtain toxicology and/or alcohol level when:

1. Patient appears impaired, intoxicated, or has altered mental state
2. Patient reports unexplained blackout, memory lapse, or partial or total amnesia for event
3. Patient or other is concerned that he or she may have been drugged
4. Samples for toxicology should be obtained ASAP

Hospital Toxicology

If toxicology and/or alcohol results are needed for patient care, hospital/agency toxicology tests should be done.

Genital Culture

1. May be done to assess for Group A Beta-hemolytic Streptococcus infection if signs and/or symptoms are present. This swab may be collected from the peri-anal area as well.

Vaginal Wet Mount

1. May be used to assess vaginitis if signs and symptoms are present
2. Request that lab check and report presence of sperm and / or Trichomonasis

Sexually Transmitted Infection (STI) Tests for Gonorrhea and Chlamydia

1. STI testing, if done at time of acute assault, should be repeated at follow-up visit. It is best to wait 2 weeks from the time of the assault for STI testing secondary to incubation time.
2. Specimens for STI testing go to hospital /agency lab NOT to Crime Lab
3. Inform patient these tests are related to health issues and are not exclusively for forensic purposes
4. Positive tests may indicate pre-existing infection
5. If nature of assault is uncertain, test / culture all orifices.
6. For vaginal or penile infection
   - Urine, vaginal or penile/urethral swabs for NAAT (Nucleic Acid Amplification Test) or vaginal or penile culture for Gonorrhea and Chlamydia
   - If results to be used for forensic purposes a positive NAAT must be confirmed (prior to treatment) by culture or by a different NAAT method which detects a different DNA/RNA sequence.
7. For anal infection
   - Culture for Gonorrhea and Chlamydia
8. For pharyngeal infection
   - Culture for gonorrhea
   - Chlamydia culture not recommended by CDC

STI Tests for Syphilis and Syphilis Serology

The decision to test for Syphilis should be made on a case by case basis and should be referred to primary care provider.

HIV Testing

Serologic testing for HIV should be considered. The decision to test for HIV should be made on a case by case basis, depending on the likelihood of infection of the assailant(s).

1. Review community epidemiology
2. Assess risk of assailant
3. Evaluate circumstances for HIV transmission
4. Consult with specialist who treats HIV in children if HIV PEP considered
5. Follow hospital/agency policy regarding HIV testing

Hepatitis Serology

The decision to test for HBV should be made on a case by case basis and should be referred to primary care provider.

VII. TREATMENT

Medication administration should only be considered after consultation with medical provider

Pregnancy Prevention

1. Every patient who is at risk for pregnancy will be offered prophylactic treatment for pregnancy prevention.
2. Document on the medical record if the patient declines pregnancy prophylaxis.

Offer emergency pregnancy prophylaxis when:

1. Patient is at risk for pregnancy and pregnancy test is negative
2. Emergency contraception (EC) must be given within 120 hours of a sexual assault to be effective

STI Prophylaxis

Presumptive treatment for prepubertal children who have been sexually assaulted or abused is not recommended (see CDC guidelines). A positive NAAT requires confirmation by culture prior to treatment in the prepubertal child. Pubertal children / adolescents are treated as adults.

Hepatitis B Vaccine

Vaccination status should be assessed at time of exam. Hospital/agency policy should be in place if vaccination is needed.

Tetanus Prophylaxis
Vaccination status should be assessed at time of exam. Hospital/agency policy should be in place if vaccination is needed.

HIV Prophylaxis
Individual assessment of need for HIV Post Exposure Prophylaxis (PEP) should be done at time of exam. When indicated, prophylaxis must be started within 72 hours of assault. Consult with a specialist in treating HIV infected children if PEP is considered.

VIII. DISCHARGE AND FOLLOW-UP CONTACT

Discharge

1. Consider appropriateness of sharing information with parent/caregiver:
   - Parent/caregiver is assailant
   - Parent/caregiver is complacent with assailant
2. Discuss safety issues / plan
3. Appropriate medical follow-up will be identified for the patient with respect to the evaluation of possible sexually transmitted infections, pregnancy and any physical injuries sustained during the assault
4. Explain follow-up for test results
5. Confirm plans for medical and counseling follow-up
6. Give phone number for sexual assault victim advocate and other support services
7. Give written discharge instructions for all treatment and follow-up
8. Provide patient educational materials as needed.
9. Provide information on area resources including medical follow-up, crisis intervention phone numbers, sexual assault crisis centers, shelters, CPS, child advocacy center, Crime Victims Compensation Program, law enforcement and the district attorney's office as needed.

Follow-Up
Recommended within two weeks of the initial exam

Review with patient or parent/caregiver:

1. Exam findings as appropriate
2. Lab results
3. Current physical symptoms
4. Emotional reactions (sleep disorders, anxiety, depressive symptoms, flashbacks, other)
5. Concerns for safety
6. Concerns regarding STIs and HIV
7. Additional history or any new information regarding the assault
8. Report any new allegations to law enforcement and/or CPS as appropriate
9. Assess need for referral for further services
10. Document follow-up contact and additional referral(s) made within the medical record

Review / Expert Consultation
It is recommended agencies have a policy for the review of all prepubertal child examinations. Consider having all prepubertal examinations with a finding that is suspicious or diagnostic for abuse reviewed by an expert in child sexual abuse. An agency should have a policy in regards to obtaining a second opinion.

Resources

- Adams, Joyce, Guidelines for medical care of children evaluated for suspected sexual abuse: An update for 2008, Curr Opin Obstet Gynecol, 2008; 20:435-411

- Centers for Disease Control and Prevention, Sexually transmitted diseases treatment guidelines, 2010, MMWR, 2010; 59(No. RR-12)

- TeleHealth Institute for Child Maltreatment, www.THICM.org

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