Indiana Guidelines for Medical Forensic Examination of Pediatric Sexual Abuse Patients

2024

Original Contributors

Rhonda Allen
Indiana Department of Child Services
Indianapolis, IN

Amy Blackett, JD
Indiana Prosecuting Attorneys Council
Indianapolis, IN

Leslie Cook, RN, MDI, SANE-A, SANE-P
Fort Wayne Sexual Assault Treatment Center
Fort Wayne, IN

Cortney Demetris, MD
Peyton Manning Children's Hospital at Ascension St. Vincent
Indianapolis, IN

Michelle Ditton, RN, SANE-A, SANE-P
Fort Wayne Sexual Assault Treatment Center
Fort Wayne, IN

Stephanie Glover, RN, SANE-A, SANE-P
Peyton Manning Children's Hospital at Ascension St. Vincent
Indianapolis, IN

Anna Gordon
Riley Hospital for Children at Indiana University Health
Indianapolis, IN

Jamie Haddix, RN, SANE-P
Riley Hospital for Children at Indiana University Health
Indianapolis, IN

Tara Holloran, MD, MS, FAAP
Riley Hospital for Children at Indiana University Health
Indianapolis, IN

Jena Lane, RN
Riley Hospital for Children at Indiana University Health
Indianapolis, IN

James Luttrull
Indiana Department of Child Services
Indianapolis, IN

Jan Lutz, Executive Director
Indiana Chapter of National Children's Alliance
Child Advocacy Centers in Indiana
South Bend, IN

Tanya Malone, BSN, RN, CPN, SANE-A, SANE-P
Riley Hospital for Children at Indiana University Health
Indianapolis, IN

Angela Morris, MSN, RN, CEN, SANE-A, SANE-P, EMT-B
Indiana SANE Training Project
Fishers, IN

Kristen Morris, DNP, CPNP, AFN-BC
Peyton Manning Children's Hospital at Ascension St. Vincent
Indianapolis, IN

Barbie Mulvaney, MSN, RN, CPNP, SANE-P
Riley Hospital for Children at Indiana University Health
Indianapolis, IN

Holly Renz, RN, SANE-A, SANE-P
Sexual Assault Treatment Center at Community Hospital Anderson
Anderson, IN

Michelle Resendez, RN, SANE-A, SANE-P
Franciscan Alliance
Crown Point, IN

Sarah Sailors, MSW
Indiana Department of Child Services
Indianapolis, IN

Ashli Smiley, BSN, RN, SANE-A, SANE-P
Indiana Department of Health
Indianapolis, IN

Lori Wilson, BSN, RN, SANE-A, SANE-P
Sexual Assault Treatment Center at Community Hospital Anderson
Anderson, IN

Original Document released in September 2020
Revised- March 2021, February 2024
This document is a work product of the Indiana SANE Training Project.

Table of Contents

Original Contributors 2
Preface 5
Introduction 6
Indiana Medical Forensic Examination Providers 8
What is Child Sexual Abuse? 9
Age of Consent 11
Mandatory Reporting to Indiana Department of Child Services 12
and Law Enforcement 12
How to Protect Children from Sexual Abuse 13
Child Sexual Behaviors 14
What to Do if a Child Discloses Abuse 17
Examination Referral and Timing 18
When to Notify a Pediatric Sexual Abuse Provider 20
Responding to Medical Findings 21
What You Should Know About a Medical Forensic Examination 22
The Role of the Pediatric Sexual Abuse Provider 24
Triage Considerations for Facilities Without a Pediatric Sexual Abuse Provider 26
Communication with Children and Adolescents 28
Caring for Special Patient Populations 30
Multidisciplinary Collaboration 32
Indiana Department of Child Services 34
Forensic Interviews and the Role of the Children's Advocacy Center 35
Involving Advocacy Services in Pediatric Sexual Abuse Cases 36
Prosecuting Child Sexual Abuse Cases 38
Human Trafficking Indicators for Health Care Providers 41
Alcohol or Drug-Facilitated Sexual Abuse 42
Medical Forensic Examination Process 43
Informed Consent 44
Evidence Collection 45
Evidence Integrity 46
Chain of Custody 49
Medical Findings in Child Sexual Abuse 50

Normal Examination Findings: "It's Normal to be Normal" ... 54
The Value of Non-acute Medical Forensic Examinations ... 56
Documentation Guidelines for Pediatric Sexual Abuse Providers ... 60
Photo Documentation Guidelines for Pediatric Sexual Abuse Providers ... 63
Body Maps/Body Diagrams ... 66
Discharge Planning and Follow-up Care ... 68
Peer Review and Quality Improvement for Pediatric Sexual Abuse Providers ... 70
Indiana Statewide Sexual Assault Kit Tracking System ... 71
Payment of Medical Forensic Examinations ... 72
Healthcare Facility Policies and Procedures ... 73
Alcohol- and Drug-Facilitated Sexual Abuse ... 73
Consent for Examination ... 73
Continuing Education and Professional Development of Pediatric Sexual Abuse Providers ... 73
Data Collection ... 73
Documentation Guidelines ... 74
Follow-up Examinations ... 74
Multidisciplinary Collaboration ... 74
Non-acute (Non-urgent) Examinations ... 74
Populations Served ... 75
Deceased Patients ... 75
Suspect Examinations ... 75
Practice to the Full Scope of Training ... 75
Quality Assurance and Peer Review ... 76
Release of Medical Records with Forensic Content ... 76
Transferring/Referring Patients to an Offsite Pediatric Sexual Abuse Provider ... 76
Child Protection Medical Experts ... 77
References ... 78
Glossary of Terms ... 81
Resources for Pediatric Sexual Abuse Providers ... 83
Sample Forms for Pediatric Sexual Abuse Providers ... 84

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 ranking Indiana second in the nation for the number of child abuse and neglect reports; with reports more than double the national average. The report also ranked Indiana fifth in the nation for deaths as a result of child abuse and neglect. This information was extremely concerning and prompted a call to action from stakeholders throughout the state to evaluate the practice and treatment of children who experience sexual abuse.

In late 2018, the Indiana SANE Training Project (Project) was established. The Project, hosted through the University of Southern Indiana with initial funding from the Health Resources and Services Administration ("HRSA"), sought to expand access to medical forensic services through training and support of healthcare providers. 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 Project and its partners 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, the Indiana SANE Training Project coordinator initiated contact with highly qualified 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, medical child protection team members, advanced practice providers, 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 help providers optimize care and reduce unnecessary variations in medical forensic examinations throughout the state.

Introduction

Medical evaluation and treatment of the child victim of sexual abuse requires a skilled clinician with specialized training. While forensically trained *pediatric sexual abuse providers*[1] (herein after referred to as *pediatric sexual abuse 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, and more.

These guidelines also serve as a reference to support, guide, and strengthen the practices of pediatric sexual abuse 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 abuse 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 Abuse. (2019). Indiana guidelines for the medical forensic examination of adult and adolescent sexual assault patients. Retrieved from: https://www.safeta.org/wp-content/uploads/2021/08/Indiana-Guidelines.pdf

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 abuse 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 abuse 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 abuse 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 abuse 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.usi.edu/IndianaSANE. These programs are primarily staffed by registered nurses who have been trained as SANEs. Currently, fewer than 25% of Indiana counties have local access to a pediatric sexual abuse 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 SANE Training Project. Changes or updates in access to care should be conveyed to the Indiana SANE Training Project or the Indiana Statewide SANE Coordinator through the Indiana Department of Health.

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?

Often, 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. Frequently, 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 any 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 <u>*prior to*</u> 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 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 abuse 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 or a medical forensic examination. 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 abuse 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 abuse 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 abuse 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

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

When 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.
- Unless you are a forensic interviewer, law enforcement official or pediatric sexual abuse provider directly involved with the case, do not question the child about details of the event. Children who disclose sexual abuse need to be interviewed by a specially trained forensic interviewer through a child advocacy center. Please refrain from discussing details of the abuse with the child or in the presence of the child, until after the child's forensic interview has taken place. Report the matter to DCS and/or law enforcement.

Examination Referral and Timing

TABLE 3: Timing of Medical Examinations[1]

	Timing of Exam	Medical Indications
Indications for **emergency** evaluation	Exam scheduled without delay	• Medical, psychological, or safety concerns such as acute pain or bleeding, suicidal ideation, or suspected human trafficking • Alleged abuse that may have occurred within the previous 72-120 hours (or other time interval guided by jurisdiction) • 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	• 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	• 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	• 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.

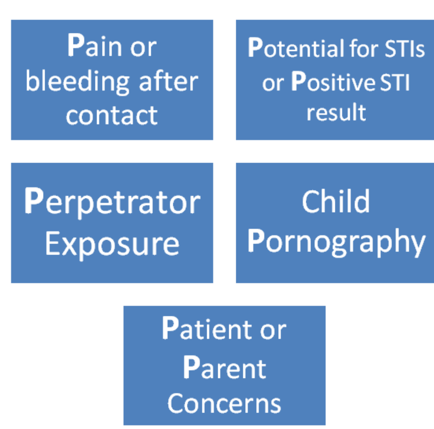
[1] Adapted from Adams, J.A., Kellogg, N.D., Farst, K.J., Harper, N.S., Palusci, V.J., Frasier, L.D., Levitt, C.J., Shapiro, R.A., Moles R.L., Starling, S.P. (2015). Updated guidelines for the medical assessment and care of child who may have been sexually abused. *Journal of Pediatric and Adolescent Gynecology*. doi: 10.1016/j.jpag.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. <u>P</u>ain or bleeding with or after contact
2. <u>P</u>otential for STIs due to nature of the contact or a <u>P</u>ositive STI result
3. <u>P</u>erpetrator exposed (i.e., sibling or household contact with an alleged offender)
4. Child <u>P</u>ornography use by caregiver/household contact
5. <u>P</u>atient or <u>P</u>arent concerns
   A child may have distorted thoughts of their bodies due to a perpetrator's manipulations. Additionally, initial partial disclosures are common.

FIGURE 1: The 5 Ps



Adapted from National Children's Alliance (2017).

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 abuse provider as soon as possible. Examination referral and timing considerations are noted in Table 3.

Viable evidence can exist well beyond a jurisdiction's timeframe for evidence collection. The determination of when, or if, a medical forensic examination and/or evidence collection will be conducted should ***never*** be based solely on a jurisdiction or facility's timeframe for evidence collection. The medical forensic examination can be beneficial for patients and investigators, even when delayed and even in the absence of physical evidence. Each case is unique and the decision for examination may be influenced by specific facts or circumstances of the incident(s), child disclosure, type of evidence, and potential for successful evidence recovery. Likewise, the decision to perform a medical forensic examination and/or evidence collection should *not* be influenced by a victim's personal characteristics, the perceived likelihood that a victim will participate in the investigative process or that a case can be successfully prosecuted (End Violence Against Women, International, 2023).

Despite the potential for forensic evidence recovery on the child's body or clothing, the child should be evaluated by a pediatric sexual abuse provider, have a comprehensive medical history taken including details of the event (when age and developmentally appropriate), 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).

In the future, as science evolves, jurisdictions may routinely collect evidence for up to ten (10) days after the abuse. Provider discretion is always important and the pediatric sexual abuse provider should be given the flexibility to consider circumstances of the case that may affect the potential for evidence recovery; such as the reported actions of the perpetrator, whether or not a victim has bathed, if a victim was seriously injured, or if the patient was unconscious or physically incapacitated during or after the abuse.

Hospitals and healthcare facilities 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.

When to Notify a Pediatric Sexual Abuse Provider

For the purpose of this document, a *pediatric sexual abuse 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 abuse 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 abuse provider, even for non-urgent examinations.

Pediatric and family practices are evolving and finding value in having pediatric sexual abuse 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 abuse 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. Some communities are now offering medical forensic care in clinics, physician offices and/or through local health departments.

The solution for each community will vary based upon available resources and access to trained pediatric sexual abuse providers. When a community lacks these services, children should be referred to the *nearest* (in proximity) qualified pediatric sexual abuse 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 abuse 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.usi.edu/IndianaSANE. 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.

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 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 abuse provider or forensic pediatrician when the initial examination findings were performed by an examiner who has conducted fewer than 100 sexual abuse evaluations.

- If an anogenital finding is the only factor raising concern for sexual abuse, the child should be examined promptly by a pediatric sexual abuse 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 abuse 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.

How Does a Medical Forensic Examination Differ from a Medical Screening Examination?

A medical screening examination is conducted solely for medical/health purposes. A medical forensic examination addresses a victim's medical/health concerns related to abuse and includes obtaining a history of events as well as the potential for collection and preservation of evidence. Please note that in most incidences a medical screening examination, especially by a provider who may not be proficient in identifying child anogenital anatomical variations and has not been forensically trained, will fall short in properly addressing, assessing and documenting information related to child sexual abuse. This is why it's important that a child is evaluated by a forensically trained pediatric sexual abuse provider.

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). The pediatric sexual abuse provider should exercise extreme caution to avoid contact with the hymen when collecting evidence and throughout the anogenital inspection of the prepubescent female. Internal pelvic samples are not indicated in prepubescent females and may cause severe pain.

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 Abuse Provider

For the purpose of this document, *pediatric sexual abuse 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.

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 abuse 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 Abuse Provider Responsibilities

Pediatric Sexual Abuse 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, 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; 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, 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 <u>same</u> initial pediatric sexual abuse provider, whenever possible*.

Triage Considerations for Facilities Without a Pediatric Sexual Abuse 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 abuse, keep them NPO (nothing by mouth) if possible (especially with an oral abuse).

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 abuse 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 abuse 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 abuse 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 abuse provider and give report on the patient. Speak directly to the pediatric sexual abuse 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. In most instances, two swabs are indicated.
- 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 abuse, 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.
- If an MFE is indicated, do NOT ask the child details of the event. This information will be obtained by the pediatric sexual abuse provider.

- If a child falls outside the recommended time frames for evidence collection, non-acute follow-up with a pediatric sexual abuse 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 of appropriate questions may 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.
- Let the child know that they are in control and can decline any part of the examination or take a break at any time.
- 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. Remind the child that they are in control of their body, even in this situation.
- 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.
- 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."

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 abuse 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 abuse 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 abuse 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 abuse 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 abuse 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
A growing number of healthcare 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 abuse 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 abuse 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 abuse provider who conducted the child's examination, whenever possible, when evaluating or reviewing a case. This ensures the pediatric sexual abuse 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 leads the state's response to allegations of child abuse and neglect and facilitates child support payments. We consider the needs and values of all we serve in our efforts to protect children while keeping families together whenever possible.

Vision
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 abuse 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.

National Standards of Accreditation for Children's Advocacy Centers

For pediatric sexual abuse providers serving accredited Child Advocacy Centers, the providers will need to be aware of and work within the National Standards of Accreditation for Child Advocacy Centers (2023) as outlined by the National Children's Alliance. These standards require an expert review of all findings deemed abnormal or "diagnostic" of trauma from sexual abuse. The National Standards of Accreditation for Child Advocacy Centers can be accessed at https://www.nationalchildrensalliance.org/wp-content/uploads/2021/10/2023-RedBook-v5B-t-Final-Web.pdf.

Involving Advocacy Services in Pediatric Sexual Abuse Cases

The National Children's Alliance (2023) outlines the essential components of comprehensive, coordinated victim support and advocacy services provided by designated individuals who have specialized training in victim advocacy. These practice standards safeguard that advocates working with child victims of sexual abuse have received specialized training and demonstrate participation in ongoing education in the field of victim advocacy and child maltreatment. This is considered the gold standard and is essential to ensure that the advocate can provide age-appropriate support to the child while balancing the needs of the family. All Indiana counties have access to the services of a Child Advocacy Center (CAC). While a CAC may not geographically or physically be situated in every county, there is a CAC within a reasonable driving distance that is available to provide services.

Most often, advocacy services are established for child victims of sexual abuse and their caregivers through the Department of Child Services (DCS) and/or the CAC. It is not best practice, nor is it recommended, for adult advocates to provide services in child sexual abuse cases without comprehensive training in responding to the needs of children, as outlined by the National Children's Alliance. Incorporating additional support or advocacy services, outside of DCS and/or the CAC, may be redundant to the resources and support the child and family have already received. It can also lead to confusion and be overwhelming for the family while they are navigating through this process and complicates the case in its entirety. They are already being supported by many members of the multidisciplinary team, including law enforcement, healthcare, DCS, and the CAC. To preserve the integrity of this process, healthcare providers must follow the gold standard for evidence-based practice, as recommended by the National Children's Alliance. Support of the child and family should focus on involving the necessary disciplines who are trained to offer these services; specifically, DCS and/or CACs and those who meet the National Children's Alliance standards, if a CAC is unavailable to support the child and family for any reason.

In many cases, it is unlikely that a child and family will request an advocate escort during a medical forensic examination. Children who meet with DCS and/or CACs before the examination are likely to have been provided information about the examination process. Many CACs and DCS representatives do an excellent job at preparing the child and their caregiver for the examination and answering questions before the examination. Once at the hospital/clinic, children are unlikely to find the examination traumatizing. The exam is conducted in a trauma-sensitive and child-friendly manner. If a child requires encouragement or support, individuals, such as friends/family, religious or spiritual advisors, and/or facility staff (such as child-life services, chaplaincy, social work, or other mental health providers) should be considered for consultation as needed to facilitate the examination or with a specific request by the child and/or non-offending family member (United States Department of Justice, 2016). Many times, the caregiver will be present with the child during the examination; however, should the caregiver wish to sit with an advocate during the examination that support should be provided by a service organization already involved in the case (DCS or the assigned CAC), whenever available.

Child advocacy and support services do not take the place of mandatory reports to DCS and/or law enforcement.

Contacting an Advocate

For *every* healthcare provider in any clinical setting, when there is a concern or suspicion of child maltreatment, including child sexual abuse, the ***first*** point of contact should be DCS and/or law

enforcement. This notification is required of the healthcare provider, without delay, whether or not the child is seen for the medical forensic examination at presenting site.

When a child/family that has not already had contact with DCS, law enforcement, and/or a CAC for their *current* concern presents at a hospital or healthcare facility for medical care or a medical forensic examination, the healthcare provider's ***first*** point of contact should be DCS and/or law enforcement. It is not appropriate, or indicated, to involve an external advocacy service agency without the advice or approval of the investigating parties.

During a medical forensic examination, the pediatric sexual abuse provider will employ techniques and strategies that are child-friendly, patient-focused, and trauma-informed to ensure a safe, painless, comprehensive examination is completed. It will be at the joint discretion of the child, their caregiver, and the pediatric sexual abuse provider whether it is in the best interest of the child for another party to be present in the exam room and, when necessary, their assistance will be requested.

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 abuse 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 abuse providers may serve as fact or expert witnesses in the courtroom. Some considerations for pediatric sexual abuse 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 abuse provider renders to the patient at the time of the MFE, as well as the statement(s) 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 can 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 abuse provider receives a subpoena, they should immediately initiate contact with the party that issued the subpoena. The pediatric sexual abuse 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 abuse 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 abuse 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). Genevia, 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 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 abuse 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 abuse (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 abuse 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 abuse 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 abuse 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 abuse 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 abuse 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 abuse provider gives information to the caregiver about the importance of any steps declined by the patient. The pediatric sexual abuse 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 abuse 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 abuse 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 abuse provider may use forensic adjuncts to complete their examination. Considerations should be made, based on the pediatric sexual abuse 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 abuse 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 abuse 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 abuse 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 abuse 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, sexual abuse 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 abuse 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 indicated by jurisdiction time frames, and in consideration of the facts of the case, 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 National Protocol for Sexual Abuse Medical Forensic Examinations-*Pediatric* offers a comprehensive overview of evidence collection. The pediatric sexual abuse 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 abuse 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 abuse 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 abuse 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.

If the abuse occurred in another state, you may still utilize the Indiana SAEK to collect and secure evidentiary specimens. These kits will be surrendered to the jurisdiction where the crime occurred. Additionally, the hospital or healthcare facility will need to apply to that jurisdiction's Sexual Assault Victim Services Fund for reimbursement of the examination expenses. For information on how to apply to reimbursement programs in other states, please visit https://www.safeta.org/page/ptaresource/.

[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 abuse providers

should not collect evidence from prepubescent patients without the supervision, guidance, or request of a trained pediatric sexual abuse 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 abuse should ***NOT*** be placed into the Indiana 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. ***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 Abuse 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 Medical Forensic Examination records, which can be found in the Resources section of this document.

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

SECTION 1: PHYSICAL FINDINGS

A. Findings documented in newborns or commonly seen in non-abused children
These findings are normal and unrelated to a child's disclosure of sexual abuse.

Normal variants

1. Hymenal variations
    a. Annular: hymenal tissue present all around the vaginal opening including at the 12 o'clock location
    b. Crescentic hymen: hymenal tissue is absent at some point above the 3 to 9 o'clock locations
    c. Imperforate hymen: hymen with no opening
    d. Micro-perforate hymen: hymen with one or more small openings
    e. Septate hymen: hymen with one or more septae across the opening
    f. Redundant hymen: hymen with multiple flaps, folding over each other
    g. Hymen with tag or tissue on the rim
    h. Hymen with mounds or bumps on the rim at any location
    i. Any notch or cleft of the hymen (regardless of depth) above the 3 and 9 o'clock location
    j. Any notch or cleft of the hymen, at or below the 3 o'clock or 9 o'clock location, that does not extend nearly to the base of the hymen
    k. Smooth posterior rim of hymen that appears to be relatively narrow along the entire rim; may give the appearance of an enlarged opening
    Asymmetry in width of posterior hymenal rim
2. Periurethral or vestibular band(s)
3. Intravaginal ridge(s) or column(s)
4. External ridge on hymen
5. Diastasis ani (smooth area)
6. Perianal skin tag(s)
7. Hyperpigmentation of the hymen, labia minora or perianal tissues
8. Dilation of the urethral opening
9. Normal midline anatomic features
    a. Groove in the fossa, seen in early adolescence
    b. Failure of midline fusion (also called perineal groove)
    c. Median raphe
    d. Linea vestibularis (midline avascular area)
10. Visualization of the pectinate/dentate line at the juncture of the anoderm and rectal mucosa, seen when the anus is fully dilatated, as with passage or presence of flatus or stool in the anal canal

11. Reflex anal dilation that occurs during examination maneuvers, such as traction applied to perianal tissues or positioning the patient, particularly in prone or supine knee-chest positions
12. Anal dilation, causing visualization of the dentate/pectinate line, anal columns, and/or anal crypts, any of which may be mistaken for anal laceration or abrasion

B. Findings commonly caused by medical conditions other than trauma or sexual contact
These findings require that a differential diagnosis be considered, as each may have several different causes.

13. Erythema, inflammation, fissuring, and/or maceration of the perianal, perineal or vulvar tissues related to poor hygiene or other irritant dermatitis
14. Increased vascularity of the vestibule and hymen
15. Labial adhesion
16. Friability of the posterior fourchette
17. Vaginal discharge that is not associated with a sexually transmitted infection
18. Anal fissures
19. Venous congestion or venous pooling in the perianal area
20. Complete/immediate anal dilation in children with pre-disposing conditions, such as current symptoms or history of constipation and/or encopresis, or children who are sedated, under anesthesia or with impaired neuromuscular tone for other reasons

C. Findings due to other conditions, which can be mistaken for abuse

21. Irritative/non-infectious: erythema, inflammation, and fissuring of the perianal, perineal or vulvar tissues due to irritant dermatitis, including Jacquet's dermatitis
22. Inflammatory: aphthous ulcers, inflammatory bowel disease (anal fissues/prominent anal tags, rectal discharge), Behcets disease (painful ulcers)
23. Dermatologic conditions: lichen sclerosus et atrophicus, folliculitis, vitiligo, angiokeratomas, and hemangiomas
24. Immunologic causes: pyoderma gangrenosum (painful ulcers)
25. Multifactorial/idiopathic: urethral prolapse, rectal prolapse, anal funneling
26. Post-mortem changes: anal dilatation, red/purple discoloration of the genital structures (including the hymen) from lividity or other rare systemic conditions. Histologic analysis needed for confirmation.

D. No expert consensus regarding degree of significance
These physical findings have been associated with a history of sexual abuse in some studies, but at present, there is no expert consensus as to how much weight they should be given with respect to abuse. Findings 28 and 29 should be confirmed using additional examination positions and/or techniques, to ensure they are not normal variants (findings 1. i. 1.j.) or a finding of residual traumatic injury (finding 38).

27. Complete and immediate anal dilation with relaxation of the internal as well as external anal sphincters, in the absence of other predisposing factors such as constipation, encopresis, sedation, anesthesia, and neuromuscular conditions
28. Notch or cleft in the hymen rim, at or below the 3 o'clock or 9 o'clock location, which extends nearly to the base of the hymen, but is not a complete transection. This is a very rare finding that should be interpreted with caution unless an acute injury was documented at the same location.

29. Complete cleft/suspected transection to the base of the hymen at the 3 or 9 o'clock location

E. Findings caused by trauma

These findings are highly suggestive of abuse, even in the absence of a disclosure, unless the child and/or caretaker provides a timely and plausible description of accidental anogenital straddle, crush or impalement injury, or past surgical interventions that are confirmed from review of medical records. Findings that may represent residual/healing injuries should be confirmed using additional examination positions and/or techniques. Isolated/few/superficial injuries that appear to be bruises or petechiae should be confirmed as traumatic injury by showing resolution on follow up examination. Photographs or video recordings of these findings should be taken, then evaluated and confirmed by an expert in sexual abuse evaluation to ensure accurate diagnosis.

1) Acute trauma to genital/anal tissues

30. Acute laceration(s) or bruising of labia, penis, scrotum, or perineum
31. Acute laceration of the posterior fourchette or vestibule, not involving the hymen
32. Bruising, petechiae, or abrasions on the hymen
33. Acute laceration of the hymen, of any depth; partial or complete
34. Vaginal laceration
35. Perianal bruising or perianal laceration with exposure of tissues below the dermis

2) Residual (healing) injuries to genital/anal tissues

36. Perianal scar (a very rare finding that is difficult to diagnose unless an acute injury was previously documented at the same location
37. Scar of posterior fourchette or fossa (a very rare finding that is difficult to diagnose unless an acute injury was previously documented at the same location)
38. Healed hymenal transection/complete hymen cleft-a defect in the hymen below the 3 o'clock or 9 o'clock location that extends to or through the base of the hymen with no hymenal tissue discernible at that location
39. Signs of female genital mutilation (FGM) or cutting, such as part or all of the prepuce (clitoral hood), clitoris, labia minora or labia majora, or vertical linear scar adjacent to the clitoris (Type 4 FGM)

3) Acute trauma to oral tissues

40. Acute oral trauma, such as unexplained injury or petechiae of the lips or palate, particularly near the junction of the hard and soft palate

SECTION 2: INFECTIONS

A. Infections not related to sexual contact

41. Erythema, inflammation, fissuring or perianal, perineal, or vulvar tissues due to bacteria, fungus, virus or parasites that are transmitted by non-sexual means, such as Streptococcus Type A or Type B, Staphylococcus sp., Escherichia coli, Shigella or other gram-negative organisms
42. Genital ulcers caused by viral infections such as Epstein Barr Virus

B. Infections that can be spread by (or are associated with) sexual transmission as well as non-sexual transmission

Interpretation of these infections may require additional information, such as mother's gynecologic history (HPV) or child's history of oral lesions (HSV), or presence of lesions elsewhere on the body (Molluscum) which might clarify likelihood of sexual transmission.

43. Molluscum contagiosum in the genital or anal area. In young children, transmission is most likely non-sexual. Transmission from intimate skin-to-skin contact in the adolescent population has been described.
44. Condyloma acuminatum (HPV) in the genital or anal area
45. Herpes Simplex Type 1 or 2 infections in the oral, genital or anal area diagnosed by culture or nucleic acid amplification test.
46. Urogenital Gardnerella vaginalis (associated with sexual contact but also found in prepubertal and adolescent vaginal flora)
47. Urogenital Mycoplasma genitalium or ureaplasma urealyticum; while sexually transmitted in adolescents, prevalence and transmission of these infections in children not well understood

C. Infections caused by sexual contact, if confirmed by appropriate testing, and perinatal transmission has been ruled out

48. Genital, rectal or pharyngeal *Neisseria gonorrhea* infection
49. Syphilis
50. Genital, rectal or pharyngeal *Chlamydia trachomatis* infection
51. *Trichomonas vaginalis* infection isolated from vaginal secretions or urine
52. HIV, if transmission by blood or contaminated needles has been ruled out

SECTION 3: FINDINGS DIAGNOSTIC OF SEXUAL CONTACT

53. Pregnancy
54. Semen identified in forensic specimens taken directly from a child's body
    - 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)

Reference:
Kellogg, N., Farst, K., & Adams, J. (2023). Interpretation of medical findings in suspected child sexual abuse: An update for 2023.
* Reprinted with permission.

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 abuse 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, or 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 abuse 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 abuse 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 abuse 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 abuse 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 abuse provider can guide the child through body safety practices and reinforce that the child is in charge of their body. The pediatric sexual abuse 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 abuse 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 abuse 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 abuse 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
- T. vaginalis
- HIV (non-transfusion and non-perinatal acquired)

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

- Genital herpes
- Anogenital warts

The American Academy of Pediatrics' Committee on Child Abuse and Neglect and the Center for Disease Control and Prevention suggest that STI testing in pre-pubescent children should be considered when:

1) Child has experienced penetration of the genitals, anus or oropharynx
2) Child has been abused by a stranger
3) Child has been abused by a perpetrator known to be infected with an STI or is at high risk for being infected (intravenous drug users, men who have sex with men, or people with multiple sexual encounters)
4) Child has a sibling or other relative in the household with an STI
5) Child discloses sexual abuse and lives in an area with a high rate of STI in the community
6) Child has signs and symptoms of an STI
7) Child has already been diagnosed with one STI
8) The abused child or their parent requests STI testing
9) The child is unable to verbalize details of the abuse
10) The sexual abuse has been witnessed or documented with photos or video

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 below will guide healthcare providers and those serving child victims of sexual abuse whether the infection provides evidence for sexual abuse and the recommended action to be taken. For infections noted *suspicious* or *inconclusive*, medical follow up should include screening for sexual abuse and may include testing for 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

Infection	Evidence for sexual abuse	Recommended action
Gonorrhea*	Diagnostic	Reportǂ
Syphilis*	Diagnostic	Reportǂ
HIV§	Diagnostic	Reportǂ
*Chlamydia trachomatis**	Diagnostic	Reportǂ
*Trichomonas vaginalis**	Diagnostic	Reportǂ
Anogenital herpes	Suspicious	Consider reportǂ¶
*Condylomata acuminata** (anogenital warts)	Suspicious	Consider report ǂ¶**
Anogenital molluscum contagiosum	Inconclusive	Medical follow-up
Bacterial vaginosis	Inconclusive	Medical follow-up

Source: Centers for Disease Control (2021) STI 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; Adams, JA, Farst, KJ, Kellogg, ND. Interpretation of medical findings in suspected child abuse: an update for 2018. Journal of Pediatric Adolescent Gynecology 2018; 31:225-31.
*If unlikely to be perinatally acquired and vertical transmission, which is rare, is excluded.
ǂ Reports should be made to the local or state agency mandated to receive reports of suspected child abuse or neglect.
§ If unlikely to have been 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. Lesions appearing for the first time in a child aged >5 years are more likely to have been caused by sexual transmission.

Additional 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.

It is ideal for STI treatment to 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 Abuse Providers

Documentation is an essential component of the medical forensic examination (MFE). In order to obtain the best possible information, a pediatric sexual abuse 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 Pediatric Medical Forensic Examination Record, which can be found in the Resources section.

Pediatric sexual abuse 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 (when indicated; *not* to be used in prepubescent females)
    - Speculum (when indicated; *not* to be used in prepubescent females with an unestrogenized hymen unless there are concerns for bleeding, mass or foreign body. If a speculum examination is required, sedation or anesthesia must be used. In this case, a consultation with an appropriate pediatric specialist is necessary.)
    - Moist swab (when indicated; not to be used on or near the prepubescent hymen)
    - 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 ("internal" female sex organ refers to all structures beyond the plane of the labia majora) During examination and evidence collection, the examiner should use extreme caution to avoid contact with an unestrogenized hymen. Do not insert evidentiary or diagnostic swab(s) into the vagina of a pre-pubescent patient.
    - Cervical (if speculum used; only if Tanner 3 or greater with menarche)
    - Speculum
    - External male sex organ
    - Anal folds
    - Anal canal
    - Perineum
    - Intergluteal cleft
    - Sacrum/lower back
    - Panty liner or tampon
    - Underwear worn during abuse
    - 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 Abuse Compensation Fund application (if the crime occurred in Indiana)
- Chain of custody form(s)

A specimen collection summary form can be found in the Medical Forensic Examination Record included in the Resources section of this document.

Photo Documentation Guidelines for Pediatric Sexual Abuse 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 abuse 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 abuse 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 (if utilized)
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 abuses).
- 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 abuse 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.

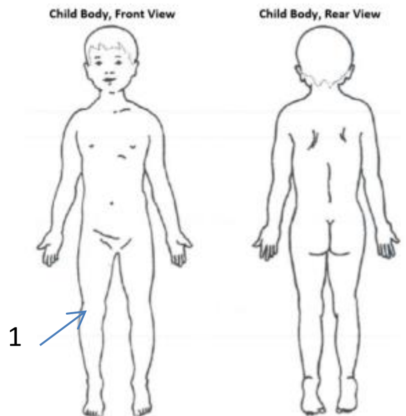
It is best practice that all patient charts include a body map/diagram even when photographs have been obtained.

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 abuse 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 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



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 within the Medical Forensic Examination record in the Resources section.

It is critical that a pediatric sexual abuse 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 abuse 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 abuse 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 abuse 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-abuse reactions of the child.
- Community sexual abuse advocacy programs.

The discharge planning process is an opportunity for the pediatric sexual abuse 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 abuse 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 abuse provider, that appointment should be scheduled with the same pediatric sexual abuse provider whenever able.

Peer Review and Quality Improvement for Pediatric Sexual Abuse Providers

Pediatric sexual abuse 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 abuse provider's competency and documentation (including photo documentation) are recommended to ensure safe, high-quality examinations from proficient providers.

Pediatric sexual abuse providers are encouraged to participate in the local Sexual Abuse Response Team (SART) as well as a multidisciplinary team (MDT). MDTs are encouraged to include the pediatric sexual abuse provider who conducted the child's examination, whenever possible, when evaluating or reviewing a case. This ensures the pediatric sexual abuse 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 abuse 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 abuse 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 abuse 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 pediatric sexual abuse providers to become accustomed to the program's practices and documentation requirements. New pediatric sexual abuse 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 abuse 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 abuse 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 abuse (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.

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 abuse 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 Abuse 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 ages 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 abuse (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 abuse 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 abuse. These services must be a result of the abuse 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.

If the crime occurred outside the state of Indiana, the hospital/healthcare facility will apply for medical forensic examination reimbursement directly to the state where the crime occurred. For information on how to apply to reimbursement programs in other states, please visit: https://www.safeta.org/page/ptaresource/

Healthcare Facility Policies and Procedures

When providing care for patients with medical forensic needs, it is judicious that each hospital/healthcare 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

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/abuse. 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 abuse 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 abuse 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 abuse 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 Abuse Providers

Pediatric sexual abuse 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 abuse 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 abuse 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 abuse 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 abuse 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 abuse 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 abuse providers should be encouraged and supported to actively participate in multidisciplinary collaborations including multidisciplinary teams (MDTs) and sexual abuse 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 abuse 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 abuse 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 violence[1] or incidents involving human factors[2]; and victims of natural causes of trauma (ANA & IAFN, 2017).

[1] Child abuse, elder and vulnerable person abuse, intimate partner abuse and abuse, sexual abuse/abuse, 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 abuse providers should participate in quality assurance and peer review initiatives. Pediatric sexual abuse 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 Abuse 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 abuse 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 abuse 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 Ascension St. Vincent
Center of Hope: (317) 338-1956
Pediatric Emergency Department: (317) 338-4366
Non-urgent needs: (317) 338-3153

References

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.

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.jpag.2015.01.007.

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.

Adams, J.A., Farst, K.J., Kellogg, N.D. (2018). Interpretation of medical findings in suspected child sexual abuse: An update for 2018. *Journal for Pediatric and Adolescent Gynecology 31*. 225-231. doi: 10.1016/j.jpag.2017/12.011.

American Nurses Association and International Association of Forensic Nurses (2017). *Forensic nursing scope and standards of practice* (2nd ed.). Silver Spring, MD: ANA and IAFN.

Bays, J., & Chadwick, D. (1993). Medical diagnosis of the sexually abused child. *Child Abuse & Neglect. 17*. 91-110.

Centers for Disease Control and Prevention. (2021). 2021 Sexually Transmitted Diseases Treatment Guidelines. Retrieved from www.cdc.gov.

End Violence Against Women, International. (2023). *Medical forensic examination timelines.* FAQ Friday email update. 17 Nov 2023.

Evidentia Learning. (Producer). (2019). *Medical evaluation of child and adolescent sexual abuse.* [Video e-learning series]. Retrieved from www.evidentialearning.com.

Indiana Coalition to End Sexual Assault, Indiana Chapter of the International Association of Forensic Nurses & Indiana Emergency Nurses Association (2019). *Guidelines for the medical forensic examination for adult and adolescent sexual assault patients*. Retrieved from: https://www.safeta.org/wp-content/uploads/2021/08/Indiana-Guidelines.pdf

Indiana Criminal Justice Institute (2020). Retrieved from https://www.in.gov/cji/.

Indiana Criminal Justice Institute (2020). *Indiana statewide sexual abuse kit tracking system*. Retrieved from: https://SAEK.cji.in.gov/Public/Home.aspx.

Indiana Department of Child Services (2020). Retrieved from: www.in.gov/dcs

Indiana General Assembly (2019). Indiana Administrative Code §16-21-8-1.8(b). Retrieved from: http://iga.in.gov/legislative/laws/2019/ic/titles/016/#16-21-8.

Indiana General Assembly. (2019). Indiana Code §31-33-5. Retrieved from: http://iga.in.gov/legislative/laws/2019/ic/titles/031/#31-33-5.

Indiana General Assembly. (2019). Indiana Code §31-33-6. Retrieved from: http://iga.in.gov/legislative/laws/2019/ic/titles/031/#31-33-6.

Indiana General Assembly. (2019). Indiana Code §35-42-4. Retrieved from: http://iga.in.gov/legislative/laws/2019/ic/titles/035/#35-42-4.

Indiana General Assembly. (2019). Indiana Code IC §36-2-14. Retrieved from: http://iga.in.gov/legislative/laws/2019/ic/titles/036/#36-2-14.

Indiana Prosecuting Attorneys Council (2020). Retrieved from: www.in.gov/ipac.

Indiana Rules of Court (2020). Rules of Evidence. Retrieved from: https://www.in.gov/judiciary/rules/evidence/.

Indiana Trafficking Victim's Assistance Program. (2020). *Quick indicator tool-healthcare*.

Jenny, C., & Crawford-Jakubiak, J.E. (2013). The evaluation of children in the primary care setting when a sexual abuse is suspected. *Pediatrics, 132*(2), e558-e567. doi: 10.1542/peds.2013-1741

Kellogg, N., Farst, K., Adams, J. (2023). Interpretation of medical findings in suspected child sexual abuse: an update for 2023. *Child Abuse and Neglect*. doi: 10.1016/j.chiabu.2023.106283

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

Kellogg, N. (2005). The evaluation of child abuse in children. *American Academy of Pediatrics Committee on Child Abuse and Neglect* 116: 506–12.

National Children's Advocacy Network. (2020). Retrieved from: www.nationalcac.org.

National Children's Alliance (2023). Standards for accredited members. Retrieved from: www.nationalchildrensalliance.org.

National Child Traumatic Stress Network, Child Sexual Abuse Collaborative Group. (2014). LGBTQ youth and sexual abuse: Information for mental health professionals. Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress. Retrieved from https://www.nctsn.org/sites/default/files/resources//lgbtq_youth_sexual_abuse_professionals.pdf.

Rape, Abuse, and Incest National Network. (2020). Retrieved from www.rainn.org.

Secure Digital Forensic Imaging. (2018). *SDFI forensic photography photo documentation protocol*. Retrieved from http://www.sdfi.com/downloads/SDFI_Digital_Protocol.pdf.

Thomson, K., & Katz-Wise, S.L. (2017). Gender identity and pronoun use: A guide for pediatric health care professionals. Boston, MA: Boston Children's Hospital. Retrieved from https://www.childrenshospital.org/-/media/Centers-and-Services/Programs/F_N/Gender-Management-Service/GenderPronouns_Ebook.ashx?la=en&hash=7661BAFAC2B9FE662B65C931D7060597D90731F6

United States Department of Justice (2013). A national protocol for sexual assault medical forensic examinations adult and adolescent. Retrieved from: https://www.ncjrs.gov/pdffiles1/ovw/241903.pdf.

United States Department of Justice (2016). *A national protocol for sexual abuse medical forensic examinations pediatric*. Retrieved from: https://www.justice.gov/ovw/file/846856/download.-

United States Department of Justice (2017). National best practices for sexual assault kits: A multidisciplinary approach. Retrieved from: https://www.ncjrs.gov/pdffiles1/nij/250384.pdf.

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

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 abuse provider: For the purpose of this document, a *pediatric sexual abuse provider* is an inclusive term that includes medical providers or clinicians, including registered nurses, pediatric sexual abuse 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 Abuse Response Team (SART): A multidisciplinary partnership that outlines a consistent and coordinated response to sexual abuse 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 abuse nurse examiners (SANEs), advocates, and crime labs.

Resources

Resources for Pediatric Sexual Abuse 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 Abuse and Human Trafficking www.icesaht.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

National Protocol for Sexual Abuse Medical Forensic Examinations-Pediatric
https://nij.ojp.gov/library/publications/national-protocol-sexual-abuse-medical-forensic-examinations-pediatric

Prevent Child Abuse Indiana www.pcain.org

RAINN www.rainn.org

Sexual Abuse 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 Abuse 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. Additional forms for forensic nurse record keeping can be accessed at www.usi.edu/IndianaSANE.

Adult/Adolescent Medical Forensic Examination Record

Pediatric Medical Forensic Examination Record

Patient Discharge/Plan of Care