

Indiana Guidelines for Medical Forensic Examination of Pediatric Sexual Abuse Patients 2020



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Preface

In January 2019, the U.S. Department of Health and Human Services (Administration on Children, Youth and Families, Administration for Children and Families) released a report identifying Indiana as ranking second in the nation for child abuse and neglect reports, with reports that were more than double the national average. Furthermore, Indiana was ranked fifth in the nation for deaths as a result of child abuse and neglect. This information was found to be extremely concerning and prompted a call to action from stakeholders to evaluate the practice and treatment of child victims.

Meanwhile, in 2019, the Indiana Emergency Nurses Association (ENA) was collaborating with the Indiana Coalition to End Sexual Assault and Human Trafficking and the Indiana Chapter of the International Association of Forensic Nurses to publish Indiana Guidelines for the Medical Forensic Examination of Adult and Adolescent Sexual Assault Patients. This document provides guidance and best practices for caring for Hoosier adult and adolescent victims of sexual assault.

Following a review of the *Child Maltreatment 2017* report and analysis of the access and quality of medical forensic services throughout the state of Indiana provided to children impacted by child sexual abuse, the Indiana ENA Forensic Committee identified the need for guidelines specific to the care and treatment of this population. Many Hoosier children with disclosures of sexual abuse were simply not receiving any level of medical forensic care or were being screened out inappropriately, thereby jeopardizing the child's long-term health and wellbeing and compromising the associated legal investigations related to these cases. Additionally, children and their caregivers who were being evaluated were often redirected for examination, many times hours away from their home. In some cases, the caregiver would forego medical forensic care for their child based upon the barriers created by the flaws and inconsistencies in the system designed to help them.

In September 2019, members of the Indiana ENA Forensic Committee initiated contact with highly qualified, experienced Hoosiers who are experts in this field and established a workgroup to create a coordinated, statewide response to the medical forensic examination of child victims of sexual abuse. This workgroup consisted of child abuse and forensic pediatricians, emergency department personnel, board-certified pediatric Sexual Assault Nurse Examiners, former sex crimes prosecutors and legal experts, child advocacy and protection professionals, and members from state government offices.

These guidelines outline a framework for the medical forensic examination of child victims of sexual abuse and provide guidance for high-quality patient care; evidence collection; and addressing the holistic, individualized needs of these children. These guidelines should assist providers in optimizing care and reduce unnecessary variations in the practice of the medical forensic examination in the state of Indiana. Most importantly, these guidelines support trauma-informed, patient-centered care and establish a foundation for building resilience necessary for healing.

Introduction

Medical evaluation and treatment of the child victim of sexual abuse requires a skilled clinician with specialized training. While forensically trained *pediatric sexual assault providers*¹ (herein after referred to as *pediatric sexual assault providers*) are available throughout the state of Indiana, access to these specialized providers remains extremely limited, especially in rural and underserved communities.

These guidelines were created under the guidance of a multidisciplinary team of professionals to establish and outline a consistent approach to medical forensic examinations for child victims of sexual abuse throughout the state of Indiana.

While this document was developed with the emergency medicine professional in mind, many individuals may benefit from the information contained herein, including, family medicine and other medical providers who care for children, legal services providers, Department of Child Services personnel, law enforcement officials, other members of multidisciplinary teams, law makers, community service providers, parents/guardians, etc.

These guidelines also serve as a reference to support, guide, and strengthen the practices of pediatric sexual assault providers, including Sexual Assault Nurse Examiners (SANEs) practicing in Indiana.

This document specifically guides the care and treatment of the *prepubescent* child victim of sexual abuse. For the purposes of these guidelines, prepubescent children are defined as those children identified by Tanner stages 1 and 2.

While *adolescent* youth victims of sexual abuse can certainly benefit from the practices established herein, their care and treatment is further outlined in the following documents:

- Office on Violence Against Women. (2013). *A national protocol for sexual assault medical forensic examinations adults/adolescents* (2nd ed.). Washington, DC: U.S. Department of Justice, Office of Violence Against Women. Retrieved from: <https://www.ncjrs.gov/pdffiles1/ovw/241903.pdf>
- Indiana Emergency Nurses Association, Indiana Chapter of the International Association of Forensic Nurses, & the Indiana Coalition to End Sexual Assault. (2019). Indiana guidelines for the medical forensic examination of adult and adolescent sexual assault patients. Retrieved from: <https://icesaht.org/guidelines-for-medical-forensic-examination-for-adult-and-adolescent-sexual-assault-patients-2019/>

It is our sincere hope that these guidelines will help to ensure that all children who disclose sexual abuse will have access to a qualified pediatric sexual assault provider within a reasonable distance of their home. These children deserve access to a medical forensic examination by a qualified

¹ For the purpose of this document, a *pediatric sexual assault provider* is an inclusive term that includes medical providers or clinicians, including registered nurses, pediatric Sexual Assault Nurse Examiners, advanced-practice providers, or physicians who have successfully completed specialized training in sexual abuse forensic evaluations for prepubescent pediatric patients.

pediatric sexual assault provider to ensure their health, wellbeing, and safety and to appropriately identify elements that may contain evidentiary value for the investigative process.

These guidelines are intended as recommendations. They should not invalidate protocols or policies already in place at hospitals or sexual assault treatment centers, nor should the guidelines supersede law. These guidelines reflect current best practices at the time of publication. It is the duty and responsibility of the pediatric sexual assault provider to stay current on the science, practices, updates, and laws related to this patient population.

Indiana Medical Forensic Examination Providers

An updated list of qualified medical forensic examination providers can be downloaded at www.indianaena.org/forensic-resources. These programs are primarily staffed by registered nurses who have been trained as SANEs. Currently, only about 20% of Indiana counties have local access to a pediatric sexual assault provider working in their community. It should be noted that some facilities are well staffed and serve many surrounding counties, while other facilities may have only one or two trained providers, thereby limiting their availability. This list is updated quarterly by the facilities self-reporting to the Indiana ENA Forensic Committee. Changes or updates in access to care should be conveyed to indianaenaforensics@gmail.com.

What is Child Sexual Abuse?

Child sexual abuse, while common, is a crisis that can result in lifelong consequences to physical and emotional health. Children who are sexually abused are at an increased risk of developing post-traumatic stress disorder, anxiety disorders, depression, low self-esteem, and social phobias and are more likely to be hospitalized for mental illness. They are at an increased risk for revictimization and propensity for future violence, either as a victim or perpetrator. These individuals also experience higher rates of substance use disorders and chronic disease and require more medical services as adults than those without a history of child sexual abuse (Jenny & Crawford-Jakubiak, 2013).

Child sexual abuse is a form of child abuse that includes sexual activity with a minor. A child cannot consent to any form of sexual activity, period. Some forms of child sexual abuse include:

- Exhibitionism or exposing oneself to a minor
- Fondling
- Intercourse
- Masturbation in the presence of a minor or forcing the minor to masturbate
- Obscene phone calls, text messages, or digital technology interaction
- Producing, owning or sharing pornographic images or movies of children
- Sexual misconduct of any kind with a minor, including vaginal, oral, or anal penetration
- Sex trafficking
- Any other sexual conduct that is harmful to a child's mental, emotional, or physical welfare

Adapted from RAINN, 2020

What are the Warning Signs?

Sometimes, there simply are no warning signs that a child is being sexually abused. Every child is different in how they respond to sexual abuse, and many children may not disclose for years, or even decades, after the abuse. Often the child's perpetrator is known and trusted by the child and their family, and coupled with the child's own shame, guilt, and confusion about the abuse or receipt of potential threats of harm, child sexual abuse can be difficult to identify. ***While overt warning signs are unlikely, they may present as:***

Physical signs*:

- Small amounts of bleeding, bruising, or swelling in the genital area
- Bloody, torn, or stained underwear
- Difficulty walking or sitting
- Pain, itching, or burning in the genital area
- Dysuria (painful urination)

****Physical signs are unlikely and uncommon. Most children do not experience physical signs of sexual abuse.***

Behavioral signs:

- Changes in hygiene, such as refusing to bathe or bathing excessively
- Abrupt development of phobias
- Signs of depression, anxiety, or post-traumatic stress disorder
- Suicidal thoughts, especially in adolescents
- Difficulty in school, including declining grades and frequent attendance issues
- Inappropriate sexual knowledge or behaviors
- Nightmares or bedwetting
- Overly protective and concerned for siblings
- Regression in behaviors such as thumb sucking, sleep patterns, and toilet training
- Running away from home or school
- Self-harm
- Shrinking away from or seeming threatened by physical contact

Adapted from RAINN, 2020

Age of Consent

The age of consent is the legally defined age at which a person is deemed legally competent to consent to sexual activity. Any individual engaging in sexual activity with someone who has not yet reached the age of consent is open to prosecution. The age of consent in Indiana is 16 years of age (IC §35-42-4-3).

The following types of sexual activity **must** be reported to the Indiana Department of Child Services:

- Any sexual activity involving a child under 14 years of age
- Any sexual activity involving any adult (18 years or older) with a child aged 15 years or younger
- Any sexual activity involving a child aged 17 years or younger with an adult (18 years or older) in a custodial role, such as but not limited to, parents, teachers, coaches, employment supervisors, and religious leaders
- Pregnancy in adolescents less than 16 years of age

ANY disclosure of child sexual abuse must be reported to the Department of Child Services and/or law enforcement. It is beyond the medical provider's responsibility and scope of practice to investigate and/or attempt to substantiate or rule out child sexual abuse disclosures.

Indiana Department of Child Services Hotline: 1-800-800-5556

Mandatory Reporting to Indiana Department of Child Services and Law Enforcement

The Indiana Department of Child Services (DCS) is the state agency charged with providing oversight to the protection of children and child support enforcement. DCS exists to protect children who are victims of abuse or neglect and works to strengthen families through services that focus on support and preservation (State of Indiana, 2020).

Indiana Code §31-33-5 outlines duties to report child abuse or neglect. Indiana Code is clear that **ANY** individual, in any capacity, who suspects child abuse or neglect is a mandated reporter. Indiana Code §31-33-6 also provides immunity from criminal and civil liabilities to persons who report child abuse or neglect presuming the individual acted in good faith.

Reports of suspected child abuse or neglect may be made in one of two ways:

- 1) Contacting the Indiana Child Abuse and Neglect Hotline: 1-800-800-5556
- 2) Contacting local law enforcement

In a situation of suspected abuse or neglect, when a hospital or facility does not offer medical forensic examinations for pediatric or adolescent patients, the hospital or facility still has the obligation to make a report to DCS and/or law enforcement prior to referring or transferring a patient to another facility for a medical forensic examination. **Never** discharge or release from your care a pediatric patient with concerns of abuse or neglect from your care without approval from DCS or law enforcement. In the case of a medically critical, emergent transfer, the hospital or facility still has the obligation to make the initial report to DCS and/or law enforcement once the patient is stabilized or immediately after transfer.

In matters of child sexual abuse, if a sexual assault evidence collection kit (“SAEK”) is collected, the physician or pediatric sexual assault provider must ensure that both DCS and law enforcement have been notified.

Always document information related to the DCS report in the medical record including date and time of notification and name and contact information of the person who provided approval to release the child.

Please note that while many hospitals rely on hospital social services departments to initiate DCS reports, **ANY** hospital team member can initiate the report. Delegation of making the report to DCS **should not** result in a delay in reporting.

How to Protect Children from Sexual Abuse

All adults share the responsibility to protect Hoosier children from sexual abuse:

- **Show an interest in their day-to-day lives.**
- **Choose caregivers carefully.**
- **Get to know the people in the child's life.** Talk openly about people the child spends time with. Is someone showing them preference, giving them gifts, or giving them more attention than others? Does the child clam up or feel uncomfortable around a certain individual? These may be reasons to be concerned. Be aware that sexual predators will groom everyone around them, including adults.
- **Talk about the media.** Incidents of sexual violence are often covered by the news and portrayed on television. Use these events as an opportunity to start a conversation with your child and ask how they might handle that situation. Coach your child about some ways they might respond in difficult situations. Share with your child your rules and expectations for their safety, but also let them know that they can come to you at any time, no matter what, without being worried about getting into trouble or being judged for their questions or actions.
- **Know the warning signs of sexual abuse.**
- **Teach your child about boundaries.** Let your child know that they are in control of their body and that no one has the right to touch them without their permission. Likewise, remind your child that they too must respect others' bodies and may not touch someone else who does not want to be touched.
- **Teach your child about how to talk about their bodies.** Teach them the appropriate anatomical names of body parts.
- **Be available to your child.** Set aside time to spend with them where they have your undivided attention. Let them know that they can always come to you with questions or concerns.
- **Let them know they will not get in trouble.** Many perpetrators use secret-keeping and threats as a means of keeping children quiet. Remind your child frequently that they will not get into trouble for talking to you, no matter what they need to say.
- **Give them a chance to raise new topics.** Ask open-ended questions to see if there are things they would like to talk about. Give them a chance to bring up stressful or difficult topics or concerns that are weighing heavily on them.

Adapted from RAINN, 2020

Child Sexual Behaviors

Many situations that involve sexual behaviors in young children do not require DCS intervention. Even so, every concern about possible sexual abuse should be addressed objectively. When a parent brings up the possibility of sexual abuse, the child should immediately be excluded from the conversation, so as not to be influenced by the parent's concerns. At times, parents are concerned by natural behaviors and may simply require reassurance and education about normal, age-appropriate behaviors (Jenny & Crawford-Jakubiak, 2013).

TABLE 1: Examples of Child Sexual Behaviors

Normal, common behaviors	Touching genitals in public or private
	Viewing or touching peer or new sibling genitals
	Showing genitals to peers
	Standing or sitting too close to others
	Trying to view nudity
	Behaviors are transient and easily redirected
Less common, normal behaviors	Rubbing against others
	Touching peers/adult genitals
Sexual behavior problems in children	Behaviors that cause emotional distress, anxiety, or physical pain
	Repeated penetration of vagina or anus with an object or a digit
	Behaviors that are persistent, and child becomes angry if distracted
	Behaviors associated with conduct disorder or aggression
	A variety of sexual behaviors displayed frequently or on a daily basis
	Sexual behaviors involving children four or more years apart in age
	One child coercing another into participating
	Explicit imitation of sexual intercourse
	Oral-genital contact
	Asking an adult to perform a specific sexual act

Reference: Kellogg, Nancy D. (2010). Sexual behaviors in children: evaluation and management. *American Family Physician*, 82(10), 1233-1238.

When inappropriate or concerning sexual behaviors are reported or identified, further evaluation and intervention may be warranted. Behaviors that involve other persons; are not easily redirected; escalate in frequency; are disruptive, coercive, or forceful; and are not age appropriate likely require, at minimum, a consultation with a pediatric sexual assault provider.

Some questions that may help to evaluate or provide insight into problematic behaviors are noted in Table 2.

When making a referral to a pediatric sexual assault provider, it is important to remain as neutral as possible about the situation with the parent and the child. Never confirm to the parent or caregiver that the behaviors are related to sexual abuse. An appropriate explanation would be that the behaviors *may* be concerning and the child should be evaluated by a specialized provider. In the meantime, pending evaluation with a pediatric sexual assault provider and/or forensic interviewer, instruct the parent not to discuss concerning behaviors and/or disclosures with the child.

TABLE 2: Examples of Questions for Caretakers to Consider Regarding Sexual Behaviors in Children

<i>Question</i>	<i>Comments</i>
<i>When was the behavior first noticed? Have there been any recent changes or stressors in the family?</i>	The behavior may be related to a recent stressor, such as a new sibling or parent separation.
<i>Does the behavior involve other persons?</i>	Most sexual behavior problems involve other persons.
<i>How often have you seen this behavior? Is the frequency or nature of the behavior changing?</i>	Escalation in the number or frequency of behaviors may indicate increased anxiety or stressors contributing to the behavior.
<i>Can the child be easily distracted from the behavior? How do you (the caregiver) respond to the behavior?</i>	Normative behavior is usually easy to divert; caregiver distress may escalate the behavior.
<i>Does the behavior occur at home, school/daycare, or both?</i>	If occurring only at home, the behavior may be related to stressors or changes at home, or the behavior may be related to differences in observer perception.
<i>If the behavior involves another person, how old is the person?</i>	Behaviors involving persons four or more years apart in age are not age appropriate.
<i>Is the activity disruptive, intrusive, coercive, or forceful?</i>	Disruptive, intrusive, coercive, or forceful behaviors are abnormal.
<i>Does the child become anxious or fearful during the behavior? Has the child been diagnosed with emotional or behavior problems?</i>	Sexual behavior problems in children have been associated with conduct and other behavior disorders.
<i>Is there any violence among persons living in the home?</i>	Intimate partner violence has been associated with sexual behaviors in children.
<i>Does the child have or has the child had access to sexual material, acts, or information, including pornographic movies or images, nudity, Internet chat rooms, and texting that includes sexual language?</i>	Children may mimic what they see or hear.
<i>Has anyone every spoken to the child about possible abuse?</i>	Sexual behaviors in children are associated with physical abuse, sexual abuse, and neglect.

Adapted or reprinted with permission from Sexual Behaviors in Children: Evaluation and Management, November 15, 2010, Vol 82, No 10, American Family Physician Copyright © 2010 American Academy of Family Physicians. All Rights Reserved.

What to Do if a Child Discloses Abuse

In the event that a child discloses sexual abuse allegations to you, your immediate response and actions are crucial!

DO:

- Allow your body language to tell the child that you hear what they are saying and that you believe them. Meet the child face-to-face. Get down on their level and make eye contact to ensure your body language does not intimidate the child.
- Write down the exact words the child uses in the disclosure and during your interactions. The words the child uses are significant, and your accuracy is very important.
- Thank the child for having the courage to tell you. Statements such as, "Thank you," "I believe you," and "We will get someone to help you," may be valuable for the child to hear.
- Inform the child, as soon as possible, of what will happen next.
- Report **IMMEDIATELY** to DCS and/or law enforcement.

DO NOT:

- Do not use shocked or disbelieving words or body language during a child's statements.
- Do not try to talk the child out of what they are telling you. If you are unsure or skeptical, try not to express your doubts to the child. Do not make conclusions about the accuracy of the child's statements.
- Do not discuss allegations with anyone who is not *essential* to the investigative process. This betrays the child's trust.
- Do not discuss the allegations with the child's peers or siblings.
- Do not discuss the allegations with a child's family member in the presence of the child.
- Do not attempt to investigate the matter on your own or on behalf of your facility.
- Most importantly, **DO NOT ASK THE CHILD ANY QUESTIONS!** Children who disclose sexual abuse need to be interviewed by a specially trained forensic interviewer through a child advocacy center. Do NOT contact a child advocacy center to see the child. Report to DCS and/or law enforcement and allow them to make those arrangements.

When to Notify a Pediatric Sexual Assault Provider

For the purpose of this document, a *pediatric sexual assault provider* is an inclusive term that includes medical providers or clinicians, including registered nurses, pediatric Sexual Assault Nurse Examiners (SANEs), advanced-practice providers, or physicians who have successfully completed specialized training in sexual abuse forensic evaluations for prepubescent pediatric patients.

As stated in *the National Protocol for Sexual Abuse Medical Forensic Examinations-Pediatric*, **ALL** children who are suspected victims of sexual abuse should be offered a medical forensic examination (MFE) performed by a provider with specialized training in sexual abuse evaluation. These providers are trained in medical assessment, evidence collection, and injury identification.

Making Referrals for Medical Forensic Examinations

In non-urgent situations, children may be referred to a pediatric sexual assault provider. This does not require that the child and their caregiver report immediately, or even the same day, for the examination, as it is likely beyond the timeframe of evidence collection. Prior to making the referral, initiate contact with DCS and/or law enforcement, ensure the child is medically stable, and assess for their safety. Obtain approval from DCS to release the patient to the caregiver, and provide the caregiver and DCS case manager with referral information for an MFE. While some caregivers may choose follow-up care after a sexual abuse disclosure with an examination by a family physician or pediatrician, best practice indicates it is in the child's best interest to be evaluated by a pediatric sexual assault provider, even for non-urgent examinations.

Pediatric and family practices are evolving and finding value in having pediatric sexual assault providers on staff to ensure access to quality, non-urgent MFEs. Despite the term *non-urgent*, emergency departments remain an appropriate location to conduct non-urgent MFEs due to the ability to access trained providers, as SANEs are generally staffed within emergency departments. While the emergency department is not the most child-friendly setting, pediatric sexual assault providers are able to comfort the child during the examination. Some communities offer non-urgent MFEs at child advocacy centers. This ensures a child-friendly setting and access to a multidisciplinary team.

The solution for each community will vary based upon available resources and access to trained pediatric sexual assault providers. When a community lacks these services, children should be referred to the *nearest* (in proximity) qualified pediatric sexual assault provider or to a facility of the caregiver's choosing. Not all children require an examination by a child abuse or forensic pediatrician. Resources are in place throughout the state to support the patients in and near those communities. Many caregivers lack the means to travel across the state for an examination that could easily be conducted by a local pediatric sexual assault provider. All forensically trained providers have access to escalate concerns to more experienced individuals when appropriate.

To access the most up-to-date list of Indiana's medical forensic examination providers, please visit www.indianaena.org/forensic-resources. While the goal is for all pediatric MFE providers to conduct non-urgent MFEs, it is recommended that you contact the facility prior to making a referral and stay up-to-date with the services nearest to your community.

Examination Referral and Timing

TABLE 3: Timing of Medical Examinations¹

	Timing of Exam	Medical Indications
Indications for emergency evaluation	Exam scheduled without delay	<ul style="list-style-type: none"> • Medical, psychological, or safety concerns such as acute pain or bleeding, suicidal ideation, or suspected human trafficking • Alleged assault that may have occurred within the previous 72 hours (or other state-mandated time interval) • Need for emergency contraception • Need for post-exposure prophylaxis (PEP) for STIs including Human Immunodeficiency Virus (HIV)
Indications for urgent evaluation	Exam scheduled as soon as possible with qualified provider	<ul style="list-style-type: none"> • Suspected or reported sexual contact occurring within the previous 2 weeks, without emergency medical, psychological, or safety needs identified
Indications for non-urgent evaluation	Exam scheduled at convenience of family and provider but ideally within 1-2 weeks	<ul style="list-style-type: none"> • Disclosure of abuse by child, sexualized behaviors, sexual abuse suspected by MDT, or family concern for sexual abuse, but contact occurred more than 2 weeks prior without emergency medical, psychological, or safety needs identified
Indications for follow-up evaluation	As determined by qualified provider	<ul style="list-style-type: none"> • Findings on the initial examination are unclear or questionable, necessitating reevaluation. • Further testing for STIs not identified or treated during the initial examination. • Documentation of healing/resolution of acute findings. • Confirmation of initial examination findings, when initial examination was performed by an examiner who had conducted fewer than 100 such evaluations.

¹ Adapted from Adams, J.A., Kellogg, N.D., Farst, K.J., Harper, N.S., Palusci, V.J., Frasier, L.D., Levitt, C.J., Shapiro, R.A., Moles R.L., Starling, S.P. (2015). Updated guidelines for the medical assessment and care of child who may have been sexually abused. *Journal of Pediatric and Adolescent Gynecology*. doi: 10.1016/j.jpog.2015.01.007. * Reprinted with permission from author.

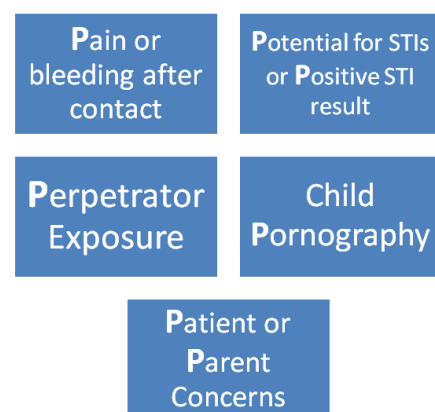
The 5 Ps

Other indications for medical evaluation, even if outside of the evidence collection window, include:

1. Pain or bleeding with or after contact
2. Potential for STIs due to nature of the contact or a Positive STI result
3. Perpetrator exposed (i.e. sibling or household contact with an alleged offender)
4. Child Pornography use by caregiver/household contact
5. Patient or Parent concerns
A child may have distorted thoughts of their bodies due to a perpetrator's manipulations.
Additionally, initial partial disclosures are common.

Adapted from National Children's Alliance (2017).

FIGURE 1: The 5 Ps

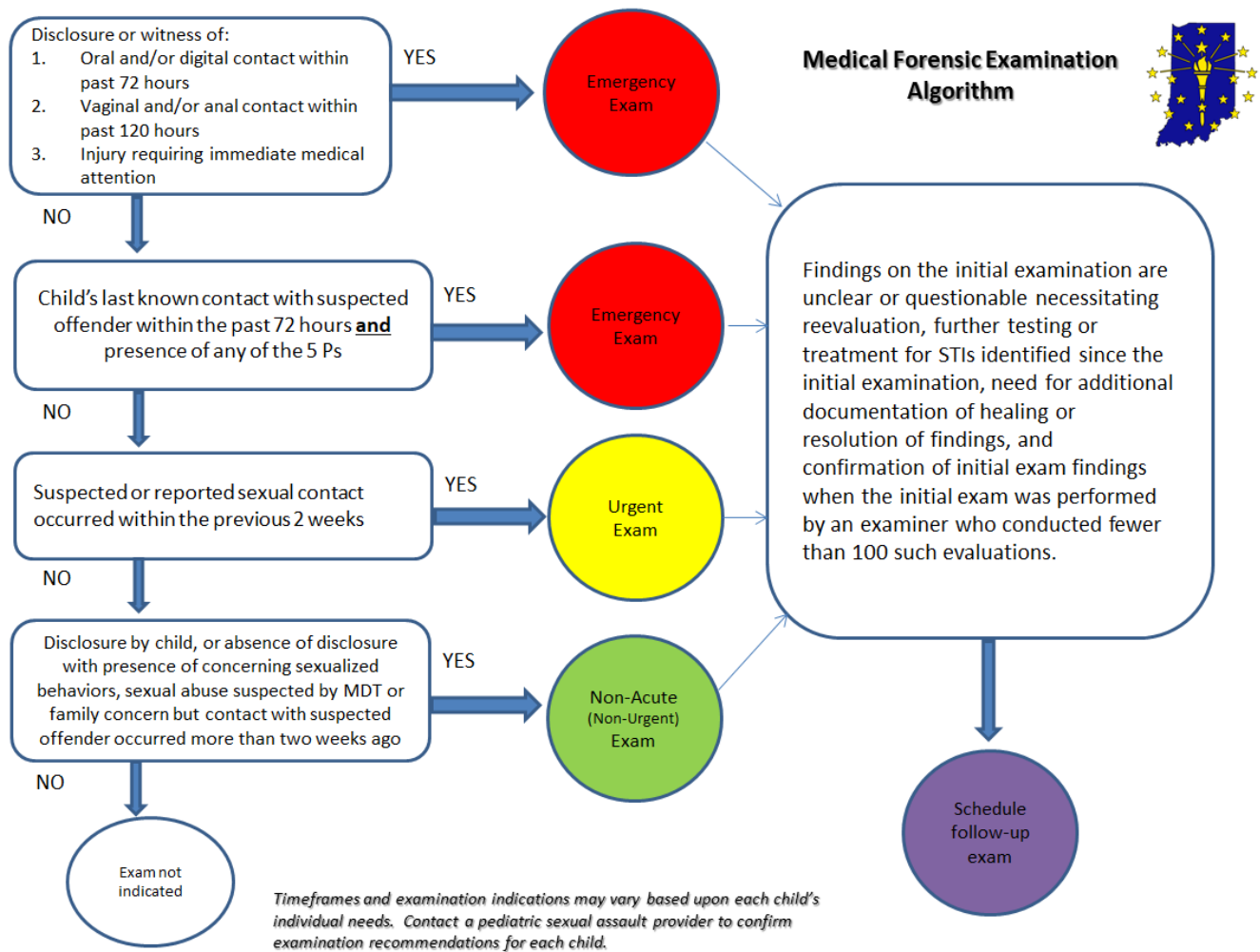


Suspected victims of sexual abuse may be identified through a child's disclosure, behaviors, witnessed abuse by an adult or another child, or exposure to a high-risk offender (such as an adult in possession of child pornography or sibling/household contact with an alleged offender). The need for emergent treatment of injuries *always* supersedes forensic evidence collection. The **MINIMUM** evidence collection window from the child's last known contact with a suspected offender should not be less than 72 hours. Children falling within the emergent and urgent timeframes should be seen by a pediatric sexual assault provider as soon as possible. Examination referral and timing considerations are noted in Table 3.

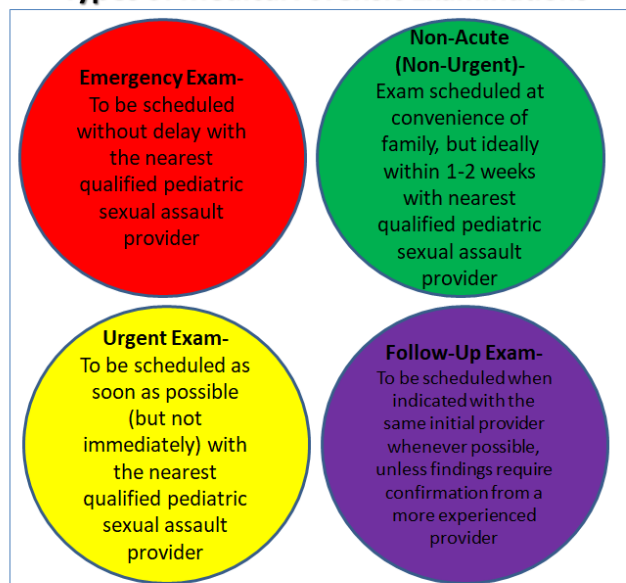
Despite the potential for forensic evidence recovery on the child's body or clothing, the child should be evaluated by a pediatric sexual assault provider, have a comprehensive medical history taken, have a head-to-toe examination with thorough documentation of exam findings, and be provided appropriate treatment. Information helpful to the investigation may be obtained from the history, exam findings, and child's medical record (United States Department of Justice, 2016).

Hospitals have a duty and responsibility to locate a site for patients needing medical forensic services. Finding a site for the medical forensic examination should never become the burden of the patient or their family member.

FIGURE 2: Medical Forensic Examination Algorithm



Types of Medical Forensic Examinations



Responding to Medical Findings

As medical providers, there may be times that patients are evaluated prior to a disclosure or concerns of sexual abuse are verbalized by a patient or their caregiver. Please be mindful of the following:

- **NEVER** confirm to a patient or family member that a finding is related to sexual abuse. This should only be determined by a forensic pediatrician or child abuse specialist.
- If a finding of concern for abuse is identified, inform the patient and the caregiver that you plan to consult on the finding to confirm its origin and/or treatment requirements. Please do not insinuate that the finding is related to sexual abuse as this can cause panic and trauma to the entire family.
- Likewise, if a finding of concern for sexual abuse is identified on a patient who has a disclosure, please note that the finding is likely not diagnostic for sexual abuse. Do not “confirm” for the patient and caregiver that the child was sexually abused based upon the examination. This may be inaccurate and provides a false sense of hope and security related to successful prosecution.
- It is best practice for any anogenital finding on a suspected victim of child sexual abuse be confirmed by a pediatric sexual assault provider or forensic pediatrician when the initial examination findings were performed by an examiner who has conducted fewer than 100 sexual assault evaluations.
- If an anogenital finding is the only factor raising concern for sexual abuse, the child should be examined promptly by a pediatric sexual assault provider to determine the need for further investigation.
- Many anogenital symptoms are NOT related to trauma or sexual abuse:
 - Bleeding (i.e. secondary to labial adhesion, dermatitis, anal fissures)
 - Blisters and/or bumps (i.e. Molluscum, warts, Herpes)
 - Discharge (i.e. pathogens not caused by STIs, foreign body in vagina)
 - Redness (i.e. irritation or inflammation)
 - “Opening too big” (i.e. normal variant, lack of experience or knowledge of normal anatomy)

What You Should Know About a Medical Forensic Examination

A medical forensic examination (MFE) is conducted when a child discloses sexual abuse, or after further assessment of a child with concerning behaviors, physical symptoms, or statements that may be concerning for sexual abuse. These examinations should only be conducted by **forensically-trained** pediatric sexual assault providers. These providers understand the medical care and holistic treatment required for a patient and are mindful of acute and long-term consequences of sexual violence victimization as well as associated legal consequences. **Any** child who discloses sexual abuse has the right to a medical forensic examination, regardless of when the abuse occurred.

The purpose of an MFE is to assess and treat the medical and mental health consequences of sexual abuse and may include the collection of evidence from the patient, such as specimens, clothing, or photographs that can aid investigators in determining whether a crime occurred.

The medical history and history of events (when age and developmentally appropriate) may provide important information that can be presented in court. Examinations can also reveal findings that have a cause other than abuse, including unrelated illnesses or underlying medical conditions. Most importantly, the MFE is conducted so that children and their caregivers know that their bodies are okay. The MFE allows the opportunity to ask questions, discuss concerns, and receive treatment for physical, emotional, and behavioral effects related to sexual abuse.

The MFE may be time consuming due to the amount of valuable information collected and the need to approach the patient in a trauma-informed, patient-centered, and child-friendly manner.

Medical forensic examinations and subsequent treatment/therapy for children and adolescents are generally at no cost to the patient. Reimbursement for services is rendered through the Sexual Assault Victim's Compensation Fund, managed and dispersed by the Indiana Criminal Justice Institute.

What Happens During a Medical Forensic Examination?

An MFE is similar to any comprehensive check-up received at the doctor's office. The provider will meet with the patient and their caregiver (separately and/or jointly) to discuss a history of the events, obtain a medical history including a review of systems, and complete a head-to-toe examination, including anogenital examination. It is important to note that the examination should NOT be painful, and an internal pelvic (or speculum) examination will **not** be conducted on prepubescent patients but may be offered, when indicated, in adolescent patients (Tanner 3 or above).

During the examination, the provider will explain each step of the process and obtain the patient's permission to complete each step. The caregiver will provide consent for the examination, but the patient must assent to each step. The patient may assent to as much or as little of the examination as they are comfortable with. The provider is responsible for advising the patient and their caregiver of any potential outcomes associated with each option. The patient will not be held down or restrained during the examination, and sedation will not be utilized, except in extreme situations that require surgical intervention or are deemed medically necessary for stabilization.

The provider may collect evidentiary specimens, clothing, photographs, and/or laboratory testing and will provide resources that may include social work consultation, access to counseling and

support services, and referrals for appropriate and medically indicated follow-up care. The provider will enlist any and all resources to help the patient and their family heal.

Limitations of a Medical Forensic Examination

An MFE, in and of itself, will not definitively determine if a patient has been sexually abused, nor will it provide information about the perpetrator, type of acts committed against the child, or timing of those acts. For this reason, it is essential that all healthcare providers manage the expectations of patients and caregivers by understanding and promoting the importance of a multidisciplinary approach to caring for these patients.

Please note:

- At the time of the MFE, it will not be known if semen or DNA is present.
- It can take several months to get evidentiary results.
- SAEKs are not tested at the hospital or sexual assault treatment center. Testing is directed by law enforcement and/or prosecution and is conducted at a crime laboratory. Prosecution is driven by the respective county's prosecutor's office where the crime was suspected to occur.
- It is possible that not all items included in an SAEK will be tested.
- Results of forensic evidence testing will be returned to the jurisdictional law enforcement agency and not to the hospital or sexual assault treatment center.

The Role of the Pediatric Sexual Assault Provider

For the purpose of this document, *pediatric sexual assault provider* includes any forensically trained pediatric providers, such as pediatric Sexual Assault Nurse Examiners (SANEs), advanced practice providers, or physicians who have successfully completed specialized training in sexual abuse evaluation for pediatric patients.

In Indiana, most children will receive a medical forensic evaluation from a pediatric SANE and follow-up care will be provided by the child's primary health care provider. In severe cases of abuse or neglect, children will be evaluated and followed by child abuse and forensic pediatricians through Riley Hospital for Children at Indiana University Health or Peyton Manning's Children's Hospital at Ascension St. Vincent.

Pediatric Sexual Assault Nurse Examiners

A pediatric SANE or Sexual Assault Forensic Examiner (SAFE) is a registered nurse or advanced practice provider with specialized training to provide evaluation and care to children and adolescents with allegations of sexual abuse. The SANE is an experienced, objective provider trained to provide comprehensive, patient-centered care for the sexual assault patient. The role of the SANE includes assessment, collecting evidence, offering suitable treatment options, providing for safety and aftercare needs, and patient education. SANEs can provide these services to patients with both acute and non-urgent needs. SANEs can serve as fact or expert witnesses in a courtroom.

In the state of Indiana, registered nurses and advanced practice providers do not require a formal certification process. To practice as a pediatric SANE, nurses must have an active unrestricted license with the state licensing entity and have successfully completed formal didactic training and competency-based clinical preceptorship in the medical evaluation of child sexual abuse. SANEs may choose to sit for certification examinations offered by the International Association of Forensic Nurses (IAFN), including Sexual Assault Nurse Examiner-Adult/Adolescent (SANE-A®) and/or Sexual Assault Nurse Examiner-Pediatric® (SANE-P®). These examinations are practice-based and require a minimum number of hours providing care for specific patient populations in order to be eligible to sit for the examination. As in many fields, certification is not required. SANEs can provide high-quality, competent care without being formally certified.

TABLE 4: Pediatric Sexual Assault Provider Responsibilities

Pediatric Sexual Assault Provider responsibilities may vary depending upon the timing of the examination.

Emergency and Urgent	Immediate treatment of acute medical, psychological, and safety concerns. Medical forensic examination including anogenital examination; evidence collection including swabs, clothing, photo documentation, history of events (when age/developmentally appropriate), STI testing, STI prophylaxis (when indicated), pregnancy prophylaxis (when indicated); thorough documentation of history, review of systems, and findings; safety planning; discharge instructions; instructions for follow-up care; contact DCS/law enforcement if not already involved; and make referrals for more advanced or specialized care when indicated.
Non-Urgent	Medical forensic examination including anogenital examination; evidence collection (if indicated); photo documentation (if indicated); history of events (when age/developmentally appropriate); STI testing; STI prophylaxis (when indicated); thorough documentation of history, review of systems, and findings; safety planning; discharge instructions; instructions for follow-up care; contact DCS/law enforcement if not already involved; and make referrals for more advanced or specialized care when indicated.
Follow-Up	Photo documentation (if indicated), STI testing, STI prophylaxis (when indicated), thorough documentation of review of systems, findings, instructions for follow-up care; and make referrals for more advanced or specialized care when indicated.

Note: Follow-up photography is done to show injury progression and stages of healing. It is useful in confirmation of normal and abnormal variants including congenital conditions and skin disorders. As such, photo documentation of a child's anogenital area is **ALWAYS** the responsibility of the medical provider. Law enforcement, DCS, and caregivers should **NEVER** photograph a child's anogenital area.

Hospitals and healthcare facilities (including emergency departments) should have policies and procedures in place that allow a child to return for follow-up examination and photography *with the same initial pediatric sexual assault provider, whenever possible.*

Triage Considerations for Facilities

Without a Pediatric Sexual Assault Provider

When a child who may require a medical forensic examination presents to your medical facility, it is important to understand your roles and responsibilities for their care, so as not to compromise the patient's medical forensic needs or cause further trauma:

- Provide immediate privacy and safety.
- Ensure you know who is accompanying the patient to the facility and their relationship to the patient *and* the perpetrator, if known.
- When documenting a patient's chief complaint, or reason for their visit, it is important to note that words matter. Avoid the use of the word "alleged" as it implies disbelief.
- During initial triage, do not obtain an oral or rectal temperature on a patient who may require an MFE.
- If a patient has to urinate, ensure no clean catch samples are obtained. Advise the patient not to wipe with toilet paper. Do not use catheters unless required for emergent medical needs.
- If the patient has not already consumed food or fluids since the assault, keep them NPO (nothing by mouth) if possible (especially with an oral assault).

To preserve the collection of evidence:

- Do not touch the patient or his/her belongings unless you are wearing gloves.
- Limit physical assessment unless medically necessary. If a child will be referred to a pediatric sexual assault provider for an MFE, **DO NOT** complete a genital, anal, or oral examination unless medically indicated for stabilization.
- Do not ask the patient (or their caregiver in the child's presence) for details of the abuse. This information will be discussed during the MFE and/or forensic interview.

Except for medical situations requiring a higher level of care, child victims of sexual abuse should be transferred or referred to the *nearest* (in proximity) qualified pediatric sexual assault provider or to a facility of the caregiver's choosing. Be mindful that not all children require an acute/emergent examination or an evaluation by a child abuse or forensic pediatrician. Local resources are in place to support patients in your community. Many caregivers lack the means to travel across the state for an examination that could easily be conducted by a local provider. All pediatric sexual assault providers have access to escalate concerns to more experienced individuals and make referrals when appropriate and medically indicated.

Note: Do not transfer a patient via ambulance unless *medically necessary*. The patient will be billed for the ambulance ride unless deemed medically necessary.

Follow all federal and state requirements, as well as hospital policies related to the Emergency Medical Treatment and Labor Act (EMTALA).

Prior to Transfer/Referral:

- Contact the facility that will be receiving the patient to ensure the availability of a pediatric sexual assault provider and give report on the patient. Speak directly to the pediatric sexual assault provider who will be conducting the MFE, whenever possible.
- Thoroughly document any interventions required to stabilize the patient including pre-hospital care.

- Obtain perpetrator information, if known.
- Complete all mandatory reports to DCS and law enforcement, and obtain approval from DCS to release the child.
- If the child is determined to be medically stable, and approved by DCS, the child and the caregiver may present by private vehicle to the examination site at a predetermined time and location, based upon examination timing and recommendations. *See Table 3: Timing of Medical Examinations.*

Evidence Collection in Emergency Situations

There may be times that your facility will be the first one to receive a patient in an **emergent, life-threatening** situation. In these instances, medical care **ALWAYS** supersedes forensic needs.

However, whenever able, consider the following:

- Collect the clothing that the patient was wearing when they arrived at the facility. Do not cut through stab wounds, gunshot wounds, or other variations in clothing that may be related to the offense. Each item of clothing collected for law enforcement should be placed into a **separate** brown paper bag and labeled with patient information, date and time of collection, collector's name, and article enclosed. Fold the bag over loosely (to allow "breathing room"), and secure the seal firmly with tape. There should be no part of the seal that remains open, broken, or unsecure. The collector should initial over the seal to ensure integrity of evidence. If items are blood soaked, double bagging may be necessary. Note on these bags, "WET EVIDENCE," to notify law enforcement and crime lab personnel to handle the specimens appropriately and timely, as the specimens did not have time to dry prior to packaging.
- If collecting forensic evidence via swab, collect the fewest number of swabs necessary for each body area. This will avoid dilution of a sample.
- Consider collection of trace evidence which may include fibers, textiles, glass, debris, soil, etc.
- Maintain chain of custody on any items that are collected. Items must remain securely in the possession and/or under the supervision of the collector until those items are surrendered to law enforcement. A formal chain of custody document should be utilized to document the transfer of evidence, and the hospital should retain a signed copy of the form prior to releasing the evidence.
- Obtain necessary forensic photographs of a patient's presentation to the facility and of any findings or injuries sustained.

Summary:

- If a child or adolescent (age 17 and younger) has been the victim or suspected victim of abuse, neglect, or molest, including sexual assault, you **MUST** notify DCS and/or law enforcement immediately. Do not discharge a child or adolescent from your care without the approval of DCS and/or law enforcement.
- Do **NOT** discuss details of the incident in front of the child. If the patient's parent or legal guardian tells you they suspect child abuse or neglect, have this discussion privately as this information could impact the child's forensic interview.
- Do **NOT** ask the child details of the event.
- If a child falls outside the recommended time frames for evidence collection, non-acute follow-up with a pediatric sexual assault provider should be arranged.

Communication with Children and Adolescents

How we interact with children and adolescents is an essential component of trauma-informed, patient-centered, child-friendly care. Simply by our interactions, words, and body language, a child may feel supported and we may begin to lay the foundation for resilience. If not considered, the child may shut down, refuse to cooperate, or incur further trauma.

Tips for interacting with children:

- Introduce yourself and explain your role. For example, “My name is Jamie. I am a nurse and I will be taking care of you today. I am going to make sure that you are safe and that your body is healthy.” This shows the child that your role is about health and safety.
- Ask children their preferred name.
- Begin by discussing things other than the reason for their visit (i.e., schools, pets, siblings, and likes or dislikes).
- Maintain a calm demeanor.
- Learn and use the words the child uses for their body parts, and reflect their language during the entire encounter.
- Ask age-appropriate questions. Do not ask questions beyond your scope or in conflict with the scope of other multidisciplinary team member roles. Examples include:
 - What can you tell me about why you are here today?
 - Do you hurt anywhere? If so, where and when did you start hurting?
 - What would you like to talk to me about?
 - What questions do you have for me?
- Avoid making assumptions about the way a child feels about the perpetrator and acts of sexual abuse. Do not speak unfavorably about the perpetrator to the child.
- Speak with the child’s caregiver in private, *away from the child*. This is especially important if the caregiver is providing **ANY** details related to the sexual abuse.
- Advise the caregiver not to ask the child any more questions related to the sexual abuse until the completion of the forensic interview and/or speaking with law enforcement.
- Allow the child to interact with the supplies you use to do your job. Let them touch, feel, and experiment with the equipment.
- Ask permission before touching the child.
- Offer the child food and fluid as soon as possible.
- Allow the child to keep a comfort item during the examination.
- This is a great time to discuss body safety. Inform the child that the examination is only okay because their caregiver knows about it, there are no secrets, and because you are a nurse making sure that the child is safe, clean, and healthy.
- Let the child know that they are in control and can decline any part of the examination or take a break at any time.
- Stay at the child’s level, face-to-face, when possible. This will allow the child to make direct eye contact. Standing over a child may be intimidating and can be interpreted as a position of authority, which is more likely to make a child feel compelled to do what you ask rather than feel supported by you.
- Affirm the child throughout the process and offer opportunities for questions. (For example, “You did a great job with that step. Here is what we are going to do next. Do you have any questions about what is happening?”)
- Do not pressure the child to respond to questions or agree to exam procedures.

Tips for interacting with older children and adolescents:

For older youth, the information above still applies; however, also consider the following:

- Respect their privacy.
- Ask them questions about their interests and things they are good at, including sports, school, music, hobbies, books, movies, etc. This helps to establish rapport.
- Understand that they may have body image issues due to the physical changes in their bodies or because of the sexual abuse. Keep them draped and covered as much as possible. Ask if they would like their caregivers to step out of the room during the examination.
- Allow choices.
- Allow them to ask questions.
- Obtain a history of the event in private without the caregiver present. This ensures that the youth may be honest and forthcoming without being concerned about their caregiver's reaction or feelings about the information.
- Facilitate difficult conversations between the youth and their caregiver when necessary. The experience can be stressful for both of them.
- The youth may have questions about virginity. Be prepared to discuss this sensitive issue. For example, "Virginity is not something that can be taken from you. It is something you give to someone when the time and feelings are right for you. What happened to you does not take away your virginity." or "Virginity is a state of mind. You were assaulted and that does not change whether or not you are a virgin."

Caring for Special Patient Populations

Disabilities

Children with physical, intellectual, developmental, and/or mental health disabilities are increasingly vulnerable to sexual abuse. It is estimated that children with disabilities are one of the highest-risk populations to be victimized and experience sexual abuse three times more frequently as compared to children without disabilities. Children with behavioral or mental health disorders are five times more likely to be victimized. The increased vulnerability is attributed to the child's ability to disclose the sexual abuse and ease of manipulation and/or access to the child, especially those who receive specialized care in or out of the home. Children with intellectual, developmental, or behavioral disabilities may have a decreased understanding and awareness of body safety and/or sexual behaviors, making them more vulnerable to sexual abuse. Considering there are more challenges for children with disabilities to endure a medical forensic examination, it is recommended that the pediatric sexual assault provider tailor the examination specifically for the child to include any special considerations and/or needs. The provider should not assume what those needs may be, but rather have an open discussion with the child and caregiver to ensure all considerations, if any, are met. Despite the child's disability, it is recommended the pediatric sexual assault provider provide developmentally appropriate education to the child and family about body safety and appropriate sexual behaviors. It is also recommended the child be given a referral to a service provider with specific training to ensure the child receives further advocacy support and mental health counseling tailored to them (United States Department of Justice, 2016).

Language, Culture, and Religion

Indiana residents are diverse and constitute several cultural, racial, and ethnic backgrounds. This diversity is often met with health disparities for minority populations due to insufficient cultural competence of service providers. It is best practice for all pediatric sexual assault providers to have extensive training in trauma-informed care, which includes cultural competency, to provide the highest level of care for all pediatric patients who have been sexually abused. It is imperative to the patient's care to ensure the provider knows and understands specific beliefs, attitudes, and ideas that the child and/or family values, especially as it relates to sexual abuse. This begins by determining the patient's preferred spoken and written language, including sign language and braille. It may be that the child's preferred language differs from that of their family. If English is not the preferred language by either the patient or family, it is their right that a qualified interpreter is present so that all parties are able to communicate with the pediatric sexual assault provider effectively and have a full understanding of the medical forensic examination. It is also recommended that all written documents be translated and available in the preferred language.

The provider should be prepared to tailor the examination to the child's cultural and religious needs. Pediatric sexual assault providers should be aware of cultural practices that are rare or uncommon in the United States, such as female genital mutilation and child marriage. Some cultures may even have a varying level of acceptance of child sexual abuse that impacts the child's disclosure. The provider should be prepared to provide education about body safety and appropriate sexual behaviors involving the child. These topics should be addressed in an unbiased and unassuming manner with respect to the child's cultural and religious background. Adhering to the child's linguistic, cultural, and religious preferences improves the quality of care and health outcomes for the child and their family. These same considerations should be tailored by service providers for follow-up care, advocacy support, and mental health counseling.

Sexual Orientation and Gender Identity

In best practice, a growing number of pediatric sexual assault providers are integrating gender-neutral language and addressing inclusivity of binary and nonbinary pronouns as identified by the pediatric patient. The child may go by a name or pronoun that differs from legal documents, such as birth certificates or insurance documents. It is best practice to have an open dialogue with the child to determine their gender identity and any alternative names they would like to be called. This is best done during the initial rapport-building phase of the examination (Thomson & Katz-Wise, 2017).

Similarly, it is important for providers to be prepared to discuss questions, concerns, or inquiries from children who have experienced sexual abuse as it relates to sex, sexual orientation, and gender identity. These conversations should be done in a developmentally appropriate manner and initiated by the child. ***It is not recommended that the provider initiate these topics during the medical forensic exam if not otherwise prompted by the pediatric patient.*** Many children and families will want an exhaustive explanation of the sexual abuse and how it may affect the child's sexual orientation and/or gender expression. It is important to explain that sexual abuse is not the result of sexual orientation or gender identity of the perpetrator, but rather preying on the child's amenability and innocence. Most importantly, sexual abuse does not explain the child's sexual orientation or gender identity despite whether the child was sexually aroused, accepted the attention, or found gratification during the sexual abuse. Like adults, children have involuntary physiological responses to sex acts, and this reaction is not indicative or determinate of the child's own sexual orientation or gender identity. Prior to the abuse, the child may or may not have disclosed their sexual orientation or gender identity and may take this as an opportunity to explore these topics. Approach the discussion in an unbiased and unassuming manner that provides a safe environment for the child to communicate with the provider and/or their family. The provider should offer support, resources, and appropriate referrals tailored to the needs of the child and family. As it is important for the pediatric sexual assault provider to appropriately address these topics during examination, they should also be considered for further exploration and discussion during follow-up care, advocacy support, and mental health counseling (NCTSN, 2014).

Multidisciplinary Collaboration

Multidisciplinary collaboration involves many different disciplines working together in a coordinated and cooperative method to ensure the best possible outcomes for the child victim of sexual abuse. The implementation of a multidisciplinary team (MDT) ensures that the child's best interests are considered and represented from many different perspectives, and it is the most effective approach in responding to child sexual abuse allegations.

How the Multidisciplinary Team Responds to Child Sexual Abuse

The child is the center of the MDT response. Each service organization has a responsibility and a duty to the patient. While the roles and responsibilities of each entity are different, it is important that the child's care is carefully coordinated to ensure the best possible outcomes.



Children's Advocacy Center

Serves as an interagency coordinated response center and conducts forensic interviews in a neutral, child-friendly manner.

Department of Child Services

Responds to reports of child sexual abuse, investigates allegations in conjunction with law enforcement, and ensures the safety of the child.

Family and Victim Advocacy Services

Provides support and education throughout the criminal justice process and connects victims and family members to community support services.

Law Enforcement

Responds to reports of child sexual abuse and investigates allegations in conjunction with DCS, makes arrests when appropriate, and presents cases to prosecutors for charges to be filed.

Medical Services

Provides noninvasive medical examinations, evaluations, testing, treatment, medical forensic evidence collection, and follow-up care.

Prosecutor's Office

Reviews cases and determines whether prosecution is appropriate, files charges, and prepares cases for trial.

Pediatric sexual assault providers are encouraged to participate in the local Sexual Assault Response Team (SART) as well as a multidisciplinary team (MDT). MDTs are encouraged to include the pediatric sexual assault provider who conducted the child's examination, whenever possible, when evaluating or reviewing a case. This ensures the pediatric sexual assault provider's ability to speak on behalf of their case and serves as a learning opportunity for the provider. This can also be helpful in building trust and establishing strong working relationships among the MDT.

Indiana Department of Child Services

The Indiana Department of Child Services (DCS) is driven by the agency's mission, vision, and practice model to serve Hoosier families and children.

Mission

The Indiana Department of Child Services engages with families and collaborates with state, local, and community partners to protect children from abuse and neglect and to provide child support services.

Vision

Indiana children will live in safe, healthy, and supportive families and communities.

Assessment of Child Sexual Abuse

When the child abuse hotline receives an allegation of child abuse or neglect, the report is sent to the local county office, along with a recommendation about the need for further investigation. If sexual abuse is suspected, DCS ensures the child receives the appropriate attention from medical staff and law enforcement and may remove the child from the home if the child's safety remains at risk.

To ensure a thorough evaluation, child sexual abuse allegations are investigated by a multidisciplinary team comprising of law enforcement, the county prosecuting attorney, and a DCS family case manager. The team also collaborates with child advocacy centers and pediatric sexual assault providers to help the child feel safe and supported while also ensuring a quality forensic interview and medical examination.

DCS supports a coordinated statewide approach to responding to child sexual abuse allegations. This statewide response ensures victims receive compassionate care that results in the best chance of holding the perpetrator accountable and enabling the first steps toward healing for all involved.

Indiana Child Abuse and Neglect Hotline

1-800-800-5556



Forensic Interviews and the Role of the Children's Advocacy Center

A children's advocacy center (CAC) is a child-focused, community-oriented facility in which members of a multidisciplinary team (MDT) work together in child abuse investigations. A CAC is not just a facility, but also serves as an interagency coordinated response center. MDT representatives, including law enforcement, DCS, prosecution, mental health, medical, victim advocacy, and CAC staff, collaborate to investigate child abuse reports, conduct forensic interviews, evaluate and provide evidence-based interventions, and assess cases for prosecution. MDT members contribute their knowledge, experience, and expertise to ensure a coordinated, comprehensive, compassionate, and professional response. MDT interventions are conducted in a neutral, child-friendly setting, are associated with less anxiety and fewer interviews, and result in more appropriate and timely referrals for needed services.

Forensic Interviews

Forensic interviews are coordinated to avoid duplicative interviewing. The interviews are conducted by specially trained interviewers in a manner that is developmentally appropriate, culturally sensitive, unbiased, fact finding, and legally sound (National Children's Alliance [NCA], 2017). The purpose of a forensic interview is to obtain information from a child about the abuse that will support accurate and fair decision-making by the MDT within the criminal justice, DCS, and service delivery systems (NCA, 2017).

The CAC must adhere to forensic interview guidelines that are research-based, allow for free recall and minimal interviewer influence, and gather information needed by all MDT members to avoid the need for repeat interviews.

Contacting a Child Advocacy Center

It is important to note that contacting a CAC and setting up a forensic interview requires coordination of many different individuals. Please ***do not*** contact a CAC directly to schedule a forensic interview. If you believe a child requires a forensic interview, it is safe to assume that you also *suspect* that child may be a victim of abuse or neglect. In this instance, your first step is **ALWAYS** to contact DCS and/or law enforcement *immediately*. If a forensic interview is indicated, DCS and/or law enforcement will work collaboratively with the child advocacy center. **Never attempt to investigate any matter of child abuse or neglect on your own, discount a child's disclosure, or screen out a case without notifying authorities.** Doing so could result in criminal prosecution and/or civil liabilities.

Prosecuting Child Sexual Abuse Cases

Prosecutors are attorneys who act on behalf of the state in criminal cases. A child victim of sex abuse is a witness for the prosecution in a criminal case against the perpetrator of the sex crime. A prosecutor seeks justice and truth from facts and evidence, whatever that may be.

Effective prosecution of child sexual abuse cases requires strong multidisciplinary collaboration and thorough review of facts and information from many different perspectives. Prosecutors must evaluate all forms of evidence available. In criminal court, based upon the protections of the United States Constitution, a defendant is presumed innocent. The prosecution has the burden of proof in a trial, and they must prove the elements of the crimes charged beyond a reasonable doubt in order to secure a conviction.

Process of a Sex Crimes/Child Abuse Criminal Case

After an initial disclosure or suspicion of child sexual abuse is reported to the Department of Child Services and/or law enforcement, law enforcement officials will investigate the case. Once the investigation is complete, law enforcement presents the case to the prosecutor's office. The prosecutor reviews the case for possible criminal charges and makes the decision whether to file charges against the perpetrator. If charges are filed against the perpetrator, the prosecutor will prepare the case, meet with witnesses, and attend pretrial hearings.

The case may go to jury trial or bench trial (a trial with a judge only, no jury). A defendant may enter a guilty plea or charges may be dismissed. If the defendant is convicted of any crimes at the conclusion of the case, the judge ultimately determines the sentence.

The Challenges of Child Sex Crimes Prosecution

Many challenges are associated with prosecuting child sexual abuse cases. The child's age, intellectual and behavioral development, and/or disability may prohibit their ability to understand what it means to take an oath of truth required by all testifying witnesses at trial. Some children do not want to talk about the abuse that happened to them. At trial, children most likely will have to testify in the same room as their abuser and a number of adult strangers. Some jurors believe that children often lie and make false accusations. Most jurors do not understand the effects of trauma and emotional distress and the development of a child's brain. Often these cases occur within a difficult family dynamic. The child victim may not have a good support system and may not be surrounded by adults who believe them. For these and other reasons, it can be difficult to achieve guilty verdicts on child sexual abuse cases.

The Role of Medical Professionals as Witnesses in a Criminal Case

Pediatric sexual assault providers are trained to provide testimony if and when matters involving the patients they care for proceed to litigation. Thorough documentation, preparation, and honesty are essential in serving as a witness in a criminal case. Pediatric sexual assault providers may serve as fact or expert witnesses in the courtroom. Some considerations for pediatric sexual assault providers and medical professionals regarding testimony include:

- Take notes during your examination. Do not rely on your memory.
- Include the patient's statements about the abuse in their own words (when able and developmentally appropriate).
- Understand the hearsay exception-Indiana Rule of Evidence 803(4).

Statement Made for Medical Diagnosis or Treatment. A statement that: **(A)** is made for - and is reasonably pertinent to - medical diagnosis or treatment; and **(B)** describes medical history; past or present symptoms or sensations; or their source.

- The care that the pediatric sexual assault provider renders to the patient at the time of the MFE, as well as the statements made by the patient and symptoms reported, are essential to medical diagnosis and treatment. This information guides the provider in developing a comprehensive plan of care that addresses medical concerns, as well as biopsychosocial issues and safety concerns. As such, a medical provider is able to provide valuable testimony about the patient's statements, signs and symptoms, and findings. This information is admissible in criminal cases under the medical hearsay exemption.
- When the pediatric sexual assault provider receives a subpoena, they should initiate contact with the prosecutor's office immediately. The pediatric sexual assault provider's testimony and knowledge are an essential component of education for all parties involved in the case. Medical records, treatment modalities, and findings are not easily interpreted or understood by those without medical training, including attorneys. Jurors, and judges also benefit from their expertise. The pediatric sexual assault provider's testimony can be helpful in ensuring that perpetrators are held accountable for their crimes and innocent people are exonerated and set free.

Additional principles for healthcare workers when providing evidence in sexual violence cases are offered in Table 5.

Types of Evidence

Evidence is used to prove or disprove facts and determine whether or not something is true. In a trial, not all types of evidence may carry the same weight. The jury (or judge in a bench trial) must consider each type of evidence and make a determination as to the credibility and value of the evidence presented.

Types of evidence evaluated by the jury/judge include:

- Demonstrative evidence (i.e. charts, graphs, diagrams, etc., useful in educating the jury)
- Documentary evidence (i.e. medical records, letters)
- Physical evidence (i.e. fingerprints, DNA, blood)
- Testimonial evidence (i.e. when a person testifies before the court during the trial)

For evidence to be useful in trial, it must be admissible, authentic, complete, reliable, and believable. For various reasons, some items may not be admitted as evidence during a trial. For example, evidence may be excluded if it might confuse or mislead jurors or unfairly prejudice jurors against a defendant. The prosecution and defense attorneys are responsible for advocating for or arguing against the evidence presented. As a result, when providing testimony as a fact or expert witness, you may be advised that you are unable to present or discuss certain information. This does not necessarily reflect on the quality or integrity of the content, rather that throughout the trial process, it was deemed inadmissible for any number of reasons.

Resources for Prosecutors

The Indiana Prosecuting Attorneys Council (IPAC) is a state judicial branch agency that assists prosecuting attorneys by preparing manuals, providing legal research, and conducting training and

educational seminars. The IPAC serves as a liaison for various local, state, and federal agencies in an effort to support law enforcement and promote the fair administration of justice.

The IPAC employs a domestic violence/sexual assault resource prosecutor to provide support and guidance regarding these matters. Prosecutors and their deputies are encouraged to reach out to IPAC for assistance.

Indiana Prosecuting Attorneys Council
302 W. Washington St., Room E205
Indianapolis, IN 46204
Telephone: (317) 232-1836

TABLE 5: Providing Evidence in Sexual Violence Cases: Guiding Principles for Health Workers

WRITING REPORTS	GIVING EVIDENCE
1. Explain what you were told and observed.	1. Be prepared.
2. Use precise terminology.	2. Listen carefully.
3. Maintain objectivity.	3. Speak clearly.
4. Stay within your field of expertise.	4. Use simple and precise language.
5. Distinguish findings and opinions.	5. Stay within your field of expertise.
6. Detail all specimens collected.	6. Separate facts and opinion.
7. Only say or write what you would be prepared to repeat under oath in court.	7. Remain impartial.

Reference:

World Health Organization. *Guidelines for medico-legal care for victims of sexual violence*. (2003). Geneva, Switzerland: WHO Press.

Human Trafficking Indicators for Health Care Providers

Notify the Department of Child Services immediately if any of the following apply.

If youth:

- Is advertised on social media or the Internet
- Was brought in unconscious
- Was recovered from a hotel
- Has evidence of implantation of a chip, as visualized by a raised area on the neck, behind the earlobe, in the webbed area between the thumb and forefinger, or inside the lower forearm.
- Admits to exchanging sex or sex acts for money or goods
- Has had a prolonged absence from home or school without explanation or consistently runs away from home for longer than 24 hours

Other Red Flags

These factors may also indicate human trafficking. Utilize professional judgment based on each patient's individual circumstances. It is recommended that if a patient presents with three or more of the following factors, the health care provider should initiate a call to DCS for a human trafficking assessment:

- Branding or tattoos including names, numbers, dollar signs, or emblems on the neck, chest, wrist, fingers, and lower back.
- Adult speaks for the youth and controls the conversation.
- Youth has no identification, doesn't have control of identification or other important documents, or possesses a fake identification.
- Youth presents with fearful or submissive behaviors such as looking down, not speaking, unaware of location, or looking to the adult before answering questions.
- Past or current homelessness.
- Genital injuries.
- Sexually transmitted infections.
- Prior pregnancies and/or abortions.
- Urinary tract infections.
- Hypervigilance, anger, or displays unwarranted paranoia or fear.
- Bruises in various stages of healing.
- Scars, mutilations, or infections.
- Signs of drug abuse or symptoms of drug withdrawal.
- Malnutrition or dehydration.

Adapted from the Indiana Trafficking Victims Assistance Program Quick Indicator Tool-Health Care

Alcohol or Drug-Facilitated Sexual Assault/Abuse

In matters of acute intoxication, it is prudent to monitor the patient for medical and safety concerns until their level of consciousness and mental status improves and the pediatric sexual assault provider is able to obtain informed consent for the examination. It is not a requirement that a patient be clinically or legally “sober” to consent to a medical forensic examination. The patient should, however, be alert, oriented, and cooperative and consent to the examination with an understanding of what the examination entails.

Urine and blood samples to rule out alcohol or drug-facilitated sexual assault (DFSA) should be collected only when indicated. Some indications include loss of consciousness, loss of motor control, lapse in memory, and patient reported intoxication inconsistent from normal response to similar amounts and types of substances. These samples should be collected *in addition to* the Sexual Assault Evidence Kit (SAEK) and shall **not** be placed into the SAEK, as they must be sent separately for toxicology testing. Toxicology samples are not a part of the standard SAEK analysis and will be evaluated separately through specialized laboratories. Costs for DFSA sample analysis can be submitted to the Indiana Criminal Justice Institute (ICJI).

Facilities and/or jurisdictions shall establish a process for testing these types of samples. The samples should not be evaluated by the exam site laboratory, and a chain of custody will be necessary to ensure sample integrity. Facilities may establish a memorandum of understanding with an offsite toxicology laboratory to analyze these samples. In the absence of access to an offsite toxicology laboratory, testing of these samples should be directed and organized by law enforcement officials, as with other forms of evidence.

Substances used in DFSA are quickly eliminated from the body; therefore, toxicology samples should be collected as soon as possible after a suspected DFSA. The window of detection is longer for urine than for blood. A urine specimen should be collected if ingestion of the substance may have occurred in the previous 96 hours. Urine should be refrigerated or frozen for storage. A blood specimen may be collected if ingestion of the substance occurred in the previous 24 hours in a tube containing sodium fluoride and potassium oxalate preservatives. Blood specimens should be refrigerated for storage. Collecting blood does not negate the need to collect urine. In this case, they should be sent together with appropriate chain of custody documentation.

It is important to note that testing for DFSA may also report legal and illegal drugs or alcohol in the patient’s system that were consumed voluntarily. Voluntary substance use in no way diminishes the seriousness of the assault or abuse or makes the patient at fault.

Follow facility policies and procedures for drug and alcohol testing necessary for medical evaluation and treatment.

Medical Forensic Examination Process

The medical forensic examination process and evidence collection are outlined in detail in *A National Protocol for Sexual Abuse Medical Forensic Examinations-Pediatric*. All pediatric sexual assault providers must be familiar with this document and associated protocols. This section will not attempt to rewrite the protocol, but rather will provide a general overview of the practices and highlight Indiana-specific information to ensure consistency and quality examinations are provided throughout the state.

The process of conducting a medical forensic examination (MFE) requires providing patient-centered, child-friendly care with precision, attention to details, and an understanding of medical and legal consequences associated with their care. The pediatric sexual assault provider coordinates the patient's care and works collaboratively to ensure the best possible outcomes for each child.

During an acute or emergency examination, the pediatric sexual assault provider begins by establishing rapport with the patient and their caregiver and explains their role and the steps involved in the examination. The pediatric sexual assault provider obtains informed consent for examination from the caregiver and ensures the child assents, or agrees, to the examination. The child may decline any part of the examination. The pediatric sexual assault provider gives information to the caregiver about the importance of any steps declined by the patient. The pediatric sexual assault provider adheres to the patient's needs to ensure the highest level of comfort by making adjustments and alterations to the examination, such as offering breaks to the patient as necessary. Any steps that have been declined or postponed may be revisited at any time during the examination, dependent on the child's comfort and ability to tolerate.

The pediatric sexual assault provider documents without bias a complete history of the reported sexual abuse and comprehensive medical history as provided by the child and/or accompanying adult. The pediatric sexual assault provider conducts a medical assessment of the child including, but not limited to, a thorough review of systems, head-to-toe examination, and anogenital examination. All, if any, medical and mental health concerns are addressed during the examination and appropriate follow-up care referrals made.

The expectation of the MFE is that the patient will receive individualized care that is tailored to the patient's history of abuse, age, intellectual and/or behavioral development, medical history, and biopsychosocial needs.

An MFE may include photo documentation. Observation and photo documentation are completed prior to evidence collection. The pediatric sexual assault provider may use forensic adjuncts to complete their examination. Considerations should be made, based on the pediatric sexual assault provider's clinical judgment, to use these adjunct tools to support best practices for the medical forensic examination. Examples include an alternate light source (ALS), toluidine blue dye, a foley catheter, and sterile cotton-tipped swabs. Further explanation and proper use of these tools can be found in *A National Protocol for Sexual Abuse Medical Forensic Examinations-Pediatric*. **Note:** Not all tools and techniques are appropriate for prepubescent patients.

The examination also includes appropriate testing and treatment options, discharge planning, referrals, consultations, and follow-up care instructions.

Informed Consent

It is standard practice to obtain written consent from a parent or legal guardian prior to conducting a medical examination or implementing treatments. The same also applies during a medical forensic examination (MFE) and expands further by also including consent for evidence collection, photography, and the release of evidence to respective parties.

Informed consent is the process of communication between a healthcare provider and a patient and their caregiver that often leads to agreement or permission to provide care or treatment.

During the informed consent process, the pediatric sexual assault provider will explain their role and provide the patient and their caregiver with information about the MFE, including risks and benefits associated with examination, evidence collection, and treatment options. The pediatric sexual assault provider will also discuss alternatives for care, including the potential consequences and outcomes of not having the examination. The patient and their caregiver will have the ability to ask questions and obtain further explanations when requested. Risks, benefits, and potential consequences must be addressed in a manner that the patient and caregiver can understand. It is imperative to ensure the patient and their caregiver understand what the provider will do, when they will do it, and why it will be done, prior to beginning the examination.

Procedures during an MFE can be unfamiliar, embarrassing, intimidating, or difficult to understand for children. While the pediatric sexual assault provider will obtain written consent from a parent or legal guardian, the pediatric patient must *assent*, or agree to, each step of the examination. The process of informed consent is ongoing throughout the child's visit and does not end when the parent or legal guardian signs the consent form(s).

Patients have the right to assent or decline any individual part of the exam at any time during the process. During the examination, if the patient expresses resistance, confusion, or noncooperation, the pediatric sexual assault provider should immediately discontinue that part of the process, discuss questions or concerns with the patient, and together determine whether they will continue. With pediatric patients, pediatric sexual assault providers may have to revisit a part of the examination at a later time or give the patient a break.

Declining portions of the exam may have a negative impact on the criminal investigation and/or prosecution. This information should be presented without judgment or intent to sway a decision, but rather to empower patients and their caregivers to make a decision that is best for them. Giving the patient power and control over the decision-making can facilitate healing. It reaffirms to the child that they are in control of their body. If a patient decides to stop an examination before it has been completed, a partial kit may be submitted to law enforcement, along with appropriate documentation. When a patient declines a portion of the exam, the pediatric sexual assault provider should use nonjudgmental language in their documentation, such as "patient declined," rather than using words like "refused" or "noncompliant."

Follow facility and legal guidelines for consent from special populations, like those with an altered mental status, or incapacitated patients. In all cases, an MFE should never be done against the will of the patient.

Evidence Collection

When applicable and within appropriate time frames, evidence may be collected from the patient utilizing the Indiana Sexual Assault Evidence Kit (SAEK). Evidence collection techniques should be obtained using the most current evidence-based practices. The pediatric sexual assault provider meticulously collects evidence from various areas of the patient's body. Specimen collection may include samples collected with sterile cotton-tipped swabs to identify bodily fluids, the presence of foreign DNA, or material. Specimens are obtained from multiple body surfaces based on the patient's history of the event, areas of suspected secretions, areas of positive fluorescence or absorption, bite marks, foreign debris, or fibers. The pediatric sexual assault provider must ensure the preservation and integrity of each item collected. For evidence collected utilizing sterile cotton-tipped swabs, those swabs should be dried or capped prior to packaging. Each collection must be packaged in a corresponding envelope, labeled respectively, and sealed. Envelopes should only be sealed with tape and/or a patient label. Pediatric sexual assault providers should not lick or dampen the adhesive seal on the envelope. Envelopes containing anatomical body diagrams may be used to map areas of the body where specific findings are identified (i.e. debris, foreign bodies, positive ALS fluorescence). The patient's underwear should be collected and placed in the white paper bag included in the SAEK. Brown paper bags are also available and can be utilized to collect other patient clothing that may contain evidentiary value. When using the brown paper bags, do not return those bags to the completed SAEK. The only items that belong in the SAEK once completed are the envelopes containing the patient's specimens and the white bag containing the patient's underwear. **DO NOT include blood, urine, or ANY SPECIMENS FROM OTHER PEOPLE**¹ such as the nurse, parent, alleged perpetrator, sibling, etc., or any other items such as empty envelopes or loose contents in a completed SAEK. Foreign bodies may be included but need to be collected and placed into an envelope and sealed appropriately.

Prior to sealing the SAEK, all items should be dried appropriately, and all envelopes must be sealed with tape, evidence tape, or patient labels. The pediatric sexual assault provider should also complete the Indiana Sexual Assault Victim Services Fund application and ensure that the application is submitted to the Indiana Criminal Justice Institute within 180 days. The Indiana Sexual Assault Victim Services Fund pays hospitals for the forensic medical examination services provided, and a patient may not be billed for a medical forensic examination.

¹ If a sample is needed from another individual, that will be collected at a later time and will be driven by law enforcement during their investigative process.

Evidence Integrity

Recommendations regarding evidence integrity may be found in *A National Protocol for Sexual Abuse Medical Forensic Examinations-Pediatric* (United States Department of Justice, 2016).

Evidence integrity is *critical* to the admissibility of the evidence should the case proceed to trial. Healthcare providers must handle forensic specimens/items properly from the moment of collection until turning the specimens/items over to law enforcement.

Follow jurisdictional policies for drying, packaging, labeling, sealing, and storing forensic specimens while also maintaining chain of custody.

General considerations for forensic evidence integrity include:

- Providers should wear powder-free gloves and change gloves frequently throughout the examination and while packaging evidence. Change gloves when changing areas on the body and/or at any time when cross-contamination could occur.
- Dry forensic specimens unless otherwise indicated.
- Package forensic specimens appropriately.
- Label forensic specimens accurately.
- Establish and document the security and chain of custody of forensic specimens throughout the examination process and until the forensic specimens are turned over to law enforcement and/or the crime lab.
- Store forensic specimens securely at the healthcare facility until released to law enforcement.

Follow jurisdictional policies for completing written documentation to be included in the evidentiary kit. At the time of this writing, the Indiana Sexual Assault Evidence Collection Kit (SAEK) does not require forms to be completed and returned with the finished kit. The SAEK includes an instruction sheet that can be used to guide healthcare providers through the evidence collection process. This instruction sheet does not need to be returned with the finished kit. The envelopes included in the SAEK allow for the provider to identify body sites, types of foreign materials, dried secretions, and debris. Some of the envelopes include body maps or diagrams. Information that may be useful to crime lab personnel in analyzing the SAEK should be noted on the respective body area's envelope. Providers may write on these envelopes and highlight, shade, or circle areas on the body maps or diagrams as needed, being mindful that any information included may be presented in a courtroom during trial proceedings. Professionalism and accuracy are always the expectation. The patient's medical record and photo documentation should not be included in the sealed SAEK.

It is important to note that while evidence in sexual abuse cases may be collected by any healthcare provider, it is not an ideal or recommended practice. A comprehensive, high-quality medical forensic examination and evidence collection requires a clinician who has been forensically trained to ensure optimal outcomes for the patient and the legal process. For the safety of the patient, healthcare providers who have not been specifically trained as pediatric sexual assault providers

should not collect evidence from prepubescent patients without the supervision, guidance, or request of a trained pediatric sexual assault provider.

The Indiana SAEK contains two types of swabs: capped and uncapped. There is no standardization regarding which samples should be collected with capped swabs versus uncapped swabs. This is based on the provider's discretion. Wet, uncapped swabs must be air-dried at room temperature, quickly, and in a clean environment, such as a drying box. When using capped swabs, the swab may be packaged prior to thorough drying as the cap allows for continued air movement and drying to take place after packaging. Programs and jurisdictions should have policies for handling evidence that takes excessive time to thoroughly dry (i.e. tampons, menstrual pads, diapers, and wet clothing). If an item cannot be thoroughly dried prior to submission to law enforcement, write on the paper bag "WET EVIDENCE" to notify law enforcement and crime lab personnel to handle the specimens safely, appropriately, and timely.

All containers for packaging evidence should be made of paper. The use of plastic bags or containers allows for moisture to be retained and promotes degradation of biological samples. The Indiana SAEK contains a white paper bag for packaging the patient's underwear and should be returned *inside* the kit. The SAEK also contains several brown paper bags for other articles of clothing. **Package only one item per bag.** All bags must be sealed, labeled with a description of the contents, initialed and dated by the collector, and include patient identification.

Blood and urine samples that are collected to rule out drug-facilitated sexual assaults should **NOT** be placed into the SAEK. These samples must be stored securely and may be kept at room temperature for no longer than 24 hours. Follow jurisdictional policies regarding the collection, storage, and testing of these types of samples. Again, ***blood and urine samples should never be placed into the Indiana SAEK.***

Other items that should never be placed into the SAEK include samples from the collector, family members, potential suspects, or other victims in the home. The only items that are to be contained within a completed, sealed SAEK are *from the patient noted on the kit*. Including samples from other individuals compromises the integrity of all the samples and may contaminate the entire kit, thereby rendering the remaining contents useless. If samples or specimens from other individuals are necessary to the investigative process, law enforcement will work to obtain those items.

The provider should never leave evidence unattended or unsecured. Patients, advocates, family members, and other support persons should not handle the evidence. Support persons present in the examination room should be positioned away from samples and specimens collected.

Attention must also be paid to the integrity of examination documentation, including the medical forensic history and examination findings as these items may be admitted as evidence during legal proceedings. Facilities should safeguard the medical forensic examination findings, including the medical forensic history and photographs, of **ANY** ongoing investigation. Only providers directly involved in the forensic medical care or continuity of care related to the sexual abuse should access these items. It is prudent for each facility to establish a process with the medical records department to appropriately identify or review records for forensic content prior to release. The

facility may consider requiring a subpoena for release of forensic content or verify that an active investigation is not ongoing prior to release. Release of medical forensic records can compromise an investigation and may result in civil liabilities for the facility.

Evidence should be transferred from the exam site to the appropriate law enforcement or crime lab agency. A fully executed chain of custody documentation form should be maintained at all times and a copy retained by the collecting facility. *The National Institute of Justice National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach* (2017) emphasizes that law enforcement and/or crime laboratories should be responsible for storing all SAEKs. It is recommended that SAEKs and evidence should be transferred from the exam facility as soon as possible, specifically no later than three business days from the date of collection. It is recommended that kits are to be submitted to the crime lab for analysis as soon as possible, specifically no later than seven business days from the date of collection.

Adapted from the Indiana Guidelines for Medical Forensic Examinations-Adult/Adolescent, 2019.

Chain of Custody

Chain of custody is a chronological documentation of the handling of evidence throughout a criminal investigation. This process involves keeping a detailed log or document that clearly outlines who collected the evidence, as well as any individual who handled, transferred, or analyzed the evidence during an investigation. The procedure for establishing the chain of custody begins at the crime scene. For those working in healthcare, establishing the chain of custody begins with the collection of any evidentiary specimens or items from the patient's body or possessions. Some common types of evidence that may be collected from a patient include: photography, clothing, specimens or swabs, debris or other trace evidence, and foreign bodies. Documentation and medical records are also evidence.

Chain of custody documentation is necessary to lay a foundation for the evidence in question. Any individual who handles the evidence must sign the chain of custody form and attest that they have not altered, substituted, or changed the condition of the evidence and that the evidence has remained under their care and custody or in a secured location while in their possession.

Any healthcare provider who collects specimens or items that will be surrendered for evidentiary value must initiate a chain of custody form. The original form will stay with the evidence collected, thereby establishing the "chain" of individuals who have been in possession of the evidence. Copies of these forms should be maintained by the facility, after the receiving signature has been collected, as a means of documenting transfer of the evidence to the next individual.

Anytime an Indiana SAEK is collected, the kit should be logged into the Indiana Sexual Assault Kit Tracking System. This system is addressed later in this document. It should be noted that the Sexual Assault Kit Tracking System does not serve as chain of custody documentation. A chain of custody form should always accompany every item of evidence collected.

A sample chain of custody form is included in the Resources section: Sample Forms – *Chain of Custody Form*.

Medical Findings in Child Sexual Abuse

Most children who are evaluated for suspected abuse will not have physical signs of injury or infection.

The child's description of what happened and report of specific symptoms in relationship to the events described are both essential parts of a full medical evaluation.

FIGURE 3: Medical Findings in Suspected Child Sexual Abuse

Normal variants

Normal variants include findings that are documented in newborns or commonly seen in nonabused children¹.

- Normal variations in the appearance of the hymen--annular, crescentic, imperforate, microperforate, septate, redundant, hymenal tag, mounds or bumps, notches or clefts (regardless of depth) above the 3- and 9-o'clock position, superficial notches of the hymen at or below the 3- and 9-o'clock position, smooth, relatively narrow, posterior rim, external ridges
- Periurethral or vestibular bands
- Intravaginal ridges or columns
- Linea vestibularis
- Diastasis ani
- Perianal skin tag
- Hyperpigmentation of the skin of labia minora or perianal tissues
- Dilation of the urethral opening

Findings commonly caused by medical conditions other than trauma or sexual contact²

- Erythema of the genital tissue
- Increased vascularity of vestibule and hymen
- Labial adhesion
- Friability of the posterior fourchette
- Vaginal discharge
- Molluscum contagiosum
- Anal fissures
- Venous congestion or venous pooling in the perianal area
- Anal dilation in children with predisposing conditions (i.e. constipation, encopresis) or children who are sedated, under anesthesia, or with impaired neurovascular tone for other reasons, (i.e. postmortem)

Conditions mistaken for abuse

- Urethral prolapse
- Lichen sclerosus
- Vulvar ulcers
- Erythema, inflammation, and fissuring of the perianal or vulvar tissues due to infection with bacteria, fungus, viruses, parasites, or other non-sexually transmitted infections
- Failure of midline fusion (perianal groove)

- Rectal prolapse
- Visualization of the pectate/dentate line at the juncture of the anoderm and rectal mucosa
- Partial dilation of the external anal sphincter with the internal sphincter closed causing the appearance of deep creases in the perianal skin
- Red/purple discoloration of the genital structures from lividity postmortem as confirmed by histologic analysis

Findings with no expert consensus on interpretation with respect to sexual contact or trauma³

- Complete anal dilation with relaxation of both the internal and external anal sphincters in the absence of other predisposing factors such as constipation, encopresis, sedation, anesthesia, and neuromuscular conditions*
- Notch or cleft in the hymenal rim at or below the 3- or 9-o'clock position, which is deeper than a superficial notch and may extend nearly to the base of the hymen but is not a complete transection*
- Genital or anal condyloma acuminatum in the absence of other indicators of abuse; lesions appearing for the first time in a child older than age 5 may be more likely the result of sexual transmission
- Herpes type 1 or 2, confirmed by culture or polymerase chain reaction testing, in the genital or anal area of a child with no other indicators of sexual abuse

Findings caused by trauma and/or sexual contact

Acute trauma to external genital/anal tissues (accidental or inflicted)

- Acute laceration(s) or bruising of the labia, penis, scrotum, perianal tissues, or perineum*
- Acute laceration of the posterior fourchette or vestibule, not involving the hymen*

Residual (healing) injuries to external genital/anal tissues (these rare findings are difficult to diagnose unless an acute injury was previously documented at the same location)

- Perianal scar*
- Scar of posterior fourchette or fossa*

Injuries indicative of acute or healed trauma to the genital/anal tissues

- Bruising, petechiae, or abrasions on the hymen*
- Acute laceration of the hymen, of any depth; partial or complete*
- Vaginal laceration*
- Perianal laceration with exposure of tissues below the dermis
- Healed hymenal transection or complete hymen cleft (a defect in the hymen between 4- and 8 o'clock that extends to the base of the hymen) with no hymenal tissue discernible at that location*
- Defect in the posterior (inferior) half of the hymen wider than a transection with an absence of hymenal tissue extending to the base of the hymen*

Infections transmitted by sexual contact, unless there is evidence of perinatal transmission or clear, reasonable, and independent documentation of nonsexual transmission

- Genital, rectal, or pharyngeal *N gonorrhoeae* infection
- Syphilis
- Genital or rectal *C trachomatis* infection
- *T vaginalis* infection

- HIV, if transmission by blood transfusion has been ruled out

Diagnostic of sexual contact

- Pregnancy
 - Semen identified in forensic specimens taken directly from a child's body
-

¹ These findings are normal and are unrelated to a child's disclosure of sexual abuse.

² These findings require that a differential diagnosis be considered, as each may have several different causes.

³ These physical and laboratory findings may support a child's disclosure of sexual abuse, if one is given, but should be interpreted with caution if the child gives no disclosure. Additional information, such as mother's gynecologic history or child's history of oral lesions, may clarify likelihood of sexual transmission for children with condyloma or herpes. After complete assessment, a report to DCS may be indicated in some cases. Photographs or video recordings of these findings should be evaluated and confirmed by an expert in sexual abuse evaluation to ensure accurate diagnosis.

⁴ These findings support a disclosure of sexual abuse and are highly suggestive of abuse even in the absence of a disclosure, unless a timely and plausible description of accidental injury is provided by the child and/or caregiver. Diagnosis of STIs must be confirmed by additional testing to avoid assigning significance to possible false positive screening test results. Photographs or video recordings of these findings should be evaluated and confirmed by an expert in sexual abuse evaluation to ensure accurate diagnosis.

*Physical findings should be confirmed using additional examination positions and/or techniques.

Reference:

Adams, J. Kellogg, N., & Moles, R. (2016). Medical care for children who may have been sexually abused: An update for 2016. *Clinical Pediatric Emergency Medicine*, 17(4), 255-263 * Reprinted with permission from authors.

Normal Examination Findings: “It’s Normal to be Normal”

Questions regarding the frequency of abnormal findings in children of sexual abuse have been difficult to answer with certainty because of varying definitions of what constitutes an “abnormality” and the lack of a true “gold standard” for proving abuse (Adams, Farst, & Kellogg, 2018; Adams, Harper, Knudson, & Revilla, 1994). Many studies estimate that normal examination findings are present in greater than 90% of children of sexual abuse. This means that there is frequently no presence of physical abnormalities or injuries in children with reports of sexual abuse.

There are several reasons for the lack of physical findings in child sexual abuse victims:

- Delayed disclosures result in the examination being conducted long after the abuse actually occurred. If findings were present, they tend to heal rapidly and completely, thereby decreasing the likelihood of positive findings at the time of the delayed examination.
- Post-abuse activities, such as bathing, urinating, and defecating can result in loss of evidence.
- The human body involuntarily responds to sexual stimulation by preparing for sexual activity and/or intercourse by activating hormones and increasing blood pressure, respirations, heart rate, and blood flow to genital structures. As a result of the human sexual response on the body, injuries during sexual contact may not occur.
- When injuries do occur, healing is rapid.
- Some forms of sexual abuse do not leave physical findings (i.e. fondling, oral contact).
- Penetration is legally defined in Indiana as any contact beyond the labia majora. This type of sexual activity can occur without damage to tissues.
- The anal sphincter is flexible, allowing for the routine passage of stools larger than the diameter of the penis without damage.
- Perpetrators take great care not to induce physical injury or pain to child victims. Doing so risks the child disclosing details of pain or injury to a parent or trusted adult, causing potential loss of access to the child and subsequent criminal charges.

“The rare presence of abnormal anogenital findings in child victims of sexual abuse reaffirms that the history provided by the child is among the most important evidence in sexual abuse cases. While widely accepted by medical providers, this fact is still not universally accepted in the legal arena. More emphasis should be placed on documenting the child’s description of the abuse, and educating others, including law enforcement officials, prosecutors, and potential jurors that for children alleging sexual abuse, it’s normal to be normal.”

Adams, J.A., Harper, K., Knudson, S., Revilla, J. (1994). Examination findings in legally confirmed child sexual abuse: It’s normal to be normal. *Pediatrics*. 94(3). 310-317.

The importance of documenting the child’s description of the abuse and educating others, including potential jurors, that it is normal for suspected child victims of sexual abuse to have normal examinations cannot be minimized. Pediatric sexual assault providers are an important and credible resource for presenting this information.

The Value of Non-acute Medical Forensic Examinations

Non-acute, or non-urgent, medical forensic examinations (MFEs) are extremely important and have immense value, even if the examination is conducted outside of the timeframe for evidence collection.

Non-acute MFEs are indicated *any* time a child has a disclosure of sexual abuse, exhibits concerning sexualized behaviors, sexual abuse is suspected by the multidisciplinary team, or there is family concern for sexual abuse but contact with the alleged perpetrator occurred more than two weeks prior without identified emergency medical, psychological, or safety needs.

During a non-acute MFE, the pediatric sexual assault provider gathers a medical history and a history of events from the child (whenever age or developmentally appropriate and staying within their own scope of practice), initiates contact with DCS and/or law enforcement (if these organizations are not already involved), and conducts a thorough head-to-toe physical examination, including an anogenital examination, and a complete review of systems. The non-acute examination may present unique opportunities for evidence collection that may not be foreseen. If the pediatric sexual assault provider believes an item may have evidentiary value based upon the information available during the examination, items may be collected for evidence. The non-acute examination is also an opportunity for photo documentation and STI testing and prophylaxis (when indicated). The pediatric sexual assault provider will provide safety planning, discharge information, and follow-up care instructions and make referrals for more advanced or specialized care as needed.

The most important reason to conduct a non-acute MFE is the benefit to the child victim. A pediatric sexual assault provider understands and utilizes principles of trauma-informed, patient-centered care and provides for holistic needs to establish a foundation for building resilience necessary for healing. The child and their caregiver can be reassured that the child's body is "normal" and "okay" and find comfort in openly expressing their worries and concerns and having their questions answered. The pediatric sexual assault provider can guide the child through body safety practices and reinforce that the child is in charge of their body. The pediatric sexual assault provider can emphasize that the child is believed and remind the child that they are **not** responsible for the abuse, no matter what the situation or circumstances. The pediatric sexual assault provider also evaluates the level of support that the child has from the caregiver in order to guide decisions related to ongoing care, treatment, and service needs.

Another critical reason to conduct a non-acute MFE is to thoroughly document history and findings. Because children are familiar with the helping role of healthcare providers, they may be more likely to disclose information to healthcare providers that they might not share with investigators. Thorough documentation is essential to the investigative process as the child's medical records may contain information of value to the investigation. For example, the presence of some sexually transmitted infections and/or pregnancy are diagnostic for child sexual abuse. Additionally, a child's statements to the pediatric sexual assault provider may be admissible under medical hearsay testimony in a trial.

Hospitals and healthcare facilities (including emergency departments) should have policies and procedures in place that support and permit pediatric sexual assault providers to conduct non-acute MFEs on suspected child victims of sexual abuse.

Sexually Transmitted Infections

The presence of sexually transmissible agents in children after the neonatal period strongly suggests sexual abuse.

Postnatal acquired infections can include:

- Gonorrhea
- Syphilis
- Chlamydia
- HIV (non-transfusion and non-perinatal acquired)

Sexual abuse should be **suspected** when a child is diagnosed with any of the following:

- Genital herpes
- T. vaginalis
- Anogenital warts

Any child with a diagnosis of a sexually transmitted infection (STI) should be screened for all other STIs. STIs are not common in prepubertal children or infants. If a child has any symptoms, signs, or evidence of an infection that may be sexually transmitted, the child should be tested for common STIs before initiation of any treatment that could interfere with the diagnosis of other STIs.

TABLE 6: Implications of commonly encountered sexually transmitted or sexually associated infections for diagnosis and reporting of sexual abuse among infants and prepubertal children

ST/SA confirmed	Evidence for abuse	Suggested action
Gonorrhea*	Diagnostic	Report [†]
Syphilis*	Diagnostic	Report [†]
HIV [§]	Diagnostic	Report [†]
<i>Chlamydia trachomatis</i> *	Diagnostic	Report [†]
<i>Trichomonas vaginalis</i> *	Highly suspicious	Report [†]
Genital herpes	Highly suspicious (HSV-2 especially)	Report ^{†¶}
<i>Condylomata acuminata</i> * (anogenital warts)	Suspicious	Consider report ^{†¶**}
Bacterial vaginosis	Inconclusive	Medical follow-up

Source: Centers for Disease Control (2015) STD Treatment Guidelines. Adapted from: Kellogg N, American Academy of Pediatrics Committee on Child Abuse and Neglect. The evaluation of child abuse in children. Pediatrics. 2005; 116: 506-12.

Abbreviations: HIV= human immunodeficiency virus; SA= sexually associated; ST= sexually transmitted.

*If not likely to be perinatal-acquired and rare vertical transmission is excluded.

† Reports should be made to the agency in the community mandated to receive reports of suspected child abuse or neglect.

§ If not likely to be acquired perinatally or through transfusion.

¶ Unless a clear history of autoinoculation exists.

** Report if evidence exists to suspect abuse, including history, physical examination, or other identified infections.

Neisseria Gonorrhea

TESTING	SIGNS AND SYMPTOMS	EVIDENCE FOR SEXUAL ABUSE	TREATMENT
<p>Culture on Martin-Lewis Agar of (preferred): Pharynx (throat) Vagina (not cervical in prepubertal) Anus Urethra in males if symptomatic (can use meatal specimen if discharge is present)</p> <p>Cultures are the preferred method of testing in children</p> <p>Nucleic acid amplification testing (NAAT) can be used as an alternative to culture; NAAT can be obtained as a “dirty” catch urine</p> <p>Retain all positive specimens in the lab for additional testing by culture or alternate sequence confirmation via NAAT</p> <p>Positive NAAT persists for weeks after effective treatment</p>	<p>Vaginal: discharge or may be asymptomatic</p> <p>Pharyngeal: may be asymptomatic</p> <p>Rectal: may be asymptomatic</p> <p>Urethral discharge may be present in males</p>	<p>Diagnostic, once perinatal transmission has been ruled out</p>	<p><u>Deferred until after initial tests are conducted and any positive results are confirmed with follow-up testing</u></p>

Chlamydia Trachomatis

TESTING	SIGNS AND SYMPTOMS	EVIDENCE FOR SEXUAL ABUSE	TREATMENT
<p>Standard viral culture for isolation of Chlamydia trachomatis</p> <p>Vagina</p> <p>Anus</p> <p>Urethra in males if symptomatic (can use meatal specimen if discharge is present¹)</p> <p>Pharyngeal is not recommended in children of either sex, as yield is low</p> <p>Cultures are the preferred method of testing in children</p> <p>NAAT can be used as an alternative to culture; NAAT can be obtained as a “dirty” catch urine</p> <p>Retain all positive specimens in the lab for additional testing by culture or alternate sequence confirmation via NAAT</p> <p>Positive NAAT persists for weeks after effective treatment</p>	<p>Asymptomatic, can persist for months or years</p> <p>Vaginal or anal discharge</p> <p>Urethral discharge in males</p> <p>Dysuria</p> <p>Abdominal pain</p>	<p>Diagnostic, once perinatal transmission has been ruled out</p>	<p><u>Deferred until after initial tests are conducted and any positive results are confirmed with follow-up testing</u></p>

¹ Likelihood of recovering C. trachomatis from urethra of prepubertal boys is too low to justify trauma in obtaining specimen

Syphilis

TESTING	SIGNS AND SYMPTOMS	EVIDENCE FOR SEXUAL ABUSE	TREATMENT
<p>Prevalence is low in children who have been sexually abused</p> <p>Recommended in high-risk situations</p> <p>Serology testing for antibodies in the absence of lesions</p>	Typically asymptomatic at primary inoculation	<p>Diagnostic, once perinatal transmission has been ruled out</p> <p>Differentiating perinatal from later-acquired transmission can be difficult</p> <p>Children presenting with primary infections after 6 months or secondary infections after 15 months should be presumed victims of sexual abuse</p>	<u>Deferred until after initial tests are conducted and any positive results are confirmed with follow-up testing</u>

Herpes Simplex Virus (HSV)

TESTING	SIGNS AND SYMPTOMS	EVIDENCE FOR SEXUAL ABUSE	TREATMENT
<p>Viral culture or polymerase chain reaction (PCR) collected from all mucocutaneous lesions</p> <p>Serology testing in the absence of lesions; detection of HSV antibody 2-3 weeks after infection</p> <p>For serology testing, request type-specific HSV-2 and/or HSV-1 serologic assays</p>	<p>Dysuria</p> <p>Genital or perianal vesicles or ulcers</p> <p>Primary infection may be accompanied by malaise and fatigue</p>	<p>Suspicious</p> <p>Must rule out self-inoculation (child with oral HSV may self-inoculate to genitalia)</p> <p>Must rule out inoculation by an adult with oral or genital HSV during caretaking</p>	<u>Deferred until after initial tests are conducted and any positive results are confirmed with follow-up testing</u>

Human Papillomavirus (HPV)

TESTING	SIGNS AND SYMPTOMS	EVIDENCE FOR SEXUAL ABUSE	TREATMENT
<p>Clinical exam of lesions suspicious for HPV</p> <p>Histological exam if clinical diagnosis unclear</p> <p>Biopsy and typing of HPV does NOT differentiate sexual from nonsexual acquisition</p> <p>Test for presence of other potential STIs</p>	<p>Condyloma presence in oral and/or anogenital area</p>	<p>Suspicious</p> <p>The older the child, the higher the risk of acquiring HPV via sexual abuse than prenatal or perinatal transmission from caregiver</p> <p>Children over age 4-5 years are at higher risk than younger children</p>	<p><u>Deferred until after initial tests are conducted and any positive results are confirmed with follow-up testing</u></p>

Trichomonas Vaginalis (TV)

TESTING	SIGNS AND SYMPTOMS	EVIDENCE FOR SEXUAL ABUSE	TREATMENT
<p>Culture for wet mount¹</p> <p>NAAT of “dirty” catch urine specimen</p> <p>No alternate sequence confirmation method available</p>	<p>Typically asymptomatic at primary inoculation</p>	<p>Suspicious</p> <p>Rule out perinatal-acquired infection</p>	<p><u>Deferred until after initial tests are conducted and any positive results are confirmed with follow-up testing</u></p>

¹ Must distinguish between different species of trichomonas. *T. Vaginalis* is the **ONLY** one specific to sexual transmission

Timing Considerations for Initial and Follow-up Testing

- Sexually transmitted infection (STI) test results after a recent exposure are likely to be negative unless associated with a preexisting condition.
- If no infection is present during the initial exam with recent exposure, consider a repeat exam and testing two weeks after initial testing.
- Gonorrhea and chlamydia can clear spontaneously in a prepubescent female.
- Decisions for testing should be made on an individual basis.
- Concern for syphilis, HIV, hepatitis B, or HPV, with baseline testing and exam negative:
 - Follow-up exam with serologic testing should be completed at 6 weeks and 3 months after last sexual exposure to allow for antibodies to develop and signs of infection to appear.
 - Repeat HIV testing should be completed again at 6 months post exposure.

STI treatment should be deferred until after initial tests are conducted and any positive results are confirmed with follow-up testing.

Presumptive treatment is not recommended for these reasons:

- Incidence of most STIs is low after prepubescent child sexual abuse.
- Prepubescent females appear to be at lower risk than adolescents or adult women.

Documentation Guidelines for Pediatric Sexual Assault Providers

Documentation is an essential component of the medical forensic examination (MFE). In order to obtain the best possible information, a pediatric sexual assault provider may obtain information from sources other than the patient and their caregiver, including law enforcement, social work, forensic interviewers, DCS, advocates, other medical providers, and medical records.

Components of a comprehensive medical forensic history include:

- **Information regarding the patient's abuse or disclosure**
What happened; who was involved (include assailant information, if known); where; when (if developmentally appropriate); body sites and actions involved; and use of threat, force, coercion, confinement, strangulation/suffocation, and associated symptoms
- **What has happened since the event?**
Physical or emotional symptoms or behavioral concerns, safety threats, school performance, bullying, family interactions, post-abuse hygiene, and activities (if emergent examination)
- **What has already occurred?**
Report to DCS and/or law enforcement, forensic interview, prior medical examination and treatment, and counseling or other mental health screenings or services
- **Past and current medical history**
 - Illnesses, surgeries, hospitalizations, preexisting injuries
 - Current physical symptoms (i.e., pain, bleeding, bruising, discharge, injuries)
 - Behavioral, educational, or mental health concerns
 - Prior abuse and sexual history with awareness of gender identity, sexual orientation, and past legal-aged consensual partners
 - Medications, allergies, and immunization status
 - Menstrual history/prior pregnancies and recent consensual sexual activity
 - Current medical care providers, including child's primary health care provider
- **Family and psychosocial history**
 - *Family:* Illnesses, diseases, conditions, abuse in or by other family members
 - *Social:* Child information including preferred nickname, date of birth, sex and gender identity, ethnicity, place of birth (including country of origin and date of arrival in the United States, if applicable), language(s) spoken, school(s) attended, grade level, caregiver(s) (including those who provide care other than parent/guardian), others living in the home (siblings, relatives, friends), family access to resources (i.e., medical, food, child care, education, assistance), prior child welfare involvement and services received, and other children who at risk for abuse
 - *Psychological:* Signs of emotional distress and/or behavioral changes such as:
 - Sadness, depression, anger, fearfulness, anxiety
 - Symptoms associated with post-traumatic stress disorder (PTSD), such as avoidance, numbing, and hypervigilance
 - Inappropriate sexual behavior
 - Loss of social competence
 - Cognitive impairment
 - Regressive behaviors (i.e., loss of bladder control, reversion to thumb-sucking)
 - Changes in eating and/or sleeping patterns
 - Substance abuse
 - Suicidal or homicidal ideation
 - Self-harm (i.e., cutting)

- **Review of systems**
 - Head, eyes, ears, nose, throat (HEENT)
 - Respiratory
 - Cardiac
 - Hematology/Oncology
 - Endocrine
 - Neurology
 - Gastrointestinal (i.e., nausea, vomiting, constipation, diarrhea, rectal pain, bleeding)
 - Genitourinary (i.e., discharge, burning, dysuria, bleeding, pain, lesions)
 - Musculoskeletal
 - Skin

Additional assessment questions and criteria to consider are included in the Resources section: Sample Forms – *Pediatric Caregiver Assessment*.

Pediatric sexual assault provider documentation also should include information regarding the following:

- Child's appearance and condition of clothing
- Child's demeanor during visit
- Persons present during examination
- Laboratory and diagnostic testing completed
- Medications provided
- Examination positions utilized for genital or anal exam
- Examination techniques utilized for genital or anal exam
 - Direct visualization
 - Labial traction
 - Labial separation
 - Foley method
 - Speculum (when indicated, and only if Tanner 3 or greater with menarche)
 - Moist swab
 - Toluidine blue dye
- Use of alternative light source on patient's body and/or clothing and any areas of positive fluorescence or absorption
- Evidentiary specimens or items collected
 - Buccal (DNA standard)
 - Oral
 - Peri-oral/lips
 - Head hair combing
 - Fingernails: swabs or scrapings
 - Hands: left/right/bilateral
 - Neck: left/right/bilateral
 - Breasts: left/right/bilateral
 - Inner thigh: left/right/bilateral
 - Abdomen
 - Pubic hair combing
 - External female sex organ
 - Internal female sex organ
 - External male sex organ
 - Anal folds

- Anal canal
- Perineum
- Intergluteal cleft
- Sacrum/lower back
- Vaginal
- Cervical (if speculum used; only if Tanner 3 or greater with menarche)
- Speculum
- Panty liner or tampon
- Underwear worn during assault
- Underwear worn during examination
- Soil/debris
- Internal foreign body: vaginal/anal
- Photo documentation
- Body maps/diagrams
- Names/contact information of others involved in the child's care
 - DCS
 - Law enforcement (include case number and agency)
 - Physician(s)
 - Social work
 - Translator
- Consent forms
- Safety plan documentation (excluding the specific address/location where the child will be discharged to, especially as it applies to families in imminent danger from the perpetrator)
- ICJI Sexual Assault Compensation Fund application (if the crime occurred in Indiana)
- Chain of custody form(s)

A specimen collection summary form can be located in Resources: Sample Forms – *Specimen Collection Summary*.

Photo Documentation Guidelines for Pediatric Sexual Assault Providers

Photo documentation of pediatric patients during a medical forensic examination is considered the gold standard in providing comprehensive care and treatment of both the acute and non-acute child sex abuse patients. Photographs may help to eliminate the need for additional examination(s) by allowing for later review of photographs for diagnostic purposes and/or a second opinion.

Photographs are useful during follow-up examinations and serve as a reference to compare an initial injury or finding to that of a healing injury or finding. Photographs also create a baseline for comparison should additional suspicions arise at a later time. Photographs help the healthcare examiner when preparing for court testimony and can serve as a means for quality assurance, peer review, and continuing education purposes. The ultimate goal of medical forensic photography is to show a true and accurate representation of what the examiner saw at the time of the examination.

Prior to obtaining photographs of the child, a special consent needs to be signed by the child's caregiver. Informed consent and signature are important to ensure that caregivers understand the purpose of the photographs. Encourage caregivers to ask questions, and be transparent in your explanation. While children will not provide written consent, they do need to give the pediatric sexual assault provider assent (or their own approval and acceptance) for the photographs to be taken. It is important to provide reassurance to the child and answer any questions they may have in a developmentally appropriate manner.

Photographs, under these circumstances, are highly personal in nature, and it is important that DCS and law enforcement investigators are **not** present during any portion of the medical forensic exam (MFE), especially while taking photographs. While the child is under the care of a pediatric sexual assault provider, nonmedical personnel should not be permitted to take their own photographs of the child's torso and anogenital region. Photo documentation of a child's anogenital area is **always** the responsibility of the medical provider. Law enforcement, DCS, and family/caregivers should **never** photograph a child's anogenital area.

Prepare for obtaining photographs by first gathering all necessary equipment, which may include a digital camera (or other still or video image capturing device with magnification capabilities), tripod, ruler, color card, tape measure, sheets or draping materials, memory card, and extra batteries. Ensure adequate lighting is available so as not to produce dark images or shadows in the photos. Prior to taking any photographs of the child, begin your series of photographs with a picture of the patient's label or another item that identifies the patient's name, birthdate, and date of service. Once you have finished taking all necessary photographs of the child and/or clothing, you must take another photograph of the same patient label (or identifying document). This process "bookends" the photographs and ensures a standard process to identify all photographs on a memory card and/or photo storage system. It also clearly identifies the entire series of photos belonging to each patient.

When photographing a particular area of the child's body, stair-step the images. *Stair-stepping* images constitutes a distance photo, a mid-range photo, and closer/zoomed-in photos. The distance photo will include the injury or finding and at least two identifying landmarks. The mid-range photo is closer but should not leave the viewer guessing about the location of the injury or finding. The next photo in the series should be a close-up photo with scale by use of a ruler or measuring device. After that, obtain a close-up photo without scale. Next, obtain a close-up photo with a color card (if used). A color card may be useful to enhance visualization in photographs. The last photo of an

injury or a finding should be the closest image possible while still capturing the entire injury or finding.

Stair-stepping Photographs

- 1) Distant
- 2) Mid-range
- 3) Close-up with scale
- 4) Close-up without scale
- 5) Close-up with color card
- 6) Closest possible while still capturing the entire injury or finding

During an emergent or acute MFE, it is important to take anogenital photographs prior to evidence collection (provided you can do so without touching the area). When taking anogenital photographs, position the child in a comfortable position that affords clarity of the genitalia being photographed, such as a supine frog leg position, supine frog leg position on a trusted caregiver's lap, lithotomy position, supine knee chest, or prone knee chest position. It is important to photograph all genital structures.

For females, start by obtaining a photograph of the labia majora and mons pubis. To fully visualize and photograph the internal genital structures (labia minora, clitoral hood, clitoris, urethra, hymen, posterior fourchette, and fossa navicularis) and perineum, the examiner must use labial separation and traction techniques.

For males, photographs should include the penis (both dorsal and ventral surfaces), urethra, scrotum, and perineum.

Both males and females should have photographs of perianal tissue or sphincter, which is generally accomplished in a supine knee chest position or prone knee chest position.

Other Photographic Considerations

- Take **multiple** photos of each body area (including different angles, light adjustments, zoom, manual setting adjustments such as ISO and f-stop, etc.). Many photos will help ensure capturing at least one high-quality image.
- Photograph areas of positive fluorescence and/or absorption (if able).
- Photograph items collected, including patient's clothing, and any corresponding foreign bodies, penetrating objects, etc.
- Photograph rips, stains, gravel, dirt, and debris that may be present on the child and/or clothing.
- Photograph injuries, including bruises, abrasions, suction injuries, bite marks, etc.
- Consider photographing areas of tenderness because an injury or finding may develop in the future.
- Photograph a patient's mouth (with oral assaults).
- Large injuries may require overlapping images.
- Photograph before and after medical intervention (i.e., cleaning up blood, sutures, etc.).
- Photograph anything you might want to have another look at or that may be helpful during consultation with another provider.
- Use a tripod with genital photos.

- You may have to control breathing and movement (of yourself and the child) to get the best photo.
- Use the macro setting for genital images.
- Photograph debris, fibers, hairs, and/or secretions before removing. Collect these items for evidence and include in the SAEK.
- Never delete photographs, even if they are not of high quality.

*If a prepubescent child has anogenital injuries, findings, areas of uncertainty, or normal/abnormal variants, the pediatric sexual assault provider **must** visualize, confirm, and photograph these findings in **at least two positions**.*

Photography Policies

Policies should identify that photographs are part of a medical record and ensure methods to safeguard these images. Policies should address the security and storage of images. Contrary to traditional hospital policies on photo storage, medical forensic photos should be stored indefinitely. These images may be necessary at a much later time, due to delayed disclosures, special conditions that might extend statute of limitations, CODIS hits, appeals process, cold case investigations, and delayed processing of evidentiary kits.

Policies should also clearly outline the process for obtaining copies of photographs and consider requiring a subpoena or warrant for any open or ongoing investigations. Images should never be released to an offending parent/guardian, and medical records departments should ensure a process to prevent this from happening.

Photography policies should also address labeling or identification of images, peer review, and quality assurance practices. Policies should note that personal cameras are never to be utilized to obtain medical forensic photos.

It is best practice that all patient charts include a body map/diagram even when photographs have been obtained.

Body Maps/Body Diagrams

All medical forensic examination records should contain a body map or body diagram to supplement documentation and photographs. Body mapping is utilized by pediatric sexual assault providers to objectively document the location and details of injuries and/or findings on a patient during an MFE. Body diagrams may be gender and/or non-gender specific and used in conjunction with genital and anal diagrams. Assessed injuries/findings should be photographed if permitted by the patient, described in detail, and drawn on the respective area on the body diagram.

Each injury/finding is documented with a numerical and/or alphabetical identifier and includes a description of the injury or finding such as size, site, shape, color, contents (i.e. dirt, debris, glass), borders, depth, and edges or patterns and can include any and all associated photographs for easy reference. You may also document details that the patient provides regarding causation of the injury.

TABLE 7: Example of body map documentation

Child Body, Front View

Child Body, Rear View

Using legend below, document findings of exam on body diagrams (use all that apply):

AB Abrasion	BI Bite Mark	BR Bruise	BU Burn	DF Deformity	ER Erythema
FB Foreign Body	IW Incised Wound	LA Laceration	PT Petechiae	RE Redness	SI Suction Injury
SW Swelling	TE Tenderness	OI Other Injury (describe): _____			

Number	Type	Description	Photo Numbers
1	AB, TE	Linear abrasion measuring approximately 4cm to lateral aspect of right knee with irregular edges and scant dried bright red blood. Bleeding controlled. Patient stated, "I was running away and tripped on a raised part of the sidewalk." Patient complains of tenderness; rates pain 4/10-FACES Pain Scale.	012-016

Common Types of Injuries/Findings

Abrasion	Ecchymosis	Petechiae
Avulsion	Erythema	Positive ALS
Bite mark	Fiber	Pressure injury
Bruising/Contusion	Foreign body	Puncture wound
Burn	Incised wound	Skin tear
Debris	Induration	Swelling
Deformity	Laceration	Toluidine Blue dye uptake
Dry secretion	Moist secretion	Other: (describe)_____

Body map images can be located in the Resources section: Sample Forms – *Body Maps*.

It is critical that a pediatric sexual assault provider have an accurate understanding of injury identification and mechanism of injury, so as not to mislabel or incorrectly identify a finding that may compromise the provider's credibility. When injury type and/or mechanism of injury is not easily identifiable, the provider's documentation should remain objective by always describing characteristics of the injury and obtaining photographs when able.

Discharge Planning and Follow-up Care

Upon completion of the medical forensic examination (MFE), the pediatric sexual assault provider, child, and caregiver, along with any members of the multidisciplinary team, will implement a discharge plan that will address safety and other post-examination needs.

The pediatric sexual assault provider should identify any additional interventions required, as to not delay discharge, such as working with social services to assist with transportation needs. Post-examination needs will include an assessment of physical/comfort and psychosocial needs of the child. Needs may include assisting the child with hygiene and clothing replacement and offering the child and caregiver food and drinks.

Multidisciplinary team members, such as social services and the Department of Child Services family case manager, will assist with safety planning ensuring measures are taken to keep the child protected in the home if the child is authorized to leave with the caregiver and return to home or if placement outside of the home is required. The pediatric sexual assault provider should be included in safety planning.

As with the MFE, discharge should be completed without bias. Forms and any accompanying materials and resources should be tailored to meet the individual needs of the child and caregiver. Verbal and written discharge information should include:

- Information regarding care provided, exam findings, any medical tests performed, medications given during the exam, prescriptions or take-home medications, and follow-up testing. The caregiver should be instructed to monitor the patient if medical concerns were addressed.
- Medical, social, and mental health resources and follow-up information.
- Victim compensation program information.
- DCS case manager contact information.
- Facility performing examination contact information.
- Law enforcement information.
- Common post-assault reactions of the child.
- Community sexual assault advocacy programs.

The discharge planning process is an opportunity for the pediatric sexual assault provider to address concerns and/or clarify information that the child and caregiver may have related to the examination as well as answer questions and discuss the next steps following discharge.

Follow-up Care

The patient and caregiver should be offered an opportunity (with permission and consideration to method) to be contacted for a follow-up call after discharge from the facility that performed the examination. This call is to discuss any questions or concerns related to the examination, resources, referrals, test results not provided at the time of discharge, and next steps. Caregivers should be instructed to make an appointment for one to two weeks following the MFE with the child's primary care provider for continuity of care and follow-up. If the child does not have a primary care provider, the pediatric sexual assault provider should provide the caregiver with information for medical providers with consideration of the child's and caregiver's preferences.

When the child requires follow-up of injuries or findings that should be reassessed, reevaluated, or re-photographed by the pediatric sexual assault provider, that appointment should be scheduled with the same pediatric sexual assault provider whenever able.

Peer Review and Quality Improvement for Pediatric Sexual Assault Providers

Pediatric sexual assault providers should deliver care under the guidance and oversight of a medical director with knowledge and experience in examining children. Ongoing annual performance evaluations of a pediatric sexual assault provider's competency and documentation (including photo documentation) are recommended to ensure safe, high-quality examinations from proficient providers.

Pediatric sexual assault providers are encouraged to participate in the local Sexual Assault Response Team (SART) as well as a multidisciplinary team (MDT). MDTs are encouraged to include the pediatric sexual assault provider who conducted the child's examination, whenever possible, when evaluating or reviewing a case. This ensures the pediatric sexual assault provider's ability to speak on behalf of their case and serves as a learning opportunity for the provider. This can also be helpful in building trust and establishing strong working relationships among the MDT.

It is recommended that the pediatric sexual assault providers utilize a quality assessment tool to evaluate and improve quality of care. It is highly recommended that a full peer review evaluation of each case be conducted for any pediatric sexual assault provider who has completed fewer than 100 examinations. Peer review should consist of a comprehensive review of the patient's medical forensic examination record, including evidence collected, chain of custody, photo documentation, and body maps. Peer review should be timely, constructive, and positive in nature, with the focus on professional growth for the pediatric sexual assault provider's proficiency, use of evidence-based practices, and improving technical skills. Peer review should promote consistent expectations between providers while taking into account differences in practice and documentation styles. Peer review can identify strengths and weaknesses of each case and outline considerations for future care. Peer review is also a great opportunity for new pediatric sexual assault providers to become accustomed to the program's practices and documentation requirements. New pediatric sexual assault providers should peer review as many cases as possible in their first six months to expand their knowledge base.

In addition to peer review and quality improvement approaches, pediatric sexual assault providers are responsible for their own professional growth and have a duty to provide the best possible care for their patients. This means ensuring their own continuing education needs, advocating for best practices, and maintaining a professional code of conduct and ethical decision-making. The pediatric sexual assault provider should not knowingly and intentionally disregard the laws of Indiana or the scope and standards of practice for their profession.

Indiana Statewide Sexual Assault Kit Tracking System

Initiated on April 1, 2020, the Indiana Criminal Justice Institute (ICJI), in coordination with the Indiana State Police and the Indiana Prosecuting Attorneys Council, implemented the Indiana Statewide Sexual Assault Kit Tracking System (Tracking System). Under Indiana Code §16-21-8-1.8(b), this system tracks standard sexual assault evidence collection kits for victims of a sex crime enabling transparency and accountability regarding the tracking, transportation, processing, storage, and inventory of each kit. The website offers victims of sexual assault (or their parent/legal guardian) a secure, confidential place to obtain information regarding the status and location of their sexual assault evidence collection kit (SAEK). While the tracking system records the location and status of SAEKs, the tracking system does **not** serve as legal documentation of the SAEK's chain of custody and should not be used as a means of recording chain of custody.

Authorized medical providers, including sexual assault nurse examiners (SANEs) and those who conduct medical forensic examinations (MFEs) and evidence collection, should register the patient's kit into the tracking system. When registering the kit, the medical provider will enter the sexual assault kit number (located on the side panel of the SAEK), patient's name, evidence collection facility name, law enforcement agency responsible for the case, date of collection, date of the crime (if known), and identification of whether the victim chooses to remain anonymous (not applicable with patients ages 17 and younger). Once this information has been submitted, a randomly assigned four-digit personal identification number (PIN) will be associated with the kit. The provider will write the PIN on the outside of the sealed SAEK near the bar code and on the ICJI Sex Crimes Compensation Application Form. The provider will also share this number with the patient so that the patient may later view the status and location of their kit using the tracking system.

Medical providers will update the tracking system when the kit is released to law enforcement or the crime lab. From there, law enforcement and crime lab personnel will also have access to the tracking system to update the location and status of each kit.

Medical providers who do not have access to the tracking system must contact their facility's tracking system administrator. If the facility does not have a tracking system administrator, providers must contact ICJI to obtain access.

The administration, access, training, and troubleshooting of the tracking system are managed by ICJI. Any questions or concerns regarding the tracking system should be directed to ICJI at 317-232-0157. A medical provider's user guide and frequently asked questions (FAQs) document can be downloaded at <https://www.indianaena.org/forensic-links>.

The tracking system is accessible via this link: <https://SAEK.cji.in.gov/Public/Home.aspx>.

Payment of Medical Forensic Examinations

The Violence Against Women Act (VAWA) requires that states must incur the costs associated with the medical forensic examination (MFE) of sexual assault victims and that victims are not required to participate with law enforcement in order to be provided with an examination. The state also may not require victims to seek reimbursement from their insurance carriers.

In the state of Indiana, the Indiana Criminal Justice Institute (ICJI) administers funding through the Sexual Assault Compensation Fund, established under the Victims of Crime Act (VOCA). The facility that performs the MFE will submit the application to ICJI and receive reimbursement from ICJI if approved. To be eligible for reimbursement, the crime must have occurred in the state of Indiana and the application must be signed by a parent/legal guardian for patients age 17 and younger. ICJI will accept the form without parental consent provided there is documentation to support such circumstances. Release from anyone authorized to sign the form or who represents the best interests of the child can be accepted.

Indiana Code requires that hospitals provide MFEs and additional forensic services to patients seeking services related to injury or trauma resulting from a sexual assault (IC §16-21-8-1). Additional forensic services consist of: initial pregnancy testing and sexually transmitted disease testing, prophylactic medication related to a pregnancy or sexually transmitted disease testing (including HIV prophylaxis medications), alcohol and drug testing, some longer-term follow-up testing, and up to \$3,000 of mental health counseling (IC §16-18-2-1.8). All of the above must be provided without charge to the patient. The Victim Services Division of ICJI will provide compensation or reimbursement for medical forensic exams and additional forensic services (IC §16-21-8-6), assuming the victim is at least 18 years of age, or if less than 18 years of age, a report has been made to child protective services or law enforcement and the sex crime occurred in Indiana (IC §16-21-8-5).

The Indiana Administrative Code (203 IAC 1-2-3) further addresses suturing, wound care, and imaging secondary to the assault as covered services. Documentation regarding services that fall outside of the standard medical forensic exam should clearly state the basis for their necessity and relation to the assault. These services must be a result of the assault or have forensic value for the ICJI to cover their costs. Thorough, high-quality documentation is imperative for ICJI to appropriately analyze these additional services.

The Indiana Violent Crime Compensation Fund, also administered through ICJI, is a fund that was established to assist victims or their dependents with certain expenses incurred as a direct result of a violent crime. Access to these funds does require cooperation with law enforcement. This fund serves as a payer of last resort, and the application for this fund must be submitted by the victim or parent/legal guardian, not the healthcare facility. For more information about the Violent Crime Compensation Fund, see the ICJI Victim Compensation website: <https://www.in.gov/cji/2333.htm>.

Adapted from the Indiana Guidelines for Medical Forensic Examinations-Adult/Adolescent, 2019.

Hospital Policies and Procedures

When providing care for patients with medical forensic needs, it is judicious that each facility proactively adopts policies and procedures that support best practices and are consistent with the principles outlined herein. Establishing policies, procedures, and guidelines for care requires active participation from individuals with forensic training. Some considerations when crafting policies and procedures are outlined as follows:

Alcohol- and Drug-Facilitated Sexual Abuse/Assault

Facilities should collaborate with their respective SART and/or legal jurisdictions to establish a process for the collection, storage, and testing of samples to rule out alcohol- and/or drug-facilitated sexual abuse/assault. These samples should not be tested at the hospital laboratory, and chain of custody should be established and maintained on toxicology samples. Urine and blood samples should **never** be placed into the Indiana Sexual Assault Collection Kit (SAEK).

Consent for Examination

Pediatric sexual assault providers should not provide care to a patient with medical forensic needs without appropriate written and verbal consent. In an emergent situation, when immediate life-sustaining medical care is essential and the patient is unable to consent, emergency medical care may be rendered and the pediatric sexual assault provider, forensic nurse, or appointed clinician may provide medical forensic care and evidence collection and obtain photographs, as supported by implied consent (IC §16-36-1-4 and IC §16-36-1-10). Evidence collected under these circumstances should not be released without a reasonable attempt to obtain consent from the patient at a later time. **Note:** In the event of the patient's death, Indiana coroners do not require a warrant for evidence (IC §36-2-14), including access to the SAEK, medical records, and photographs. In matters of acute intoxication, it is important to monitor the patient for medical and safety concerns until their level of consciousness and mental status improves and the pediatric sexual assault provider is able to obtain informed consent for the examination. It is not a requirement that a patient be clinically or legally "sober" to consent to a medical forensic examination. The patient should, however, be alert, oriented, and cooperative and consent to the examination with an understanding of what the examination entails.

Continuing Education and Professional Development of Pediatric Sexual Assault Providers

Pediatric sexual assault providers should be encouraged and supported to participate in ongoing continuing education and professional development opportunities related to any of the patient populations they serve (i.e., pediatrics, adult/adolescent, domestic violence, etc.). It is prudent that pediatric sexual assault providers keep a log of continuing education hours, certificates of completion, and continuing education hours and submit those items annually to their managers to ensure ongoing competence.

Data Collection

Facilities should keep data and records that are easily accessible regarding the number of patients who receive sexual assault examinations and their respective general demographic information, including age, county of residence, legal jurisdiction, race, and type of crime. Data should also include information regarding any patients who are transferred or referred to another facility for MFE, including the reason for transfer or referral (i.e., no SANE at this site), and their respective general demographic information, including age, county of residence, legal jurisdiction, race, and type of crime.

Documentation Guidelines

Pediatric sexual assault providers should utilize the documentation guidelines outlined herein. This includes the use of medical forensic photography, medical forensic history information, and body maps/body diagrams. The use of a standard form is recommended. A sample of a standard form can be located in the Resources section: *Medical Forensic Examination Record*. Safeguarding MFE reports and photographs is important to both defending the patient's privacy and protecting the integrity of the investigation and evidentiary process. If electronic health records are utilized, it is recommended that the forensic components of these records not be easily accessed by staff members who do not provide forensic care.

Follow-up Examinations

Pediatric sexual assault providers, including those working in an emergency department, should be encouraged and supported to conduct follow-up examinations and photography, if warranted. Indications for follow-up examinations include: findings on the initial examination are unclear or questionable necessitating reevaluation; further testing for STIs not identified or treated during the initial examination; documentation of healing or resolution of acute findings; confirmation of initial examination findings; or when initial the examination was performed by an examiner who had conducted fewer than 100 evaluations.

Note: Follow-up photography is done to show injury progression and stages of healing and is useful in confirmation of normal and abnormal variants, including congenital conditions and skin disorders. Photo documentation of a child's anogenital area is **always** the responsibility of the medical provider. Law enforcement, DCS, and family/care givers should **never** photograph a child's anogenital area.

Hospitals and healthcare facilities (including emergency departments) should have policies and procedures in place that allow a child to return for follow-up examination and photography, with the same initial pediatric sexual assault provider, whenever possible. Facilities should **not** bill the patient for the follow-up examination and photography (IC §16-21-8-6).

Multidisciplinary Collaboration

Pediatric sexual assault providers should be encouraged and supported to actively participate in multidisciplinary collaborations including multidisciplinary teams (MDTs) and sexual assault response teams (SARTs) and other activities that promote prevention, education, and treatment of patients with medical forensic needs.

Non-acute (Non-urgent) Examinations

Pediatric sexual assault providers, including those working in an emergency department, should be encouraged and supported to conduct non-acute (non-urgent) forensic medical examinations, even when they fall outside of evidence collection time frames. Despite whether forensic evidence on the child's body or clothing is potentially available, the child should be examined by a pediatric sexual assault provider and have a medical history taken, related treatment provided, and examinations findings documented. Information helpful to the investigation may be obtained from the history, exam findings, and child's medical record. Indications for non-acute examination include: delayed disclosure of abuse by child; sexualized behaviors; sexual abuse suspected by MDT; or family concern for sexual abuse, but contact occurred more than two weeks prior without emergency medical, psychological, or safety needs identified.

Other indications for medical evaluation, even if outside of the evidence collection window, include:

1. Pain/bleeding with or after contact
2. Potential for STIs due to nature of the contact or a Positive STI result
3. Perpetrator exposed (i.e. sibling or household contact with an alleged offender)
4. Child Pornography use by caregiver/household contact
5. Patient or Parent concerns

A child may have distorted thoughts of their bodies due to a perpetrator's manipulations. Initial partial disclosures are common.

Populations Served

Forensically trained providers should be encouraged and supported to provide MFEs, evidence collection, and photo documentation where intentional and unintentional injuries occur as this falls within their scope of practice and standards of care. This includes patients, both living and deceased, who may be victims; suspects; the accused or perpetrators of interpersonal violence¹ or incidents involving human factors²; and victims of natural causes of trauma (ANA & IAFN, 2017).

¹ Child abuse, elder and vulnerable person abuse, intimate partner abuse and assault, sexual abuse/assault, gang violence, human trafficking

² Occupational accidents, motor vehicle collisions, acts of terrorism, forensic-related deaths

Deceased Patients

When providing care for a deceased patient, the coroner's office and/or law enforcement officials will assume responsibility for the body and direct the investigative process. The forensically trained healthcare provider's assistance may still be beneficial to this process. In these cases, the role of the forensically trained provider is to document a true and accurate representation of the patient's presentation to the facility, or immediately after their death, as findings can quickly evolve postmortem, with the passing of time and natural physiological changes that occur as a result of death. Additionally, the forensic healthcare provider may obtain photographs, collect evidence, and ensure evidence integrity and chain of custody pending release of evidence to law enforcement.

Suspect Examinations

When providing medical forensic care to a suspect, an accused person, or a perpetrator, the forensically trained provider will complete a comprehensive medical assessment to ensure the health and safety of the patient. Suspect examinations should be requested by law enforcement and guided by a warrant. The warrant should specify from where on the suspect's body the samples are to be collected by the provider. It is essential to provide equal, unbiased care to all patients, regardless of whether the patient is a victim or suspect. When providing care for a victim and their alleged perpetrator, detailed documentation should verify cleaning practices, as well as all attempts to ensure cross contamination did not occur. **Never** place suspect specimens into the Indiana Sexual Assault Evidence Collection Kit. Suspect specimens should be surrendered to law enforcement. Providers must be transparent when providing care and collecting specimens from suspects. Providers must indicate the specimens are evidentiary in nature and will be submitted to law enforcement under direction of a warrant or by consent of the suspect (patient).

Practice to the Full Scope of Training

Providers who have successfully completed medical forensic training should be encouraged and supported to practice to the full scope of their training and education. This means that registered nurses who have completed the *Adult/Adolescent Sexual Assault Nurse Examiner* training should provide care to all patients from the onset of menarche (pubescent) and beyond. Additionally, these

clinicians should be encouraged and supported to care for other victims of interpersonal violence, including domestic violence, strangulation, elder abuse, and more, as supported by the scope of their training. This eliminates the need for unnecessary transfer of patients, who may terminate care during the transfer process. It also ensures that patients are provided with care and treatment at the facility that they originally present, likely in or near their own community. When medical forensic care of a child or youth is transferred to another community, this can be taxing on local resources, including law enforcement, DCS, prosecutors, victim advocates, and/or child advocacy centers.

Quality Assurance and Peer Review

All pediatric sexual assault providers should participate in quality assurance and peer review initiatives. Pediatric sexual assault providers should have their charts reviewed and critiqued for accuracy, for use of evidence-based practices, and to ensure ongoing competency, by not only their peers, but also clinical leadership personnel. Peer review is an essential process to ensuring consistency in practice throughout the team and allowing team members to learn from the practices and charting of others. Team members are encouraged to review every examination that takes place at their facility for the first several months of employment as a means of supplementing their learning. It is strongly recommended that all medical forensic examination records are reviewed by at least one other skilled forensically trained provider or program medical director.

Release of Medical Records with Forensic Content

Facilities shall safeguard the medical forensic examination findings, including the medical forensic history and photographs, of **any** ongoing investigation. Many times, a family member or someone close to the patient, or their parents, may be the perpetrator. The release of medical forensic examination records greatly compromises the investigation and evidentiary process. It is prudent for hospitals to establish a process with the medical records department to appropriately identify or review records for forensic content prior to their release. Additionally, the facility may consider requiring a subpoena for release of forensic content to ensure that an active investigation is not ongoing prior to release of medical forensic content. Parents may also intend to access medical forensic records for use in family court proceedings. **Note:** A patient's case may be pending with any of the following: law enforcement, DCS, and/or prosecuting attorneys. Release of medical forensic examination records is a highly confidential matter that should be reviewed and approved by more than one individual in a facility to ensure the integrity and security of the records.

Transferring/Referring Patients to an Offsite Pediatric Sexual Assault Provider

If a medical forensic examination cannot be conducted at the facility that the patient presents, the patient should be referred to the nearest (in proximity) qualified provider or to a facility of the caregiver's choosing. Do not transfer the patient via ambulance unless medically necessary as the patient will be responsible for the cost of the ambulance ride, unless deemed medically necessary. Policies should outline the process prior to transferring a patient for medical forensic examination, which should include, at a minimum, contacting the receiving facility to ensure the availability of a pediatric sexual assault provider and report, thoroughly documenting any interventions required to stabilize the patient, and completing all mandatory reports to DCS and law enforcement.

Hospitals have a duty and responsibility to locate a site for patients needing medical forensic services. Finding a site for the medical forensic examination should never become the burden of the patient or their family member.

Child Protection Medical Experts

Child Protection Medical Experts at Indiana University Health Riley Hospital for Children and Peyton Manning Children's Hospital at St. Vincent are available to any healthcare provider 24 hours a day, 7 days a week. Healthcare providers are encouraged to first contact local pediatric sexual assault providers whenever possible.

Should expert consultation be required from a board-certified forensic pediatrician, child protection medical experts can be reached at:

Indiana University Riley Hospital for Children

Phone: (317) 944-5000 (ask for Center of Hope)

Peyton Manning Children's Hospital at St. Vincent

Center of Hope: (317) 338-1956

Pediatric Emergency Department: (317) 338-4366

Non-urgent needs: (317) 338-3153

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Glossary of Terms

Adolescent: Females who have experienced the onset on menarche and males who have reached puberty. Defined in this document as children who are Tanner stage 3 and above who have potential reproductive capability.

Assent: Child's agreement (or consent) to be examined.

Caregiver: 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.

Pediatric: All aspects of the wellbeing of children. The population addressed in this document is solely prepubescent children.

Pediatric sexual assault provider: For the purpose of this document, a *pediatric sexual assault provider* is an inclusive term that includes medical providers or clinicians, including registered nurses, pediatric sexual assault nurse examiners, advanced-practice providers, and physicians, who have successfully completed specialized training in sexual abuse forensic evaluations for prepubescent pediatric patients.

Prepubescent: A child's stage of pubertal development is determined by assessing secondary sexual characteristics rather than chronological age. The sexual characteristic development of prepubescent children is reflected as Tanner stage 1 or 2.

Pubescent: Females who have experienced the onset of menarche and males who have reached puberty. Defined in this document as children who are Tanner stage 3 and above who have potential reproductive capability.

Sexual Assault Response Team (SART): A multidisciplinary partnership that outlines a consistent and coordinated response to sexual assault and abuse to ensure the survivor's needs remain a priority, while promoting public safety and holding offenders accountable. In Indiana, each county should have a SART team, generally overseen by the county prosecutor's office. Core team members may include: local law enforcement agencies, child advocacy organizations, Department of Child Services, prosecutors, sexual assault nurse examiners (SANEs), advocates, and crime labs.

Resources

Resources for Pediatric Sexual Assault Providers

Academy of Forensic Nursing www.goafn.org

Crimes Against Children Conference www.cacconference.org

Emergency Nurses Association www.ena.org

End Violence Against Women, International www.evawintl.org

Fight the New Drug www.fightthenewdrug.org

Forensic Technology Center of Excellence www.forensiccoe.org

Indiana Chapter of National Children's Alliance www.incacs.org

Indiana Coalition to End Sexual Assault and Human Trafficking www.indianacesa.org

Indiana Emergency Nurses Association www.indianaena.org

Indiana SANE Training Project www.usi.edu/IndianaSANE

International Association of Forensic Nurses www.forensicnurses.org

National Children's Alliance www.nationalchildrensalliance.org

Prevent Child Abuse Indiana www.pcain.org

RAINN www.rainn.org

Sexual Assault Forensic Examination Technical Assistance www.safeta.org

The Mama Bear Effect www.themamabeareffect.org

Training Institute on Strangulation Prevention www.strangulationtraininginstitute.com

Sample Forms for Pediatric Sexual Assault Providers

Fillable PDFs and modifiable forms

These forms are provided for your convenience by the Indiana SANE Training Project and may be utilized, reproduced, and/or edited by your facility.

[**Adult/Adolescent Medical Forensic Examination Record**](#)

[**Body Maps**](#)

[**Chain of Custody**](#)

[**Pediatric Caregiver Assessment**](#)

[**Pediatric Medical Forensic Examination Record**](#)

[**Specimen Collection Summary**](#)

[**Patient Discharge Instructions**](#)

Additional samples are included below.

Specimen Collection Summary

Specimen Obtained	Yes	No	N/A	Patient declined
Buccal-DNA Standard				
Oral				
Peri-oral/lips				
Head Hair Combing				
Fingernails: Swabs/Scrapings (circle)				
Hands: Left/right/bilateral (circle)				
Neck: Left/Right/Bilateral (circle)				
Breasts: Left/Right/Bilateral (circle)				
Inner Thigh: Left/Right/Bilateral (circle)				
Abdomen				
Pubic Hair Combing				
External Female Sex Organ				
Internal Female Sex Organ				
Male Sex Organ				
Anal Folds				
Anal Canal				
Perineum				
Intergluteal cleft				
Sacrum/Lower back				
Vaginal				
Cervical				
Speculum				
Pantyliner/Tampon (circle)				
Underwear Worn During Assault				
Underwear Worn During Exam				
Soil/debris				
Internal foreign body: Vaginal/anal (circle)				
Diaper				
Other: _____				
Other: _____				
Other: _____				
Other: _____				

Photo documentation obtained:

☐ Body ☐ Genitals ☐ Clothing

Persons present for examination:

Name	Relationship to patient

Clothing collected:

Underwear must be placed into the Sexual Assault Evidence Collection Kit

Item	Description

Total number of brown bags: _____

Please ensure that ALL items are submitted to law enforcement with the Sexual Assault Evidence Collection Kit.

Nurse Examiner

Printed Name: _____

Signature: _____

Credentials: _____

Date/time of evidence collection: _____

CHAIN OF CUSTODY

Patient Label:

(if anonymous, use MRN only)

MRN _____

[Place patient label here]

Date of Service: _____

Items Collected: ☐ Sexual Assault Evidence Collection Kit

☐ Clothing

☐ Other: _____

Total number of brown bags: _____

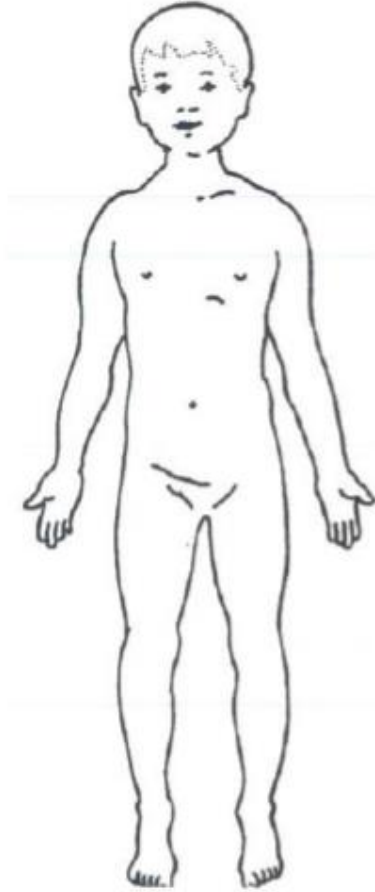
Collector's Name/Initials: _____

Date and time of evidence collection: _____

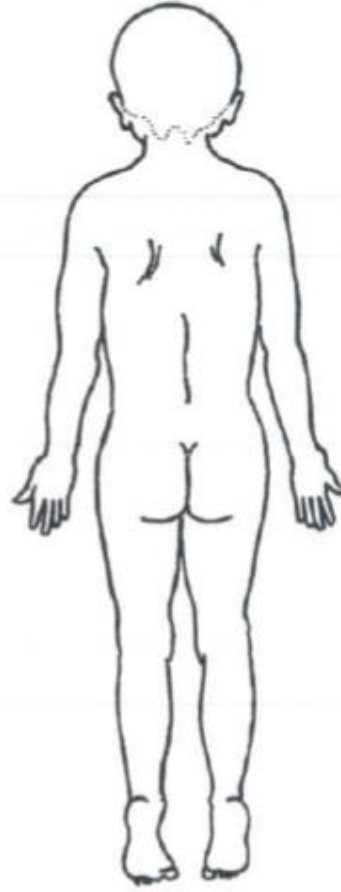
DATE/TIME	RELINQUISHED BY:	RECEIVED BY:
	Name: _____ Agency: _____ Signature: _____	Name: _____ Agency: _____ Signature: _____
	Name: _____ Agency: _____ Signature: _____	Name: _____ Agency: _____ Signature: _____
	Name: _____ Agency: _____ Signature: _____	Name: _____ Agency: _____ Signature: _____
	Name: _____ Agency: _____ Signature: _____	Name: _____ Agency: _____ Signature: _____

Body Maps

Child Body, Front View



Child Body, Rear View



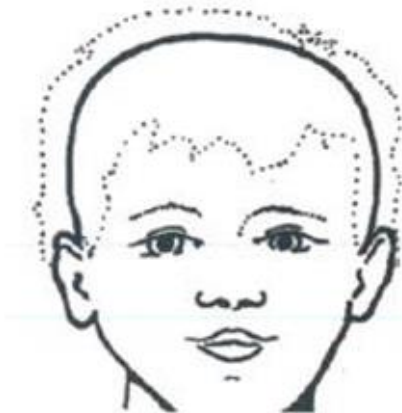
Using legend below, document findings of exam on body diagrams (use all that apply):

AB Abrasion	BI Bite Mark	BR Bruise	BU Burn	DF Deformity	ER Erythema
FB Foreign Body	IW Incised Wound	LA Laceration	PT Petechiae	RE Redness	SI Suction Injury
SW Swelling	TE Tenderness	OI Other Injury (describe): _____			

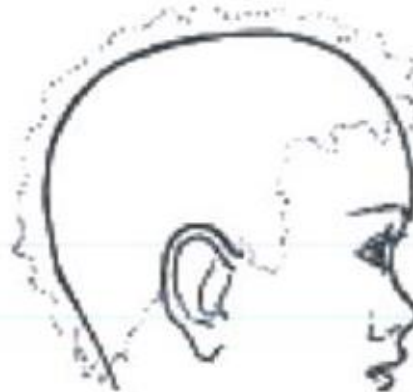
Number	Type	Description	Photo Numbers

Forensic Nurse Initials _____

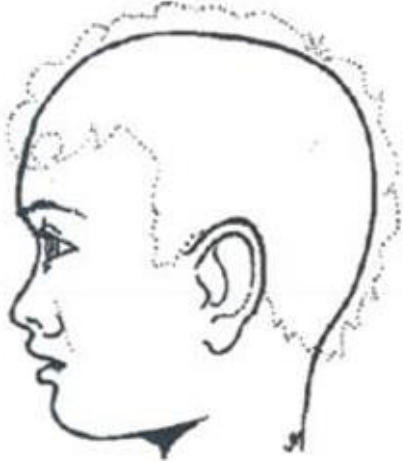
Child Face, Front View



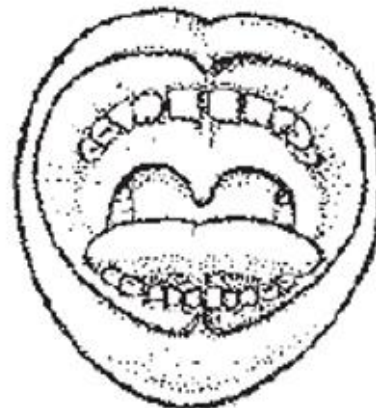
Child Face, Right View



Child Face, Left View

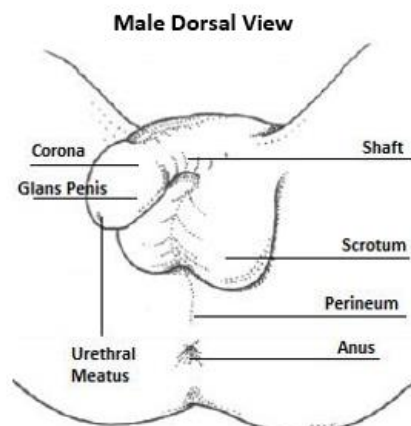
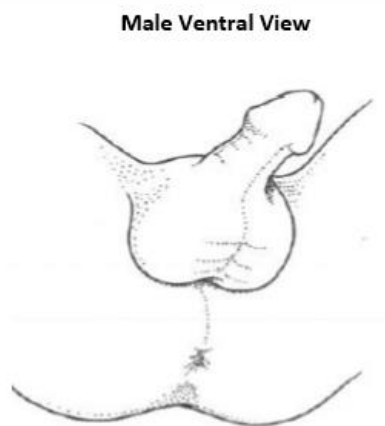
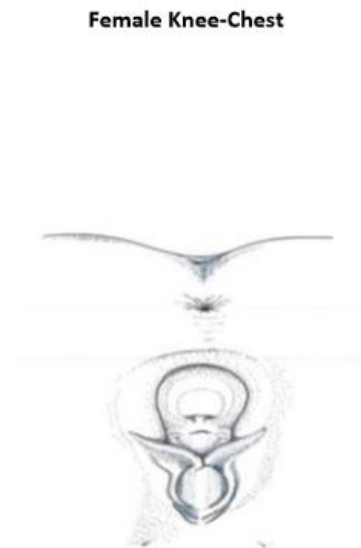
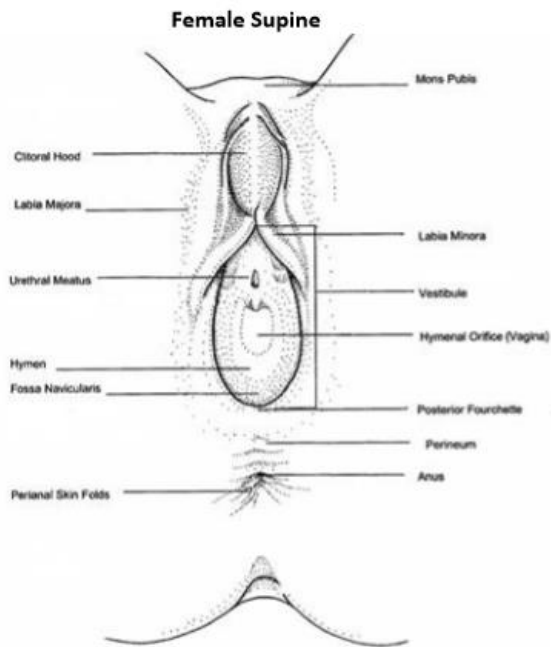


Child Face, Oral View



Using legend below, document findings of exam on body diagrams (use all that apply):					
AB Abrasion	BI Bite Mark	BR Bruise	BU Burn	DF Deformity	ER Erythema
FB Foreign Body	IW Incised Wound	LA Laceration	PT Petechiae	RE Redness	SI Suction Injury
SW Swelling	TE Tenderness	OI Other Injury (describe): _____			

Number	Type	Description	Photo Numbers



Using legend below, document findings of exam on body diagrams (use all that apply):					
AB Abrasion	BI Bite Mark	BR Bruise	BU Burn	DF Deformity	ER Erythema
FB Foreign Body	IW Incised Wound	LA Laceration	PT Petechiae	RE Redness	SI Suction Injury
SW Swelling	TE Tenderness	OI Other Injury (describe): _____			

Number	Type	Description	Photo Numbers

Diagram A

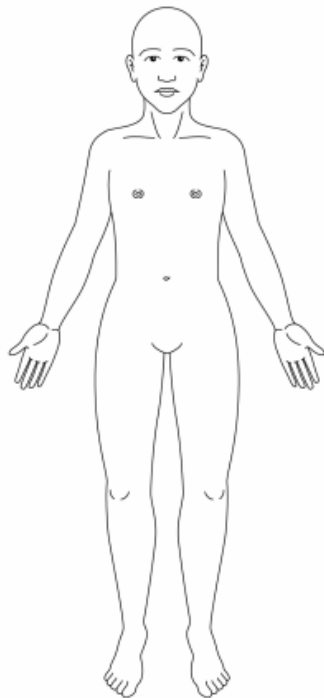
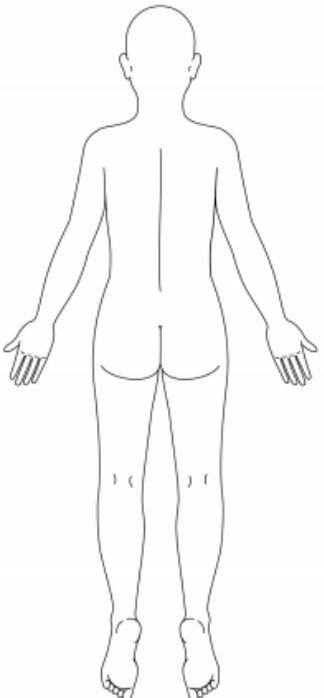
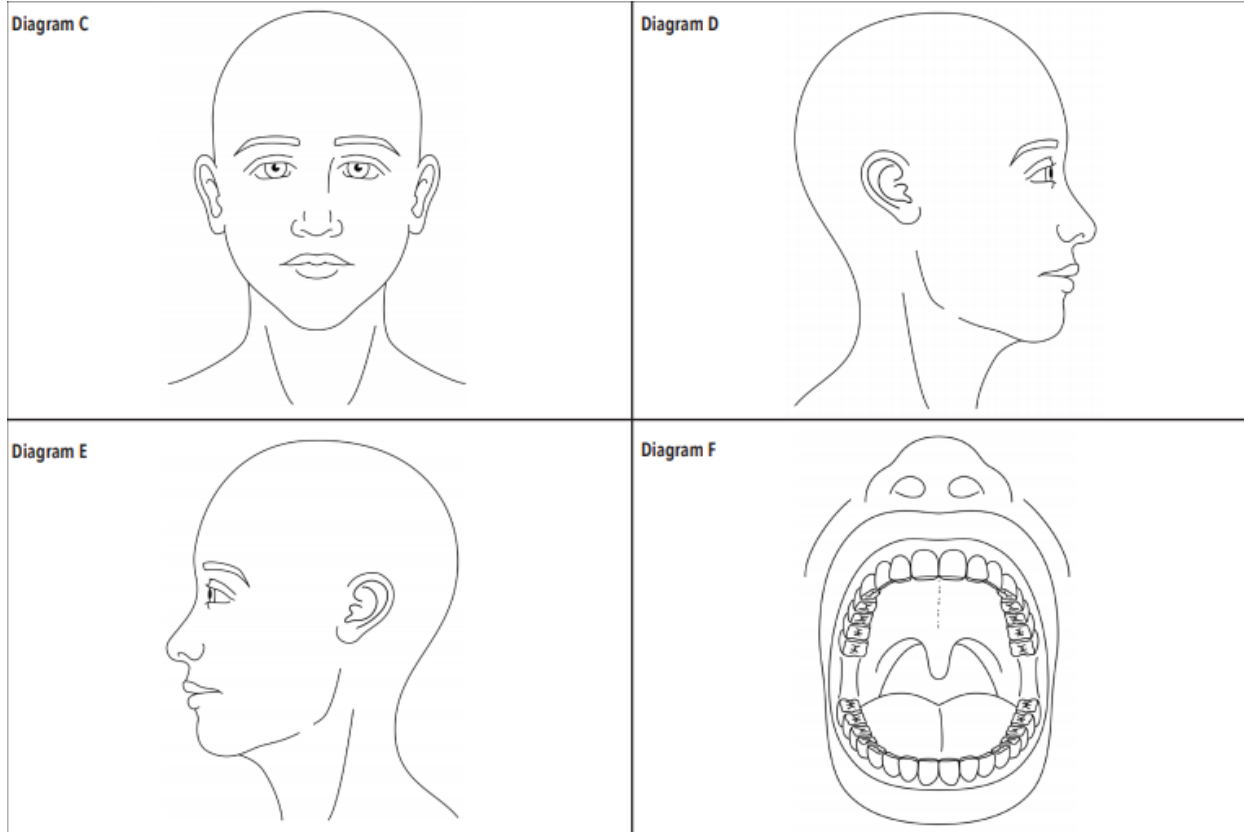


Diagram B



Using legend below, document findings of exam on body diagrams (use all that apply):					
AB Abrasion	BI Bite Mark	BR Bruise	BU Burn	DF Deformity	ER Erythema
FB Foreign Body	IW Incised Wound	LA Laceration	PT Petechiae	RE Redness	SI Suction Injury
SW Swelling	TE Tenderness	OI Other Injury (describe): _____			

Number	Type	Description	Photo Numbers



Using legend below, document findings of exam on body diagrams (use all that apply):					
AB Abrasion	BI Bite Mark	BR Bruise	BU Burn	DF Deformity	ER Erythema
FB Foreign Body	IW Incised Wound	LA Laceration	PT Petechiae	RE Redness	SI Suction Injury
SW Swelling	TE Tenderness	OI Other Injury (describe): _____			

Number	Type	Description	Photo Numbers


Diagram I


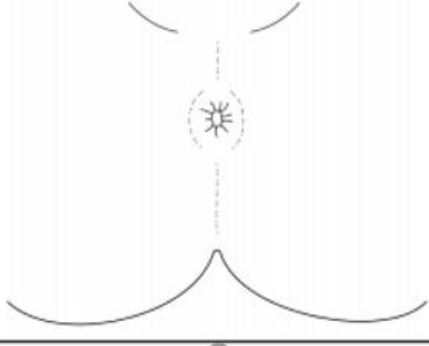
Diagram J


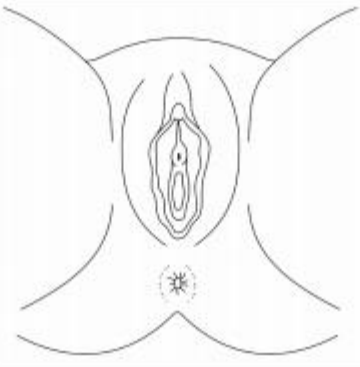
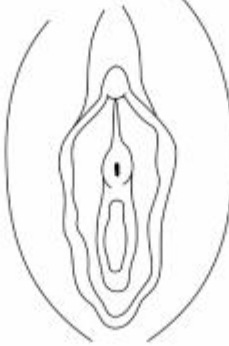
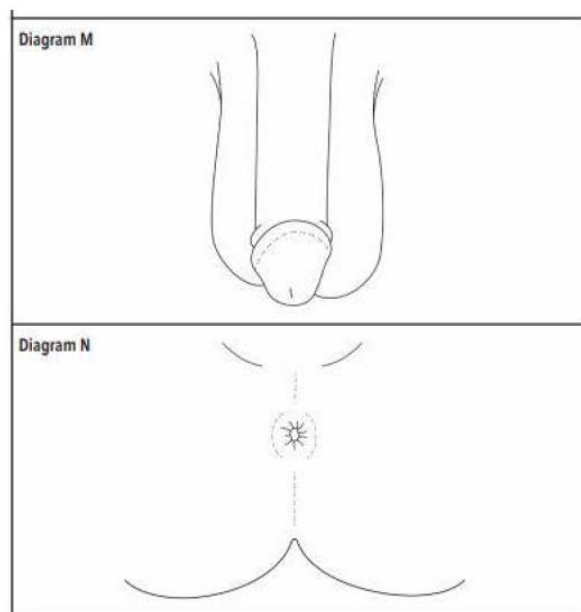
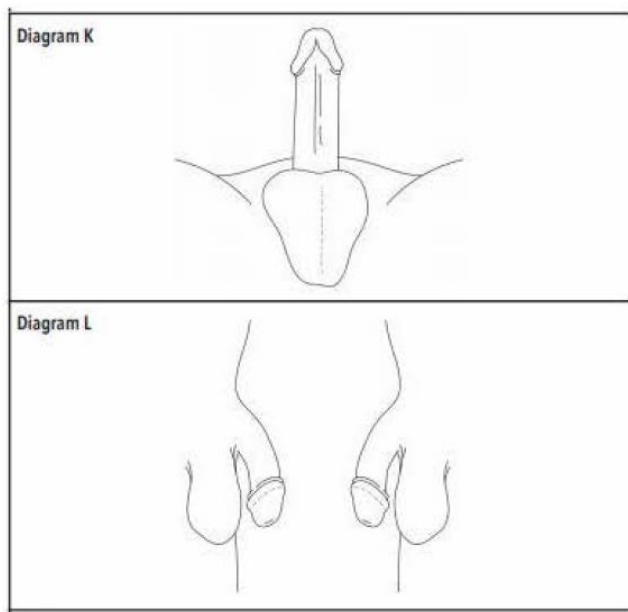
Diagram G


Diagram H


Using legend below, document findings of exam on body diagrams (use all that apply):					
AB Abrasion	BI Bite Mark	BR Bruise	BU Burn	DF Deformity	ER Erythema
FB Foreign Body	IW Incised Wound	LA Laceration	PT Petechiae	RE Redness	SI Suction Injury
SW Swelling	TE Tenderness	OI Other Injury (describe): _____			

Number	Type	Description	Photo Numbers



Using legend below, document findings of exam on body diagrams (use all that apply):					
AB Abrasion	BI Bite Mark	BR Bruise	BU Burn	DF Deformity	ER Erythema
FB Foreign Body	IW Incised Wound	LA Laceration	PT Petechiae	RE Redness	SI Suction Injury
SW Swelling	TE Tenderness	OI Other Injury (describe): _____			

Number	Type	Description	Photo Numbers