Advocate Children’s Hospital
Pediatric Sexual Assault/Abuse
Quick Guide
Pediatric ED
**Definition of pediatric sexual abuse**

“The involvement of children or adolescents in sexual activity that they do not understand to which they cannot give informed consent, or that violates social taboos.”

This includes: fondling, genital contact, penetration, exposure and pornography

**Definition of Penetration**

Contact, however slight, of the labia or rectum by the penis, other body part or foreign object

**Triage:**

- Identify sexual assault/abuse patient.
- Presentation:
  - Disclosure or outcry
  - Physical complaints related to the abuse (vaginal discharge, rash, bleeding)
  - Physical complaints unrelated to the abuse (child with recurrent somatic complaints who reveals sexual abuse when asked about life stressors)
  - Medical Evaluation
  - Make a report to police and DCFS

<table>
<thead>
<tr>
<th>Acute</th>
<th>Late Disclosure</th>
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<tbody>
<tr>
<td>7 days or less since assault/abuse or contact with the perpetrator</td>
<td>More than 7 days since assault/abuse or contact with the perpetrator</td>
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</table>
| Must offer medical forensic exam and evidence collection per SASETA 
_Evidence collection is encouraged for prepubescent patients who present with a complaint of sexual assault/abuse within a minimum of 96 hours after sexual assault/abuse._ | Needs medical screening exam to be done in ED
  - Medical concerns must be addressed |
| Refer to Advocate Children’s Child Protection Team for sexual abuse examination. 
Oak Lawn & Park Ridge: 847-723-7714 | |

- Notify Rape Advocates as soon as possible
- Place in a private room as soon as possible.
- Do not give the patient food or drink.
- Do not undress the patient if they may have evidence collected.
- If possible obtain a dirty urine specimen for GC/Chlamydia.
- Child Sexual Abuse Flowchart (Green).

**Please remember this is often not a medical emergency but it is a psychosocial emergency for the child and the family. Often you are the first contact person after a disclosure and you set the tone for the evaluation and healing process.**

.Creator: Advocate Children’s Child Protection Team/SANE  Creation Date: May 9, 2018  Review Date: July 22, 2019
History:
This is the most important part of the evaluation!

Prepubescent:
- Privately Interview caregiver
  - Obtain details of concern/outrage/disclosure
  - Document history using quotes as much as possible
  - Clearly attribute all statements to the person who made them
- Limit questioning of the prepubescent child *
  - History obtained from the prepubescent child should be limited to information needed for medical decision making.
  - Use open ended questions such as “Why you are here?” Avoid yes/no questions
  - Document any spontaneous disclosures in quotes
  - Do not ask child the detailed questions from the evidence kit paperwork.

*NOTE: Children will be interviewed by a trained forensic interviewer. DCFS and/or police will arrange a Forensic Interview (FI) at local Children’s Advocacy Center (CAC)

Adolescent:
- Interview adolescent privately
- If collecting evidence, ask detailed questions on kit paperwork
- Document history using quotes as much as possible
*Note: Adolescents under 18 years will also have a forensic interview (FI).

Remember to take the history in an accepting manner; sexual abuse is not always viewed by the child as traumatic so expressing shock or dismay could be harmful to their mental state or perception.

- Adverse childhood experiences such as this often lead to depression, suicidal/homicidal ideation, and other at risk behaviors. It is imperative to assure the child receives appropriate referral to mental health care professionals and rape advocacy services.
- Pediatric sexual abuse affects the entire family. Remember that in many cases the abuser is known to the family and is often trusted by the child and parents. This crime is a breach of trust to the entire family and there is much anger and guilt associated with it.
- Be sensitive to parental concerns as a parent may be a survivor of pediatric sexual abuse themselves.
CONSENT/ASSENT

Consent (SASETA)

- Any aged person can consent to their own treatment and evidence collection related to sexual assault
- 13yo or older may consent to photographs, report to police and to release evidence to law enforcement for testing/holding (parents may not sign consent)
  - This can be a tricky situation sometimes. It is a good idea to separate the adolescent from the parent to discuss this privately with the adolescent. The adolescent has final say.
  - Adolescent must sign forms
- Under 13yo: parents, DCFS, law enforcement consent to photography, report to police and release evidence to law enforcement for testing/holding (parents sign)

Informed Consent

- Explain the nature of the exam
  - Much like a well-child exam
  - Not an invasive procedure-no speculum in prepubescent/young adolescent girls
  - Explain options and encourage questions
- Consent can be withdrawn at any time
- Consent can be partial, that is they can decline aspects of the exam

Assent

Definition: The expressed willingness of an individual to participate in an activity

- Seek the prepubescent child’s assent for care throughout the exam process
  - Child focused, victim centered, trauma informed approach heightens the child’s comfort and trust
  - Very important, wishes are respected and control is returned to the child
  - Explain the process in terms the child can understand
  - Takes time and patience
- Do not proceed with the exam without the assent/cooperation of the child.... even if the parent consents
- Do not restrain, coerce or sedate child to do the examination
  - Re-traumatizes
- If child not tolerating exam consider if they can be re-examined in the future or utilizing child life specialist
- Exceptions: serious medical injury, pain or trauma
  - Transfer to pediatric facility for exam under anesthesia

<table>
<thead>
<tr>
<th>Child’s Age</th>
<th>Child (consider her/his development level and linguistic capacity and preferences when planning if/how to seek assent)</th>
<th>Child’s Parent/Guardian</th>
<th>If No Parent/Guardian or Parent/Guardian Is Not Acting in Child’s Best Interest</th>
<th>Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>Generally not capable of informed assent (but consider each child’s developmental capacity)</td>
<td>Informed consent</td>
<td>Follow jurisdictional/facility policies for seeking consent in these instances</td>
<td>Written consent</td>
</tr>
<tr>
<td>6-11</td>
<td>Generally capable of informed assent (but consider each child’s developmental capacity)</td>
<td>Informed consent</td>
<td>Follow jurisdictional/facility policies for seeking consent in these instances</td>
<td>Oral assent, written consent</td>
</tr>
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National Pediatric Sexual Abuse Protocol
Creator: Advocate Children’s Child Protection Team/SANE  Creation Date: May 9, 2018  Review Date: July 22, 2019
Reporting to the Police

Law Enforcement must complete a written report when they receive information about a sexual assault from a victim or a hospital, regardless of where crime occurred;

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<tr>
<th>Patient consents to reporting to police or consents to Healthcare provider making report</th>
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<tbody>
<tr>
<td>Call PD in the town where the assault occurred (use your best judgment)</td>
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<tr>
<td>Request officer to come to ED to make report</td>
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<tr>
<td>If the PD requests that patient be sent to the station to make the report, ask to speak to a supervisor and request officer be sent to ED to make a report.</td>
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<table>
<thead>
<tr>
<th>Patient does not want to make report</th>
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<tbody>
<tr>
<td>Healthcare providers are mandated reporters And <strong>MUST</strong> notify police a crime occurred</td>
</tr>
<tr>
<td>Call the PD in the town where the assault occurred (use your best judgment)</td>
</tr>
<tr>
<td>Tell PD you would like to report a sexual assault, <strong>do not</strong> provide patient name.</td>
</tr>
<tr>
<td>Ask for a report number</td>
</tr>
<tr>
<td>Document report number in the chart</td>
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<tr>
<td>If the patient has had an evidence collection kit completed, request pick up of kit</td>
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<tr>
<td><strong>If the patient had evidence collected, use the report number instead of the patient’s name as the identifier on the consent form and evidence collection box, all other paperwork sealed inside of kit should have the patient’s name.</strong></td>
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Reporting to DCFS

- Victim must be less than 18 years old
- Alleged perpetrator must be parent, step parent, paramour, guardian, foster parent, immediate family member, anyone living in the home, a person in known positions of trust, a person responsible for the well fare of the child.
  - This includes perpetrators who are minors (i.e. minor on minor)
- Complete CANTS form
**Physical Exam:**

The majority of physical exams are normal and a normal physical exam does NOT exclude abuse from the differential.

- Use Child Life Specialist when available
- Note mental state at time of exam
- Note any signs of physical abuse/neglect
- Complete head to toe physical exam
- Perform the general physical exam before the genital exam

<table>
<thead>
<tr>
<th>Prepubescent</th>
<th>Adolescent</th>
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| • Less than or equal to age 12 years  
• Pre-menarche female | • More than or equal to age 13 years  
• Post-menarche female |

**Male Genital Exam**
- A physician must be present for the genital exam unless a Pediatric SANE* is available
- Position: Lying or standing
- Examine the external genitalia for signs of injury or infection

**Female Genital Exam**
- A physician must be present for the genital exam unless a Pediatric SANE* is available
- Position**: Frog leg or lithotomy on caretaker’s lap. Prone knee/chest position should be performed if an abnormality is seen to verify presence in two positions.
- Use separation and traction techniques
- Examine the external genitalia for signs of injury or infection
- Examine the genitalia within the labia majora by visual exam using separation and traction
- Do NOT insert a speculum. If a speculum exam is required, the child will need the exam done under anesthesia

**Male/Female Anal/Perineal Exam**
- Examine anal/perianal areas
- Position: supine knee chest or side-lying

**Female Genital Exam**
- A physician must be present for the genital exam unless a Pediatric or Adolescent SANE* is available
- Position: Lithotomy
- Prone knee/chest position should be performed if an abnormality is seen to verify presence in two positions.
- Use separation and traction techniques
- Examine the external genitalia for signs of injury or infection
- Examine the genitalia within the labia majora by visual exam using separation and traction
- May consider an internal exam (speculum) on a case by case basis (e.g. older adolescent, sexually active adolescent). If done, must be done after the visual exam.

**Male/Female Anal/Perineal Exam**
- Examine anal/perianal areas
- Position: supine knee chest or side-lying

*NOTE: A Pediatric SANE (for prepubescent/adolescent children) or an Adolescent SANE who has completed all clinical requirements may conduct the medical forensic exam, genital exam and evidence collection. An ED physician will need to conduct the medical screening exam.

** See next page for diagram of anatomy of prepubescent genitalia and positioning for prepubescent females

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Positioning for Prepubescent Females:

A Supine frog-leg or butterfly position

B Knee-chest position

Labial separation

Labial traction


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Prepubescent Genitalia:

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SEXUAL MATURITY RATING

I
II
III
IV
V

I
II
III
IV
V

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Documentation of Findings:

Remember, the majority of physical exams will be normal, a normal exam does not exclude abuse from the differential.

Females:
- Presence of scars, bruises, lacerations, bleeding, lesions, ulcers, rash, or discharge on the external genitalia or perineum
- Describe hymenal tissue
- Presence of transections/lacerations, abrasions, bruising on hymenal rim and/or external genitalia
- Use a clock face orientation to describe findings (12 o’clock is the urethra and 6 o’clock is the posterior fourchette)
- Do not measure hymenal openings: varying diameters are non-specific findings
- In post-pubertal females, perform a speculum exam AFTER the visual exam if necessary.

Males:
- Presence of scars, bruises, lacerations, bleeding, lesions, ulcers, rash on the penis, scrotum, and perineum.

Anal/Perineal:
- Visual assessment of anal tone: may perform rectal exam to correlate
- Presence of scars, bruises, lacerations, bleeding, lesions, ulcers or rash.

Figure 1: Schematic representation of the female genital structures with “clock face” numbers superimposed.

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Medical Management:

- Review Pediatric Standard Protocol for Sexual Assault Prophylaxis (Blue pinstripe pages)
- Use “ED Sexual Assault Power Plan AHC” in First Net for ordering
- Physicians: utilize the Sexual Assault Macro for documentation of medical management

HIV Post Exposure Prophylaxis (HIV PEP)

- Consider HIV PEP if the patient presents within 72 hours of sexual abuse
- Review the Pediatric Standard Protocol for Sexual Assault Prophylaxis HIV PEP decision tree (Blue pinstripe pages)
- Order labs as indicated via Sexual Assault Power Plan AHC
- Order HIV PEP medications from the Sexual Assault Power Plan AHC
  - Pharmacy will send a 3-day HIV PEP starter pack, give first dose from starter pack in ED
  - Ensure patient goes home with prescription for 25 days of both meds in the HIV PEP starter pack
Evidence Collection Pearls:

According to SASETA (Sexual Assault Survivors Emergency Treatment Act) an evidence collection kit **MUST** be offered to any patient who presents to the ED within 7 days of the sexual assault/abuse. If timeframe is unclear offer evidence kit if last contact with perpetrator was within the last 7 days.

See Treatment of the Sexual Assault Patient Policy for detailed instructions on evidence collection

*Be sure evidence collection kit is new, with seal intact. Open kit in the presence of the patient.

*DO NOT LEAVE KIT “UNATTENDED” ONCE KIT HAS BEEN OPENED*

Pre-Pubescent:

- Remember assent and cooperation are crucial
- Take time to explain exactly what you will be doing. If possible allow children to touch swabs.
- Reassure that this should not hurt. Remind patient /parent that nothing goes inside a pre-pubescent girl
- Allow child to help with steps if they are able
- If you are unable to get a clear history of what occurred or a detailed account of the abuse is not available complete **ALL** steps of the kit
- If there is no oral contact you may use a buccal swab as standard instead of blood
- Collect underwear/diaper (Do not place wet items in evidence box, package separately in a paper bag)
  - Underwear and linen are the most likely positive sites for DNA in pre-pubescent children
- Female genital swabs: Do not swab hymen or vaginal canal
  - Use vaginal/penile envelope swabs to swab labia minora, clitoris, clitoral hood, posterior fourchette, and fossa navicularis. (Label envelope to indicate “external genital, internal exam deferred”)
  - Use miscellaneous envelope to swab labia majora
  - Consider swabbing additional areas based on history

Adolescent:

- Consider speculum placement if older adolescent or sexually active teen
- If no speculum placement swab as described above

**Drug Facilitated Sexual Assault (DFSA) aka “Date Rape Drugs”**

**This is an evidentiary urine toxicology, it is not sent to our lab. It is sent to the ISP Forensic Lab and will be tested for a whole slew of drugs including date rape drugs**

- Testing for “date rape drugs” can be done if the patient presents within 5 days of the encounter.
- Obtain a specimen for an evidentiary urine toxicology if patient states they’ve had a loss of memory or consciousness or just feels like she/he was given something.
- Obtain a “dirty” urine as soon as possible
  - See number 4 in Collection of Evidence Procedure (above)
- See Treatment of Sexual Assault Patient policy for Consent form, directions on completing form, and patient education materials.
- If indicated for medical treatment, send an additional urine sample to our lab for toxicology

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Discharge

- Complete evidence collection kit Patient Discharge Material
- If evidence collection completed make sure they have a copy of the evidence collection kit consent form and their police report number
- Give the patient a medication information sheet for every medication given in the ED or as a prescription
- Give patient the “After Sexual Assault” brochure and Crime Victims Compensations-Sexual Assault FAQ sheet (may be placed in a Sexual Assault Discharge folder)
- Refer to Child Protection Team for follow up
  - Oak Lawn & Park Ridge: 847-723-7714
- Fax patient face sheet to Child Protection Team
  - Oak Lawn & Park Ridge Fax: 708-684-4725

Follow Up

- Follow up in 2 weeks with Child Protection Team or primary pediatrician
  - Sooner if symptoms appear

2 week recommendations (if needed)
- If you have symptoms of infection as listed below:
  - Burning or pressure during urination
  - Sores, blisters or small, white and/or gray growths or warts
  - “Flu-like” symptoms
  - Discharge
  - Unexplained bleeding
  - Pelvic pain or painful intercourse
  - Rash on groin, mouth, palm of hands, arms, legs or torso
  - Swollen areas in groin
  - Screening for trichomonas, bacterial vaginosis, herpes, HPV
  - Re-check injuries if needed

6 week recommendations
- Serologic testing for syphilis
- HIV test
- 2\textsuperscript{nd} hepatitis B vaccination (if needed)
- 2\textsuperscript{nd} HPV vaccination (if needed)
- Reevaluate for the development of anogenital warts
- Pregnancy test (if no menses since assault)

3 month recommendation
- Serologic testing for syphilis
- HIV test
- Reevaluate for the development of anogenital warts

6 month recommendation
- HIV test
- 3\textsuperscript{rd} Hepatitis B vaccination (if needed)
- 3\textsuperscript{rd} HPV vaccination (if needed)
- Reevaluate for the development of anogenital warts

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